ECONOMY

India Must Move Beyond IPR-Protection to Focus on Better Health Outcomes

A lack of a strong IPR regime and drug price control – India is already among the five offenders on drug tariffs – delay innovation and the advent of cutting edge medicines.

People crowd outside a chemist store in New Delhi, February 2, 2018. Credit: Reuters/Saumya Khandelwal

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ECONOMY HEALTH 03/OCT/2018

While US President Donald Trump has largely focused on his grievances with trade – going as far as to refer to India as a "tariff king" – it remains to be seen how Indian policy makers handle Intellectual Property Right (IPR) related issues, which has historically been a source of contention between America and India.

After all, for all we know, IPR-related issues could have triggered the current trade war between US and China. The Trump administration has accused China of reverse engineering designs that US firms spent millions to develop. In an era of globalisation in which knowledge-based industries form the bedrock of the most successful economies, IPRs must be considered as fundamental market institutions, alongside physical property rights and the rule of law.

India also has one of the highest tariff rates when it comes to pharmaceutical imports. India is at the top (or more properly, bottom) five offenders on drug tariffs, with a levy of 10% across the board on all categories of imported medicines and vaccines. Only the governments of Nepal, Pakistan, DR Congo (11%) and Russia (10.2%) charge their ill citizens more. The value of global export in pharmaceutical items has grown from $228 billion in 2006 to $ 506 billion in 2016. In simple terms, this means people in countries such as India, Pakistan, and Russia have to pay more for medicines.

drug prices, so they should be abolished for better public health. This premise is particularly important for a country like India, with the NSSO survey pointing out 86% of the rural population and 82% of the urban population are still not covered under any health insurance scheme (private or public) and millions are pushed into poverty every year to meet their medical expenses.

The most common and often misleading perception is a stronger patent regime will increase the prices of medicines, hitting the poor harder as they spend a larger portion of their disposable income towards medical treatment. It is to be noted, as per the NSSO survey, that 70% of India's population who still reside in rural areas has to borrow more (25%) in comparison to their urban counterparts (18%) to meet their healthcare needs.

How true is the perception that a stronger IPR regime by increasing price of medicines can negatively affect health outcomes? The Indian government's National IPR Policy is a mellowed down version that purports to promote innovation and entrepreneurship while ensuring access to healthcare, food security, and environmental protection. No changes have been made to section 3(d) of the Indian Patents Act, which prevents evergreening of drug patents. Compulsory licensing is also retained despite US demands for this to be watered down.

To put things into perspective, in 1994, the push towards globally harmonised standards of IPR culminated in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), administered by the World Trade Organization (WTO). TRIPS introduced IP law into the international trading system for the first time, and set out minimum standards of IP protection that all WTO members have to afford to creators from other WTO members. TRIPS required all WTO members to grant patents with a minimum term of twenty years for inventions in all fields of technology. This new international standard had particular relevance to medicines, given the very different laws on patents that existed at the national level prior to TRIPS (India prior to 2005 did not grant product patents, for example, allowing generic manufacturers to work around existing inventions to produce copies).

To accommodate the perception that MNCs may charge higher prices for medicine, the 2001 'Doha Declaration' clarified several public health aspects

determine the grounds upon which such licences are granted." (paragraph 5(b)), wherein the government gives a third-party authorisation to override a patent.

Since 2001, several lower and middle-income countries have issued compulsory licenses (the majority for HIV medicines), generally citing high prices as a justification. However, as has been documented in academic literature, compulsory licenses are used more as a barrier for innovations, often failing to reduce price of medicines, the intention with which it is included in the TRIPS Agreement.

In fact, other IPR-plus factors such as tariffs and non-tariffs barriers, inefficient supply chains, a lack of proper healthcare service management, and cartelisation of domestic pharmaceutical companies, are important to increase in price of medicines. For India, it is also the delivery mechanism of healthcare industry that matters.

Consider this. In India, we have 0.7 doctors per 1000 population as opposed to World Health Organization (WHO) requirement to have at least 0.9 doctors per thousand population. What is worrisome is that a majority of these doctors are in big cities. In terms of hospital bed availability we have 0.9 beds per thousand population as opposed to WHO requirement of having 1.9 beds per thousand population. Our per capita expenditure on health is a meager $75 per annum, as opposed to the US figure of $9500 per capita per annum, and UK figure of $4400 per capita per annum. Even controlling for level of per-capita income, which is to say, comparing India with other similar economies in the region, it is revealed that India is having lower life expectancy and higher infant mortality rate.

Government spending on health sector (which includes, medicines, diagnostics and hospitals) is a meager 1.5% of GDP, when in fact for most other comparable developing countries in Latin America its average to 7.5% of GDP. In terms of health outcome, we have one lady dying every 12 minutes while giving birth to a child. India's infant mortality rate is 37 per thousand live births, whereas a comparable figures from Western European countries and North American countries, it is less than four per thousand live births.

India's low-income population (ranging from 41.3% to 23.2% in state government facilities). While examining availability of five generic essential medicines in 129 public health facilities across 17 states in India, one study found that availability was approaching acceptability at a median of 80% but several facilities – particularly in rural areas – had no availability at all.

Of late, issues relating to drugs price controls under the National List of Essential Medicines have encouraged domestic bigger pharmaceuticals companies to export rather than sell their produce in domestic market.

For instance, a major portion of revenue for big pharma companies in India such as Dr Reddy's Sun Pharma, are from exports rather than selling in India.

A lack of a strong IPR regime and drug price control in fact delay innovation and the advent of cutting edge medicines, which are much required for a better health outcome. It is important to focus on extra-IPR areas to ensure a better health outcome.

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