The Equitable Pricing of Medicine

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Introduction

Access to medicine is a fundamental pillar of the human right to health as established by international bodies (1). Yet in 2025, one third of the global population faced financial hardship due to healthcare costs, driven primarily by the high price of medicines, a figure that rises to one half in the poorest regions of Asia and Africa (2). Which is a consequence of medicinal pricing not being based on the needs of the most vulnerable populations. At the heart of this crisis is a pharmaceutical market defined by patent-protected market exclusivity and profit-driven incentives, maintained by strict patent protections. The result is a system in which patients' face many barriers to the realisation of their right to health. If left unchecked, countries such as the United States, where medicine prices exceed 306% above the global median (3), will continue to drive prices upward. This increases financial pressure on health systems worldwide and further entraps the most vulnerable in cycles of unaffordable care.

Current policy responses, including bulk purchasing and patent agreements, address symptoms but fail to address the systemic structural barriers in pricing models. The Trade-Related Intellectual Property Rights Agreement (TRIPS) flexibilities permit compulsory licensing during emergencies. But political pressure and trade secrecy prevent their use in practice. Tendering introduces price competition for generic drugs, but only after two decades of monopoly pricing. What is missing is structural reform that aligns pharmaceutical incentives with public health from the earliest stages of research through to patient access.
This paper argues that meaningful change must be grounded in human rights principles and distributive justice. It examines why current approaches fall short and proposes solutions targeting transparency failures, structural market power, and misaligned innovation incentives. Medicine prices should reflect both the cost of innovation and the imperative of accessibility, so that no one is denied treatment because they cannot afford it.

SfGH Position

The Students for Global Health (SfGH) position is grounded in the principles of fairness, distributive justice, and the fundamental human right to health. We hold that equitable pricing is not a concession to be negotiated with pharmaceutical companies. It is an obligation of the regulatory bodies and policy structures that govern medicinal pricing. No individual should be denied access to essential medicine based on race, gender, or country of origin. No government should be forced to choose between affording medicines and funding other essential public services.

SfGH recognises that the current pharmaceutical pricing system is not a market failure in the conventional sense. It is the predictable outcome of a system deliberately structured to maximise private profit from publicly funded innovation. We therefore reject the premise that

the choice is between innovation and access. Equitable pricing, transparency, and competition is compatible with a functioning pharmaceutical sector. They simply require that policy serves the public and shareholders.
We believe that medicines derived from publicly funded research must carry enforceable public benefit conditions. That no price should be set without transparent disclosure of its cost basis. And that the needs of the most vulnerable populations should be the primary measure by which any pricing policy is judged. We are committed to sustained advocacy at every level of government, within our universities, and within the pharmaceutical industry itself. This paper is part of that commitment to elucidate how the journey to equitable medicinal pricing could begin.

Calls to Action

For Policymakers and Governments

→ Mandate the public disclosure of Research and Development (R&D) cost breakdowns as a condition of market access. Pharmaceutical companies operating in your jurisdiction should be required to disclose what was spent on research, how much came from public subsidy, and how that compares to the list price charged. Without this, no price can be verified as fair or equitable.

→ Establish or join a cross-border joint procurement coalition modelled on the Baltic States' vaccine purchasing agreement. Coordinated buying directly undermines the price discrimination that pharmaceutical price structures depend on.

→ Codify TRIPS flexibility protections into domestic trade legislation, explicitly prohibiting future bilateral trade deals from including TRIPS-plus provisions that restrict compulsory licensing. Do not wait for another public health emergency to test whether your country can use the rights it already has.

→ Article 11 of the World Health Organisation (WHO) Pandemic Agreement reserves the transfer of trade secrets on mutually agreed terms. This must change to a mandatory transfer as the precedent is set for a company to decline to cooperate.

→ The UK government should prioritise UK national interests in response to US pricing pressures on medicines.

→ Explore new tendering models that aim to reduce costs and increase buyer negotiating power.

→ Continue to enforce legislation that increases access and accessibility conditions that result in the equitable pricing of medicine.

For Pharmaceutical Companies

→ Publish the actual R&D cost breakdown for at least one medicine currently under patent.

→ Voluntarily license at least one World Health Organisation (WHO) Essential Medicine to the Medicines Patent Pool, without restrictive conditions, to enable generic production in low- and middle-income countries.
→ Cease the use of evergreening and patent thicket strategies on medicines that appear on the WHO Essential Medicines List.
→ Work with Governments to explore new mechanisms of pharmaceutical pricing and research.

For Healthcare Institutions and NGOs

→ Pass an institutional resolution that formally opposes TRIPS-plus provisions in bilateral trade negotiations and submit it to the Intellectual Property Office (IPO) and the Medicines and Healthcare Products Regulatory Agency (MHRA).
→ Commit to procuring medicines through tendering systems rather than direct brand procurement wherever clinically equivalent generics are available.
→ Incorporate equitable pricing literacy into your advocacy training and public education programmes, using the evidence base in this paper as a foundation.

For Students and the Public

→ Formally request that your university discloses whether publicly funded research is licensed to pharmaceutical companies without equitable pricing conditions. This information is normally found by contacting the financial team at your university or the lead researcher of a specific research project.
→ Encourage your student union to pass a resolution opposing any licensing agreement that does not include access requirements.
→ Write to your MP or other elected representative requesting a formal statement on compulsory licensing and TRIPS flexibilities. A single constituent letter creates a paper trail that can be referenced in future advocacy.

Background: Defining Equitable Pricing

Why It Is the Right Pricing Model

Medicinal pricing operates through several distinct frameworks that attempt to balance manufacturing cost, profit, and demand. A common approach is value-based pricing which sets prices according to therapeutic value to patients and health systems (4). In the United Kingdom, the National Institute for Health and Care Excellence (NICE) does this by assessing whether a medicine delivers one quality-adjusted life year (QALY) within the cost threshold of £25,000 to £35,000, as of April 2026 (5). While this ensures the NHS funds treatments that work, it also justifies extremely high prices for effective medicines. New

cancer immunotherapies now cost over £100,000 per patient per year (6). This is unaffordable for most health systems without negotiated discounts and entirely inaccessible to individual patients in countries without the necessary infrastructure.

Other frameworks aim to address affordability more directly. Affordable pricing is met when a required treatment costs one day's wage or less (7). But a medicine affordable in Germany may represent weeks of income in Malawi, so identical pricing across vastly different income levels does not mean equal access. It means systematically excluding the poorest. Conversely, fair pricing focuses on the balance of exchange between patient and producer. Thomas Aquinas believed that a fair price involves 'no loss for either party' (8), and these sentiments are echoed by the public. A 2024 Swiss study of 1,000 respondents confirmed this (8): 914 prioritised transparencies of cost structures, 911 wanted prices to reflect actual production costs, and 986 valued universal access. Strikingly, therapeutic benefit ranked lower. The public wants prices that reflect real costs and guarantee access, not merely clinical effectiveness.

Equitable pricing goes furthest of all. Defined as treating everyone fairly and in the same way (9), in the context of medicine it means pricing that is proportional to both the patient's financial capacity and the manufacturer's costs. Practically, this takes the form of tiered pricing, which is a system grounded in distributive justice and the human right to health. A medicine can be value-based and technically fair, yet still inequitable if uniform global pricing excludes poorer countries entirely. Equitable pricing addresses these gaps by having prices reflect the needs of the most vulnerable populations whilst considering the production costs of the manufacturer.

How Are Medicines Priced Globally?

There is no single global system for pricing medicines. Instead, countries operate under different regulatory frameworks that produce great price variation for identical products. The United States allows pharmaceutical companies to set prices with minimal government regulation, resulting in costs over 300% above the global median (3). The United Kingdom employs cost-effectiveness assessments through NICE and NHS negotiations yet still pays 125% above the global median (3). Meanwhile, many lower-income countries pay far less, sometimes 90% below the median (3), yet millions of people still cannot afford essential medicines.

This variation is not accidental. Patent monopolies block generic competition for 20 or more years, while pharmaceutical companies withhold R&D cost data as proprietary information, preventing independent price verification (10). Wealthier countries wield greater negotiating power yet still pay inflated prices, while poorer countries often cannot access medicines at all. The result is a system in which patients pay wildly different sums for identical medicines based on where they live, rather than on what those medicines cost to produce.

The Journey of a Medicine Through the Pricing System

To understand how pricing inequality is constructed rather than as the natural consequence of expensive R&D and innovation risk, consider the path of a new cancer immunotherapy

from development to patient access. A company patents a new drug. During this long patent period, it sets a list price based on what wealthy markets will bear, not on production costs so R&D prices can never be verified. In the United Kingdom, NICE assesses cost-effectiveness, and the NHS negotiates confidential discounts: Pembrolizumab lists at £84,000 but the NHS price is undisclosed (11). In Kenya, the government lacks the negotiating power to secure adequate supply: Africa's poorest regions see half their populations unable to access essential medicines (12), even where prices are far below global norms. The result is a system in which the public bears the cost while pharmaceutical companies privatise the profits. Without mandatory disclosure of R&D expenditure, no price can be assessed as genuinely fair or equitable.

Discussion: Problems

Section 1: Monopolistic Markets

The pharmaceutical industry is monopolistic by design, not accident. It functions through what economists' term 'intellectual monopoly', where companies control not only the final product but the underlying knowledge required to produce it (13). This is structurally different from the temporary monopolies that patent law is intended to justify. It eliminates the competitive forces that would otherwise generate equitable pricing. This system stems from policies like the 1980 Bayh-Dole Act, which has been credited with generating $1.9 trillion for the US economy (14). It allows pharmaceutical companies to systematically acquire patents from universities and public research facilities, converting publicly funded innovation into private profit streams. Most of those profits are returned to shareholders through dividends rather than reinvested in R&D (15).

When companies monopolise knowledge rather than products, they can charge whatever the market will bear, not because of superior innovation but because of exclusive control over inputs. Martin Shkreli's decision to increase Daraprim's price from $13.50 to $700 per pill, a medicine on the WHO Essential Medicines List, did not reflect any improvement in the drug. It reflected exclusive supply agreements that prevented generic manufacturers from accessing the raw ingredients required to produce competing versions (16). This is intellectual monopoly in its most visible form.

Industry defenders argue that monopoly protections incentivise the expensive and risky R&D necessary for pharmaceutical innovation. This justification fails on multiple grounds. First, if monopoly profits funded future innovation, market consolidation should have accelerated drug development. Instead, it has slowed it. Second, the public already finances pharmaceutical innovation through university funding, government subsidies, and tax credits, yet receives no return on this investment when monopoly pricing renders medicines unaffordable. Third, companies demonstrably sell medicines profitably at far lower prices in some markets while choosing monopoly pricing elsewhere, proving that prices reflect market power rather than innovation costs. The Daraprim case makes this clear. A 4,000% price increase (16) on an off-patent essential medicine with no new innovation, achieved purely

through supply chain manipulation, is the logical endpoint of a system that permits intellectual monopoly without accountability. Prices reflect profit maximisation, not production costs, innovation value, or public health needs. True equitable pricing is structurally impossible in such a system.

Section 2: How Intellectual Property Barriers Create and Extend Monopolies

Intellectual property protections create not one barrier to generic competition but multiple overlapping obstacles that compound to extend monopoly control far beyond the nominal 20-year patent term (10). Patent thickets involve filing multiple overlapping patents on different aspects of a single drug, creating a web of intellectual property rights through which no generic manufacturer can navigate without infringement (17). Evergreening extends this further: companies file patents on minor modifications to existing drugs, effectively restarting the 20-year exclusivity clock. Supplementary Protection Certificates (SPCs) and data exclusivity provisions further complicate the process so cumulatively a 20-year patent can extend much further due to strategy rather than necessity (18) (19).

Trade Secrets: The Deepest Barrier

Even where a government exercises its right to issue a compulsory licence under TRIPS flexibilities the licence is frequently rendered meaningless. Key manufacturing details such as synthesis processes, quality control methods, and production techniques remain protected as trade secrets. During COVID-19, most countries did not issue compulsory licences for vaccines, partly due to the recognition that without access to trade secrets, a licence would have been unenforceable (20). TRIPS can override patents. It cannot compel companies to share the knowledge needed to use them. (21)

TRIPS-Plus: Undermining Flexibility Through Trade Agreements

TRIPS-plus provisions, embedded in bilateral trade agreements, systematically undermine the limited flexibilities the original TRIPS framework provides. They extend patents beyond 20 years, restrict compulsory licensing, and introduce data exclusivity obligations. These provisions are typically inserted through pharmaceutical industry lobbying by wealthy nations and are negotiated with countries that have little leverage to resist. Countries that attempt to use TRIPS flexibilities risk legal challenge and trade retaliation (20). The result is that developing countries face longer monopoly periods and fewer policy tools than the already-restrictive TRIPS baseline allows.

Section 3: Why Lack of Transparency Enables Monopoly Pricing

The pharmaceutical industry operates behind a veil of commercial secrecy that makes assessing fair or equitable pricing fundamentally impossible. Companies claim that high prices reflect enormous development costs but refuse to disclose the actual figures as the industry frequently cites a median cost of $1.3 billion to bring a new drug to market (23). This information asymmetry systematically favours monopoly pricing by eliminating accountability. Confidential NHS negotiations compound this problem. This prevents public scrutiny of whether negotiations achieved value for money. As coordinated transparency is a precondition for equitable pricing, it is currently a barrier that still needs to be addressed.

Section 4: Policy Failures and Market Fragmentation

Brexit demonstrates what happens when even a wealthy, well-resourced country cannot control pharmaceutical prices in the face of monopoly power. It reveals dynamics that affect all countries, but with far greater severity in low-income nations. After Brexit disrupted EU supply chains, manufacturers prioritised more profitable European markets (24), leaving the UK market undersupplied and driving price increases above standard pricing references.
The Nuffield Trust estimates the NHS spent £220 million more in 2022/23 than equivalent products would have cost before Brexit (25). These medicines did not become more expensive to produce. Pharmaceutical companies simply used supply chain disruption to extract higher prices from a captive market.

What Brexit reveals is not a peculiarity of British trade policy. It is a demonstration of what pharmaceutical monopoly power does when structural constraints are removed: it extracts maximum price from whoever cannot escape. If Britain, a wealthy nation with substantial NHS purchasing power, is this vulnerable, what does that mean for countries negotiating from a far weaker position?

Discussion: Solutions

Section 1: Aggregating Demand to Counter Pharmaceutical Market Power

When countries pool their purchasing power, they can counter the fragmented buyer problem that allows pharmaceutical companies to maintain exploitative pricing. Collective procurement reduces a suppliers' ability to optimise pricing strategies across fragmented markets and can significantly lower unit prices (26). Framework agreements (which are ¼ of procurement approaches) and cross border purchasing initiatives strengthen these effects by requiring suppliers to commit to transparent pricing structures. For instance, cross border collaboration is demonstrated by the Baltic state's joint vaccine procurement initiative (27) (28).
However, these mechanisms require administrative capacity and institutional infrastructure that many lower-income countries lack (26). Addressing these gaps requires technical assistance programmes, procurement capacity building and regional pooling arrangements that allow countries to participate in collective purchasing systems without independently developing full institutional infrastructure.

Section 2: Competitive Tendering in Post-Patent Markets

Tendering addresses the post-patent market failure in which legal patent expiry fails to translate into actual price competition. When governments solicit competitive bids from multiple manufacturers, they create the downward price pressure that economic theory predicts should occur naturally upon patent expiry but rarely does. Even where multiple

generic manufacturers exist, meaningful price competition does not always emerge. Tendering restores competition by making price the main criterion for awarding a contract. This allows prices to fall rapidly once patent production ends (29) (30). The critical limitation of tendering is its restriction to post-patent drugs. It cannot improve access during the patent period, when prices are highest, monopoly power is strongest, and therapeutic advantages are often greatest. Patients needing patented medicines therefore face very different access conditions from those treated with off-patent generics. This temporal limitation makes tendering a necessary but insufficient component of comprehensive equity reform, and it requires complementary mechanisms that target patent-period pricing.

Section 3: The Bolar Exemption: Compressing Monopoly Duration

The Bolar exemption addresses the procedural extension of pharmaceutical monopiles caused by regulatory delays embedded in Article 30 of TRIPS. It allows generic manufacturers to conduct experimentation and regulatory trials during the active patent period, enabling market entry immediately upon patent expiry (31). By preventing delays between the patent expiring and generic competition it shortens the period during which patients pay monopoly prices.

Section 4: Compulsory Licensing

Compulsory licensing provides the most direct mechanism for overriding pharmaceutical patent monopolies when public health requires it. Grounded in TRIPS flexibilities and reaffirmed by the Doha Declaration (9), it authorises generic production without patent holder consent when monopoly pricing creates access barriers that threaten population health.
Even when not used, the possibility of compulsory licensing can control pricing by signalling that excessive prices may trigger government intervention. This creates an incentive to negotiate voluntary licences at affordable prices rather than risk forced generic entry (32).

In practice, political and practical barriers can limit its use. For example, during COVID-19, most countries didn't issue compulsory licences for vaccines despite having the legal authority to do so, due to political pressure and manufacturing capacity constraints. Compulsory licensing cannot function as a genuine safety valve without international political coalitions that provide diplomatic cover for its legitimate use, and without technical assistance programmes that enable developing countries to translate legal authorisation into actual production capacity.

Section 5: Spending Caps: VPAG and the Statutory Scheme

The Voluntary Pricing and Access Agreement (VPAG) and Statutory Scheme cap the rate at which branded medicine spending can grow. VPAG allows pharmaceutical companies to set prices for newer branded medicines while capping spending growth. Companies that join the voluntary scheme repay revenue that exceeds the threshold set at 14.5% as of 2026. If companies don't voluntarily join VPAG they fall under the Statutory Scheme which requires higher repayments of 24.3% in 2026 (4). These mechanisms provide fiscal predictability and create automatic correction when spending exceeds caps. When revenue is clawed back by

the NHS, it can fund other health interventions, serving populations who would otherwise see reduced access as pharmaceutical budget pressure crowds out competing services.

However, both schemes reveal a limitation: they accept branded medicine spending growth as inevitable rather than questioning whether that growth reflects genuine therapeutic value. The declining VPAG repayment rate, falling from 22.9% to 14.5% (4), reduces the financial burden on pharmaceutical companies over time, making the scheme progressively more favourable to industry. This suggests the scheme's function can be altered to accommodate for industry revenue expectations rather than actually control the price of the medicine.

Conclusion: No Single Mechanism Is Sufficient

No single mechanism is sufficient to achieve equitable medicine pricing. Demand aggregation counters market fragmentation but requires institutional capacity that many low-income countries lack. Tendering drives post-patent price competition but cannot touch medicines still under monopoly protection. The Bolar exemption compresses monopoly duration but does not challenge the underlying patent architecture. Compulsory licensing provides a legal safety valve but is rendered unusable by political pressure and manufacturing constraints. Spending caps manage cost growth without questioning whether that growth is justified. Each mechanism addresses a specific failure within the current system, but none fully address the pharmaceutical market structure itself.

Equitable pricing therefore requires these solutions to operate together, reinforced by two structural preconditions that make all others possible: mandatory transparency of R&D costs, so that no price can be charged without public accountability; and protection of TRIPS flexibilities from bilateral trade erosion meaning governments retain the legal tools to act when markets fail. Without these foundations, individual policy interventions will continue to negotiate at the margins of a broken system rather than reform it. The evidence in this paper makes the scale of that failure clear.

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