Bayer CEO's callous comments highlight failure of current biomedical innovation model

by TESSEL MELLEMA

Last week, Bayer CEO, Marijn Dekkers, caused global indignation when, in a Bloomberg Businessweek article, he was quoted as saying that his company's cancer drug, Nexavar, had never been developed for the Indian market—only "for Western patients who can afford [it]."

With a whopping $69,000 per year price tag in India, the reported benefits of Nexavar had long been out of reach for Indian cancer patients; that is, until the Indian patent office issued a compulsory licence for the drug to a manufacturer that produced a generic version for 97 percent less. Calling compulsory licensing, "theft", Dekkers and Bayer are fighting the issuing of the compulsory licence for Nexavar in the Indian courts.

Dekkers' comments, along with Bayer's and other pharmaceutical companies' battles against compulsory licensing, demonstrate the fundamental flaws of the current biomedical innovation model. Bayer states that medicines are not developed for people who cannot pay. At the same time, it seems that governments of low- and middle-income countries are expected to *not* make use of available legal means to provide medicines access for their people.

This for-profit system of biomedical innovation does not provide medicines that respond to priority global health needs for a price people across the globe can afford. Innovation needs are set by those who can afford to pay for high-priced drugs. Those who cannot pay—particularly those in developing countries, but increasingly, some citizens in Europe and elsewhere—are left to suffer because they cannot afford the drugs they need, or the drugs are simply not being developed. After all, people who cannot pay do not constitute a profitable market for the pharmaceutical industry.

Developing countries are well within their legal right under the TRIPS Agreement to award compulsory licenses to better ensure their citizens have access to affordable medicines. Pharmaceutical companies must respect this fact and stop pressuring countries that make use of these licences.

Further still, we must recognise compulsory licensing only as a potential short-term, patchwork solution to the bigger, structural failure of the current biomedical innovation model. What we really need is a model based on global health needs, not profits.

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