REPORT OF THE CONFERENCE
“ACCESS TO MEDICINES IN THE BALTICS: CHANGING THE NARRATIVE”

October 13, 2017
Riga, Latvia
Introduction

Published literature reveals the problem with access to medicines (affordability) is no longer the concern of low and middle income countries alone, but that the ever escalating cost of new medicines threatens health systems of poor and rich countries alike. For example, a highly effective 12 week course of a direct-acting antiviral (DAA) for the treatment of hepatitis C entered the market in 2014 at a list price of USD 84 000 in the US and EUR 45 000 in Europe. Despite the fact that equally effective DAAs are manufactured by several companies and generics are available (e.g. India), in Europe due to patent protection the prices for this therapeutically valuable treatment are still so high, vast numbers of patients are left without treatment. Similarly, an effective treatment for leukemia has just been registered in the USA but will be out of reach of the majority of the world. The price that the manufacturer has set is USD 475 000. These and other examples have initiated discussions questioning the transparency, efficacy and cost of the current research and development (R&D) model for medicines, that relies on patent protection which rewards the company with the opportunity for monopoly pricing for up to twenty years.

Changing the Narrative

2016 marked a turning point in the debate on pharmaceuticals in Europe, when during the Dutch Presidency of the EU, the 28 European Health Ministers signed off Council Conclusions on strengthening the balance in the pharmaceutical systems in the EU and its Member States. The conclusions named and addressed the major shortcomings of the current pharmaceutical business model including the question of the overprotection, misuse and abuse of intellectual property incentives for medical innovation, questionable therapeutic value of new drugs and prices that leave innovative treatments out of reach for patients in many countries. In September 2016, the UN Secretary-General’s High-Level Panel report on access to medicines was published demonstrating that, as the The Lancet put it, “the status quo is no longer an option”. In March 2017 the European Parliament adopted its resolution on EU options for improving access to medicines.

The Baltic countries – due to limited resource allocation to reimburse medicines coupled with a relatively small market find themselves in a particularly unfavourable situation with limited financial and physical access to health technologies, especially high-priced innovative medicines. To raise awareness, to discuss and suggest concrete steps that could bring about change, Health Projects for Latvia convened a conference “Access to Medicines in the Baltics. Changing the Narrative.”

The event attracted up to 100 stakeholders including decision makers from Latvia, Lithuania and Estonia, the regulatory sector, payers (health insurance companies and governments), health NGOs, patients, doctors and pharmacists, academia, the media, pharmacy students and the industry.

2 http://www.unsgaccessmeds.org/final-report
3 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31706-8/fulltext
In his keynote speech, Natsis highlighted the latest developments in the EU debate on pharmaceutical policy. He referred to the EU Council conclusions – signed by all the ministers of Health in EU - of June 2016 as a milestone which changed the current debate and brought such issues as the “holy cow” of intellectual property rights, early market access schemes, poor therapeutical value of new drugs to centre stage. Natsis gave examples how the pharmaceutical industry, by no means happy with the new debate, attempts to shift the focus away from the real problems by talking about innovative payment methods, personalized medicines, “investment” rather than expenditure etc. Natsis stressed the important role of the European Medicines Agency (EMA, EU-wide regulator), as it is where the standards are set and signals are sent to the market. He suggested that the influence of the industry on the decisions of EMA is too great, and that society expects the regulator to work for the best interests of the public, not the industry.

He concluded that new rules of the game are needed, for example transparency – transparency of prices the governments are paying for drugs, transparency of public investment in the process of drug development and transparency of costs of R&D. Another aspect in the new game is collaboration among countries. Currently asymmetry of information, whereby the pharmaceutical industry is in possession of full information (e.g. drug prices in all countries) yet countries themselves are negotiating in the dark. This is due to compulsory confidentiality agreements insisted upon by the pharmaceutical industry, resulting in governments ‘not even aware what happens in countries next door’. Government joint action and transparency of price negotiations are needed when negotiating prices otherwise the balance between what the industry gets and what the patients need cannot be restored.
Panellists

Raf Mertens, Director General of the Belgian Health Care Knowledge Centre (KCE).
Erki Laidmäe, Head of Insurance Benefit Package, Estonian Health Insurance Fund
Inese Kaupere, Director of Pharmaceutical Department, Ministry of Health of Latvia
Romualds Ražuks, Member of Latvian Parliament, Chairman of Public Health Subcommittee of the Social and Labor Affairs Commission

Raf Mertens shared Belgium’s experience on joint price negotiations with the pharmaceutical industry (BeNeLuxA initiative – by Belgium, Netherlands, Luxemburg and Austria) and admitted that it is, in fact, very difficult to work together with other countries. Cooperation deserves specific additional resources and takes an “extra layer of energy” to be successful. Furthermore, even if price negotiations are common for several countries, the decision in the end is local in each of the countries. They all have their local pressures and political interests. However, despite the difficulties, when countries are joining forces, the pharmaceutical industry gets “very nervous”. “Keep the momentum,” Mertens advised.

He also raised a very important question – what is the status of drugs and healthcare in general in economic systems and society as a whole? Indeed, are lifesaving drugs of the same importance as vacuum cleaners or iPhones or should their status acknowledge that they correspond to the fundamental human right to healthcare?

Transparency of the price is very essential and transparency of how the price for a drug is built must be an essential element in any new discussion. If the pharmaceutical industry comes with good innovation, governments will want to make it available to patients who need it and will be willing to pay a fair price. The fair price, however, must not be calculated as the upper limit of the price the governments can pay. The upper limit is not the willingness to pay, it is “the inability not to pay”. What can a ministry say to a very high price for a treatment for a child? Asking an unaffordable price for a treatment for a child is not a fair price. “It is taking a child hostage”, Mertens argues, “and asking a ransom from the public health purse. It’s not a fair pricing mechanism.” Fair pricing would be agreeing about the margins so that fair return from investments could be recouped. This can create a new start for discussion.
According to Erki Laidmäe, the situation in the Baltic countries is “a bit different” than found in Belgium, for instance, because, unfortunately, “we are quite used to the fact that not all medicines are available to patients”. On the one hand the payers and the patients are used to the situation on the other hand patients are not happy with it. They know that new medicines are available and they want them to be reimbursed. Laidmäe referred to the conclusions of Gastein Forum in 2016 and said that the payers should not be complaining about the high prices and accept part of the responsibility because for a very long time they had been ready to pay the prices the pharmaceutical industry was asking. As much as the payers are ready to pay today, as much the industry will be willing to ask in future and actually it’s up to the payers – to accept the price the industry has set or not. Laidmäe also said that the governments often are forced to agree with the high prices the industry is asking due to pressure from the society. According to Laidmäe, a common argument for keeping the discounts and the real prices secret is the threat that if the real prices would be transparent, the medicines that are cheaper in Estonia will be shipped to Germany where the prices are supposedly higher. The good news, however, is that the debate is changing even though in the Baltics “we are only at the very beginning”. He concluded that for change to happen and for the governments to be able to really tackle the issue of high medicines’ prices raising awareness of the public is very important and collaboration between the Baltic countries is necessary.

In line with previous interventions, Inese Kaupere also raised concerns that the lack of transparency and secret negotiations that the governments are forced to accept put the payers in weaker positions. ‘How can we cooperate among neighbouring countries if we have to stay secretive?’ Kaupere asked. She also referred to the joint vaccine procurement for Latvia and Estonia and explained that the savings from this joint procurement was approx. 400 – 500 000 EUR. Despite the many years she has worked for National Health Service (payers for reimbursed medicines in Latvia) Kaupere still admitted that she had many questions to the industry unanswered: How are the prices are set? Are they set taking into account the purchasing power of the country? Or the number or patients? She agreed with the previous speakers that the prices should become transparent and emphasized that everyone expects transparency from the government and governments are responding, but transparency should be granted also from the side of the pharmaceutical industry.
Romualds Ražuks told the audience that the problem of access to medicines is in the attention of the decision makers and this summer the working group has been established to tackle problems with access of medicines in Latvia. According to Ražuks, “not much could be done with prices of reimbursed drugs because that system is well regulated”. The drugs that are not compensated by the state could be made cheaper. It is important to allocate more money for state reimbursed drugs, especially in oncology. Ražuks also emphasized that the problem with high drug prices cannot be solved on a local level. As Latvia is not a champion in financing its healthcare system it’s difficult to talk only about the access to medicines, there are a lot of other problems, too. He admitted, though, that the discussion on how to improve access to medicines needs to be continued as is cooperation with other countries.

TAKEAWAY MESSAGES FROM ACCESS TO AFFORDABLE MEDICINES SESSION:

- Linkages between what happens in Brussels and in the member states are needed

- We need to raise the voice of small countries in Brussels, because we share the same concerns and problems

- Price negotiations in the dark are not effective but – don’t despair, there are opportunities out there to move forward

- Engagement of the expert civil society is very important

- Work-arounds are there but the most important is to aim at systemic change

- Conflicts of interests exist in every country; for the good of the society we have to open them up

- The major challenge is for the politicians and the decision makers to believe that change IS possible (we have to help policy makers believe that change is possible)
Beate Wieseler opened the session in a keynote speech in which she gave a brief overview of what HTA is and explained why it can be considered as the best tool we have to provide information for good decision making. Wieseler explained that HTA enables choice between the best possible treatments from all options available and at the same time, attempt to ensure healthcare system sustainability. Wieseler stressed the need for HTA bodies to be independent from politics, doctors and Ministries of Health. According to Wieseler, voluntary cooperation among countries could be helpful and if HTA systems are harmonized across Europe, the highest common denominator must be chosen, standards must by no means be lowered. She presented IQWiG data on the therapeutic value of new drugs showing that for less than half of the new medicines there is evidence that they provide added therapeutic value to patients. This must lead us to question whether the current R&D model system incentives the drugs patients really need. It’s been hammered in our minds that new medicines are better but it’s not true’, said Wieseler. Wieseler also touched upon the issue of transparency and stressed that for drug assessment it’s extremely important to have all the necessary data. In Germany there has been fierce opposition from the pharmaceutical industry regarding data transparency but there is a political support, hence German law regulates transparency about drugs. Wieseler, in line with previous interventions, encouraged transparency on drug prices.
Alessandra Ferrario is a Postdoctoral Research Fellow at Harvard Medical School and Harvard Pilgrim Health Care Institute where she is currently engaged in research on access to oncology drugs. In her presentation, she noted that it can be challenging for researchers to pull data together on the subject—information is scattered. For instance, not all countries have centralized data on hospital medicines. According to Ferrario, when speaking about access to medicines first we need to define access to medicines and what represents an improvement in access—what are the indicators to measure performance? In Europe we often talk about access in terms of HTA decisions—i.e. is the drug reimbursed?—but the reality is more nuanced, a positive decision may still not guarantee access for all patients in need. Ferrario commented on the current practice of external reference pricing (comparison of published price with other countries) by saying that it is not a fair comparison because the payers do not know what discounts the other countries receive. This is particularly relevant for new high cost medicines which are often introduced through risk-sharing and managed entry schemes. One issue with the way HTA is currently organized is that it is a reactive process, based on the medicines the pharmaceutical industry decides develop and submit. For countries to be more proactive it is very important to have priorities in place—to define areas where they are ready to pay and areas where they are less willing to pay because medical need is not as high. International collaboration in pricing negotiation is not easy due to difficulties with coordination, language issues, different legal frameworks and willingness to pay to mention a few. Despite that, joining forces and pulling expertise across European countries is essential in order not to accept the high prices the industry has set and countries should build a common front.

Panellists

Beate Wieseler, Head of Drug Assessment Department, Institute for Quality and Efficiency in Health Care in Germany (IQWiG)
Igors Trofimovs, Director for Development, Riga East University Hospital
Juris Bārzdinš, Assoc. professor in Health sciences at University of Latvia
Ancel.la Santos, Senior Policy Advisor at Health Action International
Tomas Alonderis, Head of Pharmacoeconomics and Drug Pricing Department, Ministry of Health of Lithuania
Igors Trofimovs gave a brief introduction of HTA in Latvia and underlined that HTA must be independent from the payers and decision makers. According to Trofimovs, the impact on the economy as a whole and the health system, has to be taken into account, not just impact on patients – such data could be better understood by politicians. To exemplify what he meant Trofimovs suggested that when a healthcare budget is separated from social budget, bad decisions or savings in healthcare may have long lasting impact on social budgets. “The problem for Latvia is that we have some budget pool and we are trying to do everything in this one budget framework. Latvian National Health Service is very restricted by a very small amount of money that is allocated for medicine reimbursement. Cost-utility analysis showing the incremental cost to gain an extra quality-adjusted life-year (QALY) and cost-benefit analysis to value both incremental costs and outcomes in monetary terms should be introduced to show the cost of the productive value to society of life-year gained. He noted that small countries like Latvia really appreciate and may benefit from HTA sharing from powerful agencies from other countries.

Juris Bārzdīņš, representing the University of Latvia, explained that historically, several small agencies in Latvia were combined and hence lost their independence as HTA bodies, but are now united with the payer. He agreed with previous speakers that letting the industry steer the boat may not always have lead to the best possible decisions taken in Latvia. On the contrary, in the past, it has created a situation when we started to spend more money than other countries on selected, specific things, not only drugs but also some interventions in invasive cardiology, etc. We are still paying a lot for those decisions made in the past. These examples highlighted the previous argument that setting priorities for the government are very important. Bārzdīņš explained that in not so wealthy countries such as Latvia, the political decision to allocate public money for healthcare (in 2017 in Latvia it was less that 4% of GDP) influences a series of other decisions. Even if science provides considerable improvements for patients for certain new therapies, it’s not enough because the resources are still very limited. Bārzdīņš referred to doctors as “the most powerful group who can help distribute the limited sources in healthcare” if existing treatments and processes are carefully analysed and doctors are involved in discussions and analysis of real life situations. Bārzdīņš addressed yet another aspect of transparency that can play an important role when limited resources need to be distributed in a smart way: the taxpayers should be able to see and judge the results from the different health technologies they are paying for. If the data that already is at the disposal of payers were transparent, the public and the decision makers would understand better why more money for healthcare is needed. Latvia needs to learn how to make the data that is there transparent; currently the understanding of what transparency means at University differs from understanding of transparency within the National Health Service (owner of the data). For instance, the current data on how investments are made for cancer patients during their last year of life show “that we are spending money on expensive drugs when there is no point any more, and in fact, more money should have been invested for palliative care and home care.”
Tomas Alonderis - Head of Pharmacoeconomics and Drug Pricing Department, Ministry of Health of Lithuania gave a brief summary of how HTA has developed in Lithuania and agreed with the previously argument that no money should be spent on unproven therapeutic value. He indicated that much of therapeutic data and data on effectiveness are comparable in many countries, explaining that “if the drug prolongs life in Germany, it prolongs life in Lithuania, Latvia, Spain, etc.” Different comparators that different countries are using are, according to Alonderis, an important issue to find solution for.

During her intervention Ancel.la Santos followed up on the question of standards in HTA, indicating that some of HTA agencies “are more flexible about surrogate end-points”. If there is harmonisation among government appointed HTA bodies in Europe (currently EUnetHTA) high standards must be used, they need to go upwards not downwards. Santos also indicated that some HTA bodies rely on fees from the industry when they provide scientific advice, therefore their independence can be questioned. Under circumstances when the resources are limited, essential medicines need to be the priority. According to Santos, “governments are not good enough in steering public R&D” and better prioritisation is needed.

If public money goes into drug development, conditionalities have to be established so that when products reach the market, the price is reasonable and medicines available to all. She also called for research data to be made available.
Beate Wieseler

Following up on the question who decides what needs to be assessed, Beate Wieseler emphasized that the healthcare systems must be the driving force, industry has to submit a dossier concerning the intervention the governments decide to assess. For smaller countries it can be beneficial if they looked at what is available from other HTA bodies and see whether it is what they need in their countries. Wieseler expressed her reservations as to doing common assessment together and favoured a model where something already available in other HTA bodies is re-used elsewhere. What can we do to make this model of HTA recognition more useful? What can be done for German reports to be more useful in other countries? Perhaps small details that the German agency can introduce can make big difference for other countries? Joint scientific advice by EMA and HTA are part of the plan to make drug development more efficient. The regulators might need to take into account some aspects that are important in HTA, too. Wieseler questioned the current practice to label discussions on a study design as confidential now and called for a transparency as “study design is no business secret, that’s just a standard methodology”.

TAKEAWAY MESSAGES FROM HTA SESSION:

- Collaboration, Latvia with such a small population and local competence should not be alone

- Assessments should be based on high standards

- Early dialogues could be helpful but transparency is important e.g. about the study designs

- Making public aware of how the decision has been made, also including the political aspects might be helpful

- Prioritisation of public health necessary (governments rather than the industry must set the priorities and agenda)

- Independence of HTA (from politics, decision makers and doctors) is very important.
The third and last part of the conference was dedicated to intellectual property (patents) and how the current practice of extended patent protection influences access to medicines and public health.

The third keynote speech of the day was given by Ellen ‘t Hoen, Medicines, Law & Policy. ‘t Hoen gave an overview of what patents are - a “patent is a right to exclude, a negative right to exclude others”. Initially created with the idea to benefit society as a whole but has now ended up as a tool for the pharmaceutical industry to maintain monopoly pricing and keep generics off the market as long as possible. ‘t Hoen told the audience about the Doha Declaration (2001) which introduced some flexibilities to the global agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and recognised the human right of access to medicines. According to Doha declaration, if governments think that public health must be protected, they may issue a Compulsory License (CL) to ignore the patent status of a medicine and manufacture or import a generic version. It is legally possible and “from a human rights perspective you can argue it very well”, said ‘t Hoen. She also raised additional concerns about other market exclusivities such as data exclusivity, supplementary protection certificates, orphan drugs exclusivity and paediatric extension that keep medicines out of reach of many governments and the patients. She called for greater transparency as to why such exclusivities are granted, since currently there is no sound data. As immediately recommended actions (locally) ‘t Hoen named bundle buying power of the countries and action (such as TRIPS flexibilities) in cases when patents hamper access to proven effective medicines. As actions recommended on a EU level, ‘t Hoen outlined increased transparency in pricing and R&D costs, investigation on high medicines prices and policy change proposals after EU incentives have been reviewed.

On an international level ‘t Hoen calls for ensuring efficient financing for R&D and new global agreements on sharing cost of R&D based on de-linkage principles (separation of the cost of R&D from the price of the medicine). Transparency of R&D cost is needed and that would lead to much better decisions. On the subject of delinkage, she said that to ensure better access to medicines entirely different model is needed where the costs and risks associated with R&D are rewarded by means other than price of the product. It goes back to transparency issue and it is not only about how much does it cost to develop a new drug but also who pays what. Currently large part of the research is done with the public money. For example, a large part of funding in the development of sofosbuvir was coming from the US government. The problem in the current system is that when promising products are discovered and when they are transferred from universities or publicly funded research institutes to the private sector for marketing approval, it’s done without conditions with regards to affordability and availability. We as the public should ask for it: we as the public want to be sure that we are not paying twice, first as tax contribution to R&D and secondly through high prices of medicines. Creating public funds to finance R&D could be a solution for then instead of spending taxpayers money on high drug prices it would be possible to spend it directly on R&D. If you give somebody money to do something (to come up with a new drug for treating X), it usually happens. When you finance like that, there is no need for market exclusivity because there is no ground for recouping the investment. The good news is that such new models are being tested right now.
To illustrate a Latvian case study on how patents influence public health, researchers Anda Kīvīte and Elita Poplavska presented study data. There is a new publication on Hepatitis C in Lancet where the evidence shows that the Baltic countries have the highest prevalence rates of Hepatitis C. Additionally, Latvia is one of 3 countries which has experienced more than 10% increase in prevalence numbers since 2007 (after Russia and Iran), due to infections among people who inject drugs. Genotypes 1A and 3 dominating in Latvia (46 + 32%). Cascade of care in Latvia (2015) is as follows: approx. 43 000 Hep C patients, 19 400 (45%) are diagnosed, 910 treated (2%) and 560 (1.5%) cured. Kīvīte said that these numbers are obviously “far too low for stopping the epidemics”. Another problem currently characteristic to Latvia is that there are no effective medicines available for genotype 3. 100% reimbursement for Hep C was introduced in 2016, and the government allocated the budget for innovative medicines but given the high prices, only a very small number of patients could be treated and cured so far.

The researchers also presented data from interviews of the study of Health Projects for Latvia carried out earlier in 2017. Some of the stakeholders believe that we have a good deal for the price of Hep C drugs but if the deal is that good, how come we can afford to treat only 228 (2016) plus 760 (2017) patients with Hep C per year? The interviewees also expressed worries that pharmaceutical companies have too great an influence on the process of treatment of Hep C in Latvia.

Panellists

Signe Mežinska, Board Member of Health Projects for Latvia, Associate Professor at the University of Latvia
Antons Mozalevskis, Medical Officer at the WHO Regional Office for Europe in Copenhagen
Kristaps Kaugurs, Head of Latvia Hepatitis C patients’ organization
Ellen ’t Hoen, LLM, an independent consultant in medicines law and policy to a number of international organisations and governments and a researcher at the Global Health Unit of the University Medical Centre at the University of Groningen
Kristaps Kaugurs introduced the audience with the latest developments in Hep C care in Latvia. During the last couple of years there has been tripling of the budget for Hep C treatment (3 million EUR at the start, now 10 million EUR), new generation drugs are 100% reimbursed; the number of patients that are treated and cured continuously increase; and a patients’ registry is in the process of development. Kaugurs also expressed his concern that the imported generic medicines for personal use can jeopardize patients’ safety. Yet another concern to Kaugurs is that the pan-genotypic treatment expected in 2018 might be a monopoly with even more difficulties to control prices. Kaugurs presented numbers of Hep C statistics in Latvia and said that if there are 40 – 50 000 possibly infected people and approx. 1000 new cases every year in order to eliminate hep C by 2030, the minimums patients that have to be treated are approx 2200 every year. “What are our options?” he asked. To get more money? To push down the prices and get 50% discount? Is compulsory licensing a realistic third option?

Signe Mežinska said that from the ethical point of view it is problematic that when encountering a problem nobody asks questions. “The good thing is that we have started asking questions”, she noted. The second worst thing concerns the social justice – some people are able to get the medicines and others are not. “We should not be scared of speaking out in a situation if there is injustice”, Mežinska encouraged. Not only governmental institutions should and could do something but also civil society and academia should be involved. If so many people are infected, they are all around us, we should do something to help them. Mežinska also raised an issue of conflicts of interest and emphasized that we have to work on understanding conflicts of interests and unless we work on understanding how important it is for the decision makers to declare their interests we will not be successful in reaching best possible results for the society.
Antons Mozalevskis, representative of WHO, is responsible for technical support to Eastern and Western Europe with regards to Hep C remarked on a positive shift: now we are living in a new era when viral hepatitis has finally received political attention and the global strategy has been adopted which calls for elimination of hepatitis. All member states have signed-up to this target. He admitted that the price is one of the biggest barriers but there are opportunities for how to overcome this problem and move closer to the target. The situation differs from country to country; there are different initiatives to tackle the high price issue. If we learn what other countries are doing, we can learn from them. There is a possibility of Compulsory Licensing and Romania was also thinking about CL. Romania is one of the most affected country in EU (about 4% of population are infected with Hep C). In Latvia, Mozalevskis admitted, it is very concerning that 30% of patients do not have access to the new therapies and interferon that is still used in Latvia for those patients who do not qualify to receive DAAs is no longer recommended by WHO. Genotype 3 (currently left out of the treatment) is usually characteristic to people who inject drugs. This could also be a function of discrimination, Mozalevskis noted. When the governments cannot do what they have committed to – to ensure the human right to universal access to health, the patients take the initiative in their own hands and create buyers’ clubs, in some countries they are quite well regulated. Concerns about self-bought generic drugs are there, because not all of the patients are being supervised by doctors.

Ellen ‘t Hoen

According to Ellen ‘t Hoen, if governments here in the Baltics would consider introducing a CL for Hep C, strategizing is important - medical, pharmacy and law experts should get together and work out the scenarios. Assuming that there are CL provisions in the law, the first consequences in terms of money would be to pay a certain percentage of remuneration to the patent holder as royalties. Patent holders will most probably challenge the decision in court or come back with a much better price deal and insist of keeping it secret. Latvia could probably also face pressures from other EU countries and especially European Commission to not move ahead with CL. But again – is being scared the right way to change things? If such initiative would seriously be considered lessons learned from countries who use these mechanisms have to be taken into account. In Thailand, for instance, they managed to get very strong support from the community. When US said we don’t want you (Thailand) to do CL the whole Thai society was behind the decision and they were able to move forward. In the end, the company gave the drugs away for free (cancer drug, few patients). According to ‘t Hoen “encouraging winds are blowing” and countries have to be more forceful, move forward and say strong no to such high prices. Possibly seeking collaboration with other countries is a good idea – for the Baltics to work together, possibly with Romania, where the numbers of infected people are high as well. ‘t Hoen told that the physicians associations might be important allies, too as in countries like France, Ireland, Italy and Spain, they were the physicians who actually petitioned the government and asked for action to help their patients.
TAKEAWAY MESSAGES FROM SESSION ON PRIVATE PATENTS AND PUBLIC HEALTH:

- Don't despair, put up a fight, it works!

- Laws need to be fixed, transparency of R&D costs must be ensured.

- Bundle buying power for countries must be considered.

- There is a need for the new global agreement on sharing cost of R&D based on de-linkage principle.

- Tools of ethics and tools of justice give us confidence to ask questions that need to be asked.

- Plurality of actions in different EU countries – we can learn from each others’ lessons.
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