



Public Pharma

A public pharmaceutical industry for
a sustainable drug supply

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GLOSSARY

APL: Apotek Produktion & Laboratorier AB (Sweden)

Biosimilar: a copy of a biologically produced medicine

Biological products, biologics: medications with active ingredients made from or by living organisms, cells or biotechnological procedures

Blockbuster drug: a medication that generates \$1 billion or more in annual sales

Evergreening: a strategy to extend patent protection, mostly by secondary patents

Essential medicines: a selection of medicines required for public health needs, that are supposed to always be available, affordable and of assured quality

Generic: an identical copy of a chemically synthesized drug

MPP: Medicines Patent Pool

NIH: National Institutes of Health (USA)

R&D: Research & Development

SDGs: Sustainable Development Goals, established by the United Nations

Secondary patents: subsequent patents that for instance protect product modifications

TLV: Swedish Dental and Pharmaceutical Benefits Agency

TRIPS: Agreement on Trade-Related Aspects of Intellectual Property Rights (WTO)

WHO: World Health Organization

WTO: World Trade Organization



Public pharma – a choice of direction. Photo: © hamzaturkko/iStock

PUBLIC PHARMA FOR A MORE EQUITABLE SUPPLY

High prices, recurring shortages of supply and research prioritizing highly lucrative areas characterize the pharmaceutical system of today. In order to sustainably enable the worldwide access to life-saving medicines, vaccines and tests, a fundamental change of course is needed.

The decisions regarding which pharmaceuticals are researched and produced are driven more by profit motives than by global social needs. The current patent system drives up prices and complicates access to vital products for millions of people – especially in the Global South. Growing financial pressure is also testing the limits of healthcare systems in wealthier countries. The human right to health is in acute danger all around the world.

In order to sustainably deal with the variety of current problems, a structural approach is necessary. As a result, a global movement calling for a public pharmaceutical industry has emerged around the term “public pharma”¹. At its core, the goal is to align research, production and access to medicine according to actual public interest. The movement includes patient representatives, scientists and a growing number of public officials.¹

In scientific literature, public pharma is described as “[...] the development, manufacture, and distribution of drugs and biologic products by the public sector,

rather than by private entities”². Initiatives in this field also emphasize the “building of infrastructure, political measures and control mechanisms”¹.

The conversation around the concrete development of public pharma contains different approaches and ideas. Above all, perspectives differ in the desired or even the necessary extent of the changes that are aimed at. Some concepts rely on a complete adoption of pharmaceutical research, production and distribution by the public sector. Other concepts primarily suggest step-by-step reforms, or the more consistent utilization of the already existing political room for maneuver. However, it is widely agreed upon that the expansion of public production capacities alone does not suffice. Only through regulatory measures - which orient the pharmaceutical system according to public interest - can the unhealthy commercialization and privatization of global supply be sustainably diminished.³ An example of such a regulatory measure would be to make public funding for pharmaceutical research contingent on certain conditions, such as the obligation to offer the resulting drugs at affordable prices. This could simultaneously enable better working conditions for healthcare professionals, and also public participation in decision-making, for example regarding research priorities.⁴

The discussions surrounding public pharma are not starting from scratch. Already today, public research

and the public funding of research make an essential contribution toward the development of most pharmaceutical innovations. The success of public pharmaceutical production is already evident, as shown by examples in Asia, Europe and Latin America.⁵

This publication provides an overview on the topic of the future that is public pharma, while expanding on

selected aspects via compelling examples. Also, an analysis is provided on why the current pharmaceutical system needs fundamental reforms, and approaches are introduced which as of now already contribute toward a provision of medicines that is oriented according to public interest. (EF)

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*"Fix the patent laws" campaign in South Africa
Photo: © Shayne Robinson*

UNHEALTHY GREED

Why pharmaceutical policy needs radical change

Headlines about billions in profit and potential breakthroughs in research cannot hide the fact that the business model of the commercial pharmaceutical industry is in a fundamental crisis. The consequences: not only countless patients, but entire countries are deprived of sustainable healthcare. Even in wealthy countries the situation is escalating.

Each day, large parts of the world population experience first-hand that their healthcare is inadequate. An important cause of this is the limited access to adequate and affordable medicines. The World Health Organization (WHO) has been warning for years that

about two billion people worldwide do not have access to essential medicines.¹

A matter of justice

In many low- and middle-income countries, such questions of medical care are a highly political problem that directly relates to the human right to health. In South Africa, for example, cancer patients have recently followed in the footsteps of the famous Aids-activists of the 1990s and 2000s.² Meanwhile, however, even societies in richer countries feel that something fundamentally got out of control. In the US, the popular comedian Jon Stewart lately lamented to an audience

of millions: “Pharmaceutical companies get everything from our government. Tax breaks, research grants, patent extensions worth billions of dollars. And what do we the people get for it? The highest drug prices in the Western Hemisphere!”³

Health is a commodity today, more than ever before. The commercial pharmaceutical system is not geared toward real global health needs, but rather toward maximizing profit. Many voices within the industry see no contradiction in this – those who want innovation simply need to “reward it accordingly”.⁴ According to the theory, the highest possible profit is the most important incentive for (human) progress – ultimately a variation on the famous “Wall Street” monologue from 1987: “Greed [...] is good. Greed is right. Greed works.”⁵

In fact, market mechanisms have been failing for decades when it comes to urgently required research, for example regarding antibiotics or widespread diseases of poverty. For the diagnosis and treatment of neglected tropical diseases, the Tanzanian researcher Dr. Mwelecele Ntuli Malecela once stated: “at the moment we are using 19th century tools in the 21st century”.⁶

Dividends instead of patients

Despite all this, the myth of greed as a driver for progress is perpetuated by one of the most financially powerful industries worldwide, which in 2025 spent around \$340 million on lobbying activities in the US alone, more than any other industry.⁷ It is often overlooked however, that its business model is noticeably different today from what it was in the 20th century (see quote box).

This carries negative consequences not only for the development of drug pricing, but also for the innovative research that the industry often proudly cites as its *raison d'être*.⁹ Among other things, this financialization leads to dividends for shareholders cutting into actual research investments: “To put it bluntly, it is no longer patients who are a pharmaceutical company’s target audience, but shareholders.”¹⁰ Due to the central role of intellectual property rights (IP) in this context, critical analyses draw clear parallels to the technology sector. In both cases, global players would establish their dominance not primarily in free markets through the competitive sale of goods or services, but through monopolized control of the production and distribution of knowledge in the form of intellectual property.¹¹

How you’ve changed!

“The pharmaceutical industry has been transformed since the beginning of the 1980s. While its core business is still that of producing and selling substances with therapeutic value for the benefit of patients, and there continue to be some important successes, the companies now differ considerably in character from those in the decades following the Second World War. The changes in character are linked to neoliberal economic policies and an increasing financialisation of the industry, most obviously visible in the high proportions of shares in pharmaceutical companies held by major financial companies, but also in the business strategies they adopt. These include changes to the size and character of the financial packages paid to senior managers, [...] along with the extensive use of share buybacks and increased spending on marketing, all of which take up a growing proportion of company expenditure. They also include the heavy reliance on securing new, potentially profitable drugs, via mergers and acquisitions, and in many cases the dependence on borrowing with the aid and encouragement of the financial sector to accomplish them.”⁸

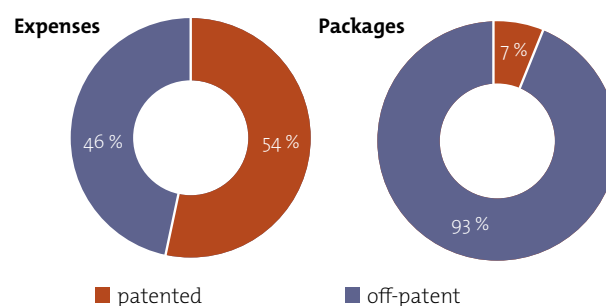
Joan Busfield

Patents, prices, problems

Intellectual property has many facets, with patents usually being at the center of interest. Their effects have a direct impact on patient care, as illustrated by a look at the expenses of the statutory health insurances in Germany in 2024: despite making up only 7% of packages dispensed, pharmaceuticals protected by patents accounted for more than 50% of the costs.¹²

Pharmaceuticals in the statutory health insurance companies in Germany, 2024

Financial expenses and dispensed packages



Own illustration according to Techniker Krankenkasse (2026)¹²

Patents make it possible to charge high drug prices, resulting in massive profits that are far higher than those from generic drugs.¹³ Despite forming the backbone of global medicine supply, generic drugs are coming under increasing pressure, especially due to lower profitability and companies focusing on more lucrative markets – one consequence of this are highly problematic supply shortages.¹⁴

The pharmaceutical industry has found ways and means to secure patents, trade secrets and other forms of intellectual property as comprehensively as possible (see Production & distribution, p. 11). At the same time, the public sector plays a key role in research which has led to the existence of “a state-subsidised pipeline in which universities and startups generate discoveries while large corporations consolidate ownership. It is a mechanism that socialises costs and privatises profits.”¹⁵

What comes after the peak?

The relentless defence of the business model described here was reflected particularly starkly in the global vaccine inequity during the COVID-19 pandemic. Dr. Ayoade Olatunbosun-Alakija, then co-chair of the African Vaccine Delivery Alliance, summarized in 2021: “We are allowing people to die because of selfishness from high-income countries and because of greed, quite frankly, from the pharmaceutical industry.”¹⁶ The World Trade Organisation (WTO) long stalled concrete discussions about a patent waiver only coming to an arguably watered-down decision in late 2022 – rich countries with pharmaceutical industry had prevailed.¹⁷

Also due to the international upheavals of that time, there is a growing number of voices suggesting that the current pharmaceutical model is heading toward a kind of tipping point, referred to in expert circles as “peak pharma.” That peak is characterized by “peak pricing, peak resource concentration, peak financialization, and peak expansion.”¹⁸ However, as anyone who has hiked in the mountains knows, after the peak comes the descent. This makes it all the more urgent to look for alternatives and to give new approaches like public pharma a greater chance in practice. (MK)



Unequally distributed worldwide: COVID-19 vaccine
Photo: © Matt Hunt/iStock

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Research is a complex web
Photo: © Doris Teng/iStock

RESEARCH: TO THE ROOT OF PROBLEMS

Innovation without the pursuit of profit is possible

Research is the starting point for new pharmaceuticals as well as for improving or potentially repurposing active ingredients already known. It is hardly surprising that the structural crisis in the private pharmaceutical sector is very evident there. But how can change be initiated?

A publicity campaign by the pharmaceutical umbrella organization IFPMA in 2023 called pharmaceutical innovation “the core of our industry’s work”, using the hashtag #AlwaysInnovating.¹ This perpetuated the widespread myth of the industry as the driving force behind medical progress. In reality, however, the commercial research system has traditionally been heavily influenced by the taxpayer-funded public sector. For example: Five out of six first-generation Aids drugs originated in the laboratories of state institutes and universities.² Unfortunately, both policymakers and the public are largely unaware of this constellation, even though it means that a solid basis for public pharma already exists.

Check, please – twice

Due to the lengthy and often confusing process leading up to the approval of a drug, the state’s contribution in terms of funding and scientific work is quickly overlooked. This is most evident in basic research, which is both fundamental and risky. In general, large

corporations often buy innovations from outside (see quote box). As a result, patients easily end up paying twice for a product: once through taxpayers’ money and again through health insurance premiums and co-payments - even though industry representatives like to deny this.³

Who is actually doing the research here? —

“Typically, the pattern is as follows: the public sector pays for the entire basic research, which takes many years to succeed. As soon as a patentable result is achieved, commercial exploitation is being promoted by the universities’ respective technology transfer offices. Then, a biotech spin-off (a so-called university start-up) is founded, also with significant public funding, to conduct the first pre-clinical trials. Pharma companies have “patent scouts” who closely monitor what universities are researching so that — as soon as the first positive results emerge — they can make an offer. They purchase the patent, negotiate an exclusive license or even buy the whole start-up right away, in order to then conduct clinical trials to test the drugs in humans. In the meantime, there may be one or more sales of the companies along with their products.”⁴

Claudia Wild

Examples of the costly privatization of knowledge are easy to find, with the history of insulin being particularly noteworthy (see In focus: insulin). The mRNA vaccines developed during the COVID-19 pandemic are another notable example; despite political lip service, they were not treated as a global public good, even though the roots of key technologies involved lie in public research.⁵ In 2021, Pfizer alone generated nearly \$37 billion in revenue from its vaccine Comirnaty®.⁶ The company repeatedly emphasized that it had not

received any government funding for its research. Their partner Biontech, however, which had been the primary driver behind the product, not only built on public research but also received additional government funding.⁷ Their competitor Moderna, which also generated billions in revenue from mRNA vaccines, benefited even more extensively, both directly and indirectly, from public research and money.⁸

In focus: insulin

Few medications have revolutionized their field of application as dramatically as insulin – unfortunately, its history also serves as a warning. Frederick Banting and his colleagues filed their innovation for a US patent, but in 1923 they sold the rights to the University of Toronto for a symbolic dollar each. They assumed that publicizing the production method would lead to the emergence of many producers, thus preventing profitable monopolies. “The desire was straightforward: that everyone who needed this life-saving drug should have it.”¹⁰ Banting himself said, insulin belonged to the world.¹¹

It didn’t even take a century for their hopes to be dashed. A research paper in 2013 for example identified a “double scandal”, because one lives “[...] in a world where resources are being wasted on products that show only small benefits, while people are not benefiting from a product that was first used some 90 years ago.”¹² After Banting’s and his colleagues’ landmark achievement, laboratories began producing as early as 1923 under manufacturing licenses in Denmark, Germany and Austria, later followed by Hungary, Australia, and Argentina.¹³ Today, however, more than 90% of the insulin market is controlled by three manufacturers (Eli Lilly, Novo Nordisk, and Sanofi).¹⁴ Among the drastic consequences of this lack of competition are high prices, gaps in research on temperature stability, and the industry-driven shift of supply toward more expensive insulin variants, often without adequate additional benefits.¹⁵ Meanwhile, in many low- and middle-income countries, even older products remain unaffordable.¹⁶

Consequently, it is not surprising that this particular drug is often a subject of discussion in debates around public pharma. Domestic production could

solve several problems for countries at once, including not only the crushing cost burden but also supply shortages.¹⁷ An initiative by California has recently attracted a great deal of attention: the US state currently offers an insulin variant as a more affordable biosimilar through a manufacturing partnership (see Production & distribution, p. 11), while planning to produce it on its own in the foreseeable future.



Frederick Banting and Charles Best with a dog at the University of Toronto, 1921
Photo: © Thomas Fisher Rare Book Library, University of Toronto

What if?

How things might look differently can be explored using the example of caplacizumab (brand name Cambli®), which is used to treat a rare but dangerous blood clotting disorder. The drug originated from research activities on nanobodies at the publicly funded Flemish Institute for Biotechnology (VIB) in Belgium. Through a spin-off from the VIB called Ablynx, investors like venture capital funds took notice of the work. In 2018, they were able to cash in: Shortly before the approval of caplacizumab, Sanofi bought Ablynx for nearly 4 billion € and subsequently charged high prices, even in Belgium itself.¹⁸ Within the framework of public pharma, the state would have retained ownership of the rights, profits could have been reinvested in research, and prices could have been set appropriately. This would have resulted in greater independence from industry pressures, and greater transparency.¹⁹

The community should benefit appropriately from the fruits of public research. Jonas Salk, pioneer of polio vaccine development, did not patent his most important discovery in 1955, because he believed it belonged to the people (see Rethinking Europe's pharmaceutical system, p. 19). He emphasized this with the famous question, "Could you patent the sun?"²⁰



Indian stamp for a polio vaccination campaign, 1998

Photo: © raclo/iStock

Setting aside such categorical decisions, concrete requirements could at least be used as a smaller-scale solution: "Patents and licenses should be tied to clear conditions of access and pricing, as well as a disclosure of research and development costs."²¹ The promotion of open access and open source also fits into this context, so that research is transparent and knowledge can be easily transferred globally.

Improper care here and there

Alternatives to the status quo are urgently needed. As mentioned before, vital fields of research have been alarmingly neglected in the 21st century. Therefore, there have been calls for years for the public takeover of antibiotic development.²² For globally widespread poverty-related diseases like parasitic worm infections, patients' hopes in turn, rest on veterinary medicine rather than on human medicine.²³ At the same time, underfunded research into neglected diseases, mostly conducted by universities or product development partnerships, often depends on the goodwill of a few donors. This includes large foundations that lack democratic legitimacy and pursue their own agendas.²⁴

The counterpart to this undersupply, which for the most part affects countries in the Global South, is the oversupply in the Global North. Lucrative markets in rich countries are intensely served by companies and fiercely contested. In this context, high prices are one of the "collateral damages" for the population, but far from the only problem. To gain a foothold, the pharmaceutical industry, for example, invests vast sums in advertising, public relations, and influencing the prescribing practices of healthcare professionals. This has had drastic consequences, for example, in the United States in the form of the ongoing opioid crisis, which has claimed hundreds of thousands of lives, in part due to the aggressively marketed painkiller OxyContin®.²⁵

Innovation without access

When investigating the causes of this unhealthy state of global pharmaceutical supply, the role of intellectual property inevitably comes into focus – not as the sole problem, but a central one. The focus is usually on patents, although other aspects of IP such as market exclusivity, data exclusivity and trade secrets are also significant.²⁶

Patents are a regulatory tool and should encourage innovations that are useful to society. The basic idea is that an innovation can be protected from competi-

tion for a limited time, allowing “inventors” to profit from monopoly pricing. However, as noted not only by Joseph Stiglitz, winner of a Nobel Prize in economics, healthcare is not a usual market, plus there is another catch. “The fundamental problem with the patent system is simple: it is based on restricting the use of knowledge.”²⁷ In extreme cases, this results in medical innovations without access, and in fact, this means that for a large portion of the world’s population, many new drugs are effectively nonexistent.

Brazen delaying tactics

The commercial pharmaceutical industry is currently shaped by the pursuit of high-priced blockbuster drugs that remain unchallenged for as long as possible. For a long time now, products have not just been guarded by a single patent, but by an entire thicket, “a dense, overlapping web of intellectual property rights that wraps around a single drug like a legal fortress.”²⁸ One aspect of this is the so-called evergreening, an “[...] abusive accumulation of secondary patents”.²⁹

Patent thickets carry severe consequences for patients and supply systems. For example, more affordable generic versions of the blood thinner Eliquis® (active ingredient apixaban) reached the US-market years later than Europe, thereby costing additional billions of US-dollars, benefitting manufacturer Pfizer.³⁰ Similarly the manufacturers of Humira® (adalimumab) and Keytruda® (pembrolizumab) benefited from various brazen delaying tactics. This way Humira®, used to treat autoimmune diseases, generated more than \$200 billion in revenue for AbbVie.³¹ The cancer medicine Keytruda® generated \$25 billion in sales in 2023 alone, about 40% of the sales of MSD.³²

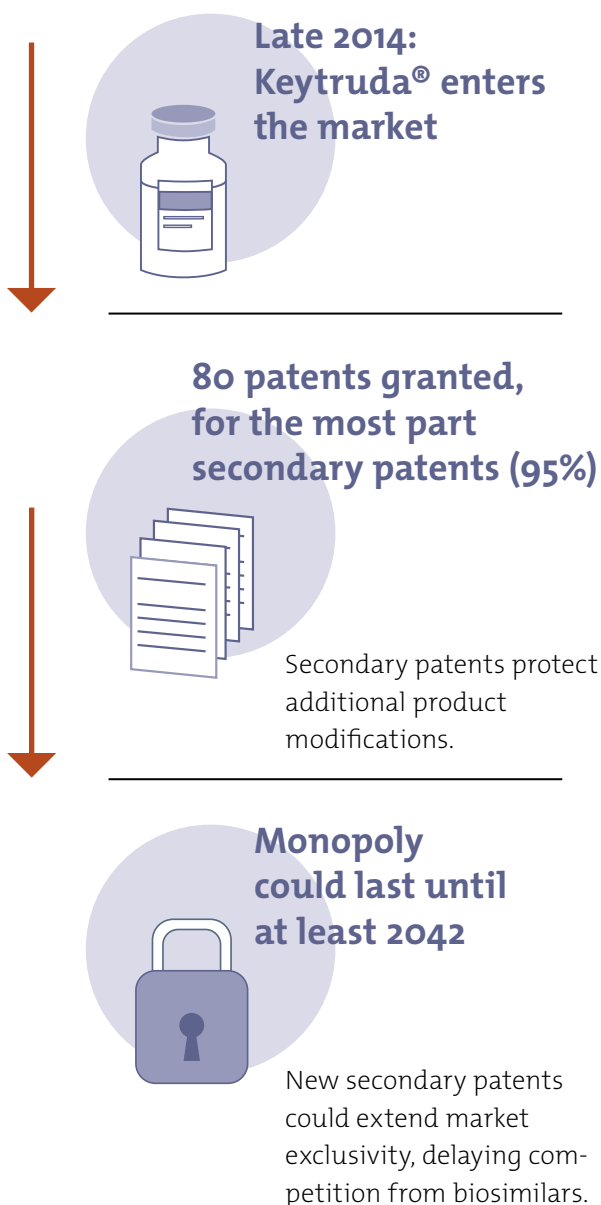
However, there are even more tools to restrict free competition, such as the “pay-for-delay”-approach. Through this, companies have undermined competition many times, “[...] by offering patent settlements that pay generic companies not to bring lower-cost alternatives to market.”³³

More appearance than substance

Paradoxically, yet logically, there is a phenomenon that coexists with this artificial scarcity, namely the flooding of profitable markets with drugs that are new, but unnecessary or even inferior. Remarkably, these pseudo-innovations are also routinely prescribed and paid for at a high cost, for example in oncology: “An evidence-based selection of appropriate cancer medica-

How evergreening can extend the monopoly

The case of Keytruda® (active ingredient pembrolizumab)



Own illustration according to Public Eye (2026)⁴⁹

tions is therefore just as important as the lowering of prices.”³⁴ As a general rule, when independent authorities and watchdogs take a closer look, they find that the lion’s share of new drugs does not offer a verifiable additional benefit.³⁵

Lack of transparency is one of Big Pharma’s most important allies. In the case of clinical trials, for example, when data remains undisclosed due to unfavorable results, this fuels inefficient duplication of research and also leaves the true benefit of a drug (or the lack thereof) unclear.³⁶ Furthermore, due to the lack of transpar-

ency driven by the industry, the actual costs of research are traceable only in the rarest of cases. Just how easy it is for rather arbitrary figures to gain traction is illustrated, for example, by the often-cited claim over the years that developing a new drug costs companies an average of one billion US dollars. A figure that even the then-CEO of the pharma giant GSK once called “one of the great myths of the industry”³⁷.

Buying instead of researching

Academic studies have repeatedly tried to shed some light on the matter. An analysis of 60 new drugs on the US market from 2009 to 2018 found no correlation between estimated research and development investments and the list prices.³⁸ As mentioned, buying innovations, especially from the startup-scene, has been the dominant strategy for quite some time now: “So it is not the expensive research which drives up the price, but rather the estimated value of a company at the financial market when it is sold or acquired.”³⁹ This became particularly clear during investigations of the US Senate Committee on Finance into the sales practices of the company Gilead regarding its hepatitis C drug sofosbuvir (Sofaldi®). The active ingredient was bought up with a start-up that had calculated the research costs leading up to approval at \$188 million. Ultimately, however, Gilead sold the drug for 100 times its production cost, generating exorbitant profits in the billions for the company.⁴⁰

Whatever the cost

The composition of a price asked by a corporation is hard to trace, even setting aside research costs. Furthermore, an overview of the different prices paid by buyers is missing: “Public purchasers negotiate, as it were, blindfolded with pharmaceutical companies on the price of new medicines.”⁴² It is highly concerning that some countries have recently even passed laws that further tighten price secrecy, for example in Spain⁴³ and Germany⁴⁴.

The dynamics behind these negative developments are alarming, as shown by a look at Germany, where spending on medications by statutory health insurances has risen by more than 70% since 2010: “the biggest cost drivers are new, patent-protected medications, especially expensive gene therapeutics, cancer therapeutics and immunotherapeutics. This is also reflected in the average cost of a package of patent-protected medications. While in 2014 this figure was still [at] 190 euros, by 2024 it had already reached approximately

590 euros, and the trend is upward.”⁴⁵ In many poorer countries however, where a large portion of the population is uninsured, high prices result in the complete exclusion of patients from care. And this is despite the fact that those very countries were sometimes even the sites of clinical trials in the past.⁴⁶

Plaster on a fracture

From a historical perspective, these developments constitute an extreme escalation, because patents on active pharmaceutical ingredients are a recent phenomenon (see quote box).

However, in the wake of the WTO’s founding in 1995, the TRIPS Agreement led to the globalization of drug patents, and a large number of them got filed also in countries of the Global South. As a result, new drugs for the most part cannot be manufactured there with low costs any longer. The legally enshrined option of compulsory licensing has proven to be a selective remedy, but it seems like a plaster on an open fracture—relying on the industry’s voluntary cooperation, in turn, is highly risky (see Production & distribution, p. 11).

Critical voices therefore call for a greater public pharma commitment: “Instead of continuing to attempt to cajole industry to do something it’s not designed to do, we can choose to develop many essential medicines in the public sector [...]”⁴⁷ With an eye toward the Sustainable Development Goal (SDG) of universal health coverage, the reorganization of pharmaceutical research is urgently needed.⁴⁸ (MK)

A turn for the worse

“For almost 100 years, physicians and pharmacists successfully opposed the idea that therapeutic agents are industrial commodities like any other. However, as the number of industrially made specialties grew, the pharmaceutical firms specializing in the relatively large-scale production of standardized and ready-made therapeutic preparations as well as the trade associations in the chemical sector started to argue and lobby for changes in the patent law. [...] Then, in a decade after World War II, a wave of legal measures established procedures for patenting drugs in one European country after another.”⁴¹

— Jean-Paul Gaudillière

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Pharmaceutical production — an intricate process
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PRODUCTION & DISTRIBUTION: ENSURING MEDICINES REACH PEOPLE

Public pharma creates alternatives

The availability of a drug relies heavily on its profitability. Supply shortages of affordable generics and excessive prices of patented medicines are two sides of the same coin. Public pharma counters these unhealthy market mechanisms with a more sustainable logic.

Essential medicines cover the most important health needs of a population. Therefore, they should always be available and affordable. But reality looks different: data of the WHO Global Health Observatory from 2010 until 2019 shows that in selected low- and middle-income countries, only 8 to 41% of health facilities consistently had an appropriate range of essential medicines.¹ This supply gap becomes particularly apparent with neglected diseases of poverty, for instance globally frequent envenomings from snakebites (see info box In focus: antivenoms, p. 12).

Medicine supply in the profit trap

Producing certain medicines whose patents expired long ago can be economically unattractive for manufacturers. More than 90% of reported shortages of critical medicines² involve generics. In two-thirds of these cases, only a small number of suppliers are available (see quote box).³

Shortages by design

“Drug shortages are a decades-old problem arising, in part, from market forces [...]. Key issues include a broad lack of transparency, concentration among middlemen, and prices for generic drugs that are driven to levels so low that they create insufficient incentives for redundancy or resilience-oriented manufacturing, distribution, and purchasing. These market failures lead to pharmaceutical supply chains that are brittle, disruption-prone, and too slow to recover from shortages.”⁴

————— U.S. Dept. of Health and Human Services

How far-reaching the effects of price pressure can be is shown by the example of Xellia in Denmark. In 2025, the pharmaceutical company announced the closure of its production facility for active pharmaceutical ingredients (APIs) for antibiotics in Copenhagen, relocating parts of the production to China. Affected by this was, among others, vancomycin, an important antibiotic of last resort used to treat severe infections caused by resistant bacteria. The company attributed the decision to the lower cost of production in competing markets. This does not only eliminate significant local production capacities – in addition, it exacerbates

the dependence from a limited number of sites outside of Europe.⁵

Public production as an alternative

The generics market offers an obvious starting point for public pharma, because when the patent protection expires, public or non-profit manufacturers can join production, or they can hire private companies to produce under fixed conditions (for example lower prices).⁶

Practical examples for government production can be found worldwide, for example in Brazil (see In focus: Fiocruz (Brazil), p. 15) and Sweden (see In focus: APL (Sweden), p. 17). India, too, has public pharma production. The state-controlled company Karnataka Antibiotics & Pharmaceuticals (KAPL) manufactures, among other products, antibiotics and supplies public health facilities.⁷

MassBiologics on the other hand, an institution of the public UMass Chan Medical School in the US-state of Massachusetts, has been developing and producing vaccines and, today, also biologics for over a century – expressly also for areas which are less attractive due to their smaller market size.⁸

But there are also non-profit pharma companies like Civica Rx in the US. The firm, founded in 2018 by hospital systems and foundations, deliberately focuses on important generics which are threatened by shortages. The supply is oriented according to the needs of the hospitals involved. Long-term distribution contracts and reserves are designed to further secure availability. According to its own statements, Civica RX by now supplies more than 1,400 hospitals in the country with over 70 pharmaceuticals.¹⁴ Civica also collaborates with California in the public program CalRx in an effort to deliver affordable insulin to the market.¹⁵

In focus: antivenoms

More than five million people are bitten by snakes each year, according to conservative estimates by the WHO – tens of thousands die from envenoming, hundreds of thousands “suffer from disabilities such as amputations, scarring leading to impaired limb function and post-traumatic stress disorder.”⁹ Antivenoms are the only direct antidote used in the treatment of people who have been bitten, but in many places, they are not available, affordable, and/or suitable.

For decades, the global antivenom market has been caught in a vicious circle characterized by high prices, limited supply and frequent quality issues.¹⁰ Private manufacturers avoid the complex production required to supply mostly poor patients. Government involvement is therefore crucial. Costa Rica is a prime example for this. As early as the 1960s, the country began taking the antivenom supply into its own hands – today, it is an international heavyweight in this field. With the founding of the public Clodomiro Picado Institute (CPI) in 1970, the problem was addressed from multiple angles: “It was conceived as an academic center that would combine production, intense scientific and technological research, teaching of undergraduate and graduate students and various social extension activities.”¹¹ Thus, for example by a better epidemiological over-

view, the production could adapt to national specifics such as the frequent cases of envenoming caused by the so called terciopelo (see photo). The CPI is part of the University of Costa Rica and independently produces antivenoms for the veterinary use as well as for human medicine. The latter are provided directly for the social security system which makes them available extensively and free of charge to patients.¹² Thanks to the CPI’s work, not only has the national provision improved significantly, but the institute also supplies other countries, even beyond Latin America.¹³



Terciopelo (Bothrops asper) – not a rare sight in and around Costa Rica
Photo: © Mark Kostich/iStock

Examples like these demonstrate: in many places, public and non-profit production already exists.

Principles and Licenses

Basic research on pharmaceuticals is often financed publicly, later innovation however is often privatized through sale (see Research: to the root of problems, p. 5). Equitable licensing aims to intervene at this stage: when granting intellectual property rights, universities and other public research facilities should not only be driven by their revenue. Rather, the primary point of reference for an innovation should be its public health value.¹⁶

How such principles could be anchored institutionally is shown by McGill University in Canada. In 2019, it introduced its “Global Access Licensing Principles” to tie the licensing of university research to affordable access to emerging medicines and other health technologies.¹⁷ The practical possibility of integrating access conditions into licensing agreements is also demonstrated by the University of California. Since 2020, it has been using a clause in its exclusive biopharma-licenses which binds licensees to present a concrete plan for affordable access in low- and middle-income countries in case of a successful approval.¹⁸

Voluntary agreements and their limitations

But what if a patent has long been granted? High prices for patented drugs put healthcare systems under financial pressure, while making access more difficult for many people. In the Global South, this imbalance is exacerbated: even though the largest part of products on the WHO’s list of essential medicines is available as generics, the rest is often only available on paper in poorer countries due to their lower purchasing power.

A widespread approach that is often emphasized by the industry puts voluntariness at the center, for example by granting licenses to institutions like the Medicines Patent Pool (MPP). Founded in 2010 by Unitaid, it can demonstrate success especially for HIV drugs, because it enables the cheap production of generics.¹⁹ Another example of its work is the cancer medication nilotinib. A license for it was granted to the MPP by Novartis in 2022. Generics producers then were able to enter manufacturing: in 2025, initial shipments were reported to El Salvador, Indonesia and the Philippines, among others.²⁰

Voluntary obligation of Big Pharma however is a delicate instrument. More often than not, commitment is lacking in the truly lucrative fields, which was recently illustrated by the so-called C-TAP in the COVID-19 pandemic, an initiative that was missing vaccine licenses in its portfolio.²¹ And voluntary also means: the patent holder gets to have a say in the decision on who gets access under which conditions. But what happens when companies exclude certain countries or whole groups of countries? In the case of lenacapavir for example, a new active ingredient for the prevention of HIV, agreements between the manufacturer Gilead and producers of generics exclude important emerging countries like Brazil.²² In cases like this, states have to resort to further legal measures, among them compulsory licensing.

Compulsory licensing as an instrument of the state

The TRIPS-agreement gives leeway to states when patents obstruct the access to medicines. With compulsory licenses, a state can allow other producers to make a patent-protected drug without the approval of the rights holder, thereby lowering prices. The patent itself notably remains, the owner receives a compensation.

The 2001 Doha-Declaration expressly clarified that the TRIPS-rules should be interpreted in a way that allowed states to take such measures for the protection of public health and that they should be able to support the access to medicine.²³ Non-voluntary licenses however are regularly met with massive resistance by Big Pharma and by the countries in which large corporations have their headquarters. Manufacturer lawsuits and pressure on states not to grant such licenses in the first place are not rare occasions.²⁴

Compulsory licenses actually creating room to move is exemplified by Thailand. Starting in 2006, the local government used the instrument for several patent-protected drugs, among them HIV medications and clopidogrel against cardiovascular diseases. Thereby, significantly cheaper generics were able to be sourced: according to the WHO, the price of efavirenz was 87% lower than the original price of the patented medicine, in the case of clopidogrel it was even 98% lower.²⁵

Non-voluntary licenses: globally used

A recent evaluation of the years 2001 to 2024 shows that this leeway in international patent law was used many times around the world – interestingly enough, especially by wealthy nations. More than half of the

non-voluntary licenses granted in the past ten years were attributed to high-income nations.²⁶ And even the threat alone can be effective: in almost half of the cases which were not followed through, companies reacted with concessions like lowering prices, voluntary licenses or donations.²¹ In 2014, civil society organizations in Colombia proposed a compulsory license for Glivec® (imatinib), a cancer medication by Novartis. A technical committee recommended in 2016 that the conditions for further steps should be determined. A compulsory license was not granted after all. Instead, the government declared the medication subject to public interest, laying the foundation for a price regulation by the state which led to a lowering of the price by 44%.²⁷

But scope of action on paper does not guarantee medicinal provision. Even a granted license is of little help when production capacities and necessary know-how are lacking. This was shown in Rwanda: because the country could not produce the needed HIV medication on its own, it had to be produced abroad. On the basis of a special WTO mechanism, the generics manufacturer Apotex in Canada received a compulsory license to produce the medical preparation there and export it to Rwanda.²⁸

Domestic production creates negotiating leverage

How strong the dependence on few pharma companies can be in general, is illustrated by the example of cystic fibrosis medications by Vertex. For the same therapies, European nations pay very different figures. Small states in particular have the cards stacked against them: in Lithuania and Cyprus, the medications were not refunded for a period of time, negotiations with Vertex did not lead to an acceptable outcome for years. The problem is exacerbated by secret price-fixing. This makes it harder for countries to know which prices other nations actually pay – weakening their negotiating positions with the producers.²⁹

Public pharma creates an alternative: when one is not completely reliant on a few providers of important pharmaceuticals, one can more successfully negotiate prices and shipping conditions. Public production can additionally create extra capacities while setting standards for environmental responsibility and working conditions, that are not only oriented toward short-term profitability. Thus, public pharma means more than just a state-run factory. (EF)

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*Fiocruz headquarters in Rio de Janeiro, Brazil
Photo: © Cristian Lourenco/iStock*

IN FOCUS: FIOCRUZ (BRAZIL)

Active from the plague to COVID

From a public pharma perspective, Latin America offers a wealth of interesting case studies. Brazil for example, the most populous nation in the region with over 200 million people, is home to Fiocruz, a public health institution of great national and global significance.

Its origins can be traced back to devastating plague and yellow fever epidemics that ravaged several cities around 1900. From the Instituto Soroterápico Federal, founded by the government, later emerged the Fundação Oswaldo Cruz (Fiocruz).¹ Today it “[...] works in all stages of public health, from basic research and health care to innovation and production of supplies, such as vaccines, diagnosis kits and drugs.”² Despite its extensive involvement in training and education, it should not be mistaken for a university, also additional state research institutions and producers in the health sector exist alongside of it.³

Research for the population

Fiocruz is subordinate to the Ministry of Health and comprises 16 technical-scientific units, spread over several states.⁴ Its work has always been specifically geared toward national health needs. When Brazil introduced its public, universally accessible health sys-

tem, the SUS (Sistema Único de Saúde), in 1988, Fiocruz played a central role.⁵ This was also highly symbolic: “In the historical context of the struggle for the re-democratization of the country, SUS was the concrete project to guarantee health as a right for all and as a duty of the state.”⁶

In this context, it is particularly noteworthy that Fiocruz focuses on diseases that primarily affect poor parts of the population and therefore receive little attention from the profit-driven pharma industry. Pioneering research on the transmission cycle of Chagas disease,⁷ a parasitic infectious disease widespread in Latin America, has even gained historical significance. Clinical trials are currently underway for a first specific vaccine against leprosy, for which Brazil has the second-most cases worldwide.⁸ In general, vaccines remain a major focus. For example, yellow fever is still a top concern and Fiocruz one of only four manufacturers worldwide with a WHO-prequalified vaccine against this globally widespread infection, also exporting it on a large scale.⁹

From the laboratory to the bedside

The institution is distinguished by “[...] a very peculiar and rare characteristic in the international bioindus-

trial market, which is this possibility, of being able to go from discovery by researchers, to developing a final product to be used at a patient's bedside."¹⁰ The bulk of Fiocruz' production at its affiliated facilities Bio-Manguinhos and Farmanguinhos however, consists of well-known pharmaceutical products, rated indispensable by the state and required in public healthcare by the SUS. Among these are antibiotics, painkillers, biosimilars for oncology as well as diagnostics and therapeutics for neglected tropical diseases, plus "The Big Three" (HIV/Aids, malaria, and tuberculosis).

In addition, there are vaccines, for example against measles, mumps and rubella (MMR). During the COVID-19 pandemic, the Oxford-AstraZeneca vector vaccine was produced through a cooperation.¹¹ For several years, Fiocruz has also been involved in Brazilian insulin production.¹² At the same time, Brazil's ambitions in domestic manufacturing face a problem in many areas that is all too familiar in Europe – the heavy reliance on imports of active pharmaceutical ingredients from Asia.¹³

A balancing act

The current work of Fiocruz also reflects the internal tensions of Brazilian health policy since the turn of the millennium, for example with regard to production. In 2007, Farmanguinhos was involved in enforce-

ing the compulsory license for the HIV drug efavirenz (Sustiva®) from MSD, and in 2017, it participated in the official patent opposition against Gilead's hepatitis C drug sofosbuvir (Sovaldi®).¹⁴ However, Farmanguinhos additionally relies on so-called "Partnerships for Productive Development"¹⁵, which, starting in 2009 at the latest, were increasingly promoted at the national level as a tool and which "[...] are public-private agreements aimed at transferring technology from private to public pharmaceutical companies for the production of specific medicines, intending to bolster local industry, reducing import dependence, and enhancing technological capacity in Brazil."¹⁶ Bio-Manguinhos also pursues such partnerships, some of them with major international companies such as Merck Serono and Pfizer. Thus, Fiocruz uses government leverage against Big Pharma players, but also employs demand-driven incentives for the industry.¹⁷

This balancing act can also be found elsewhere. For instance, Fiocruz is generally committed to an open-access approach¹⁸, however it does indeed patent innovations itself while working with a range of licensing models. Ultimately, this renowned institution can thus also be seen, to some extent, as symbolic of the criticism voiced by some supporters of Public Pharma that attempts to find solutions to the current crisis often remain within the familiar framework of market-oriented approaches involving private actors.¹⁹ (MK)

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APL headquarters in Stockholm, Sweden

Photo: © Ryno Quantz/APL

IN FOCUS: APL (SWEDEN)

Production to meet public needs

When a medicine is not offered by the pharmaceutical market, it is produced by a state-run company in Sweden. The enterprise provides patients with important medicines and even took over a penicillin factory in 2025.

Apotek Produktion & Laboratorier AB (APL) emerged from the public pharmacy sector - from 1970 to 2009, all Swedish pharmacies belonged to the government-owned enterprise Apoteket AB.¹ Earlier during that time, individual pharmacies produced customized drugs (compounded medications) themselves. Starting in the 1980s, Apoteket AB bundled this task in centralized production facilities.² Out of these sites, APL emerged. However, Sweden opened the market for private suppliers in 2009, selling most of its pharmacies.³ The centralized production of individually adapted medicines however stayed in the public sector: APL was carved out of Apoteket AB in 2010 and has been producing as a standalone state-run enterprise since then.²

Pharmaceuticals by demand

APL fills the gap when approved medical preparations do not cover the needs of patients – for example when the appropriate potency or dosage form is not available.⁴ Preparations are either made individually for the patients, or, in case of regular demand, they

are pre-produced in larger batches. Overall, it offers around 2,000 different formulas, APL states.⁵ The public mission of APL however goes beyond the supply for individual patients as of today. In 2023, the company was commissioned to secure production, also in times of crisis and in situations of national emergency.⁶ It produces the antibiotic isoniazid against tuberculosis as a drinking solution for children, it processes bevacizumab into a nasal spray for people with hereditary hemorrhagic telangiectasia⁷ and it produces morphine solutions for infusion for the continuous pain treatment in home-based palliative care.⁸

The importance of these capacities was illustrated by a supply shortage of a medicine containing the active agent alteplase in 2022, which among other things is used for the acute treatment of strokes. A national coordination office asked APL, whether the missing medication could be substituted by in-house manufacturing. Then, from July 2022, APL produced a complying drug. The same office subsequently distributed the available dosages according to the determined demand to the Swedish regions.⁹ Speaking of distribution: APL delivers individually produced medicines to all pharmacies in the outpatient care market as well as to the inpatient care, under equal and non-discriminatory conditions. APL does not only produce and distribute however; it also develops new formulas and manufacturing processes.

The prices of drugs provided by APL are integrated into the Swedish system of public regulation and reimbursement. These pharmaceutical products are subject to the co-payment rule which limits patient expenditures.¹⁰

Penicillin supply as a litmus test

A 2025 study investigated, why global supply chains for generic antibiotics are so vulnerable to disruption, and which political measures could help stabilize them, using Sweden as an example. It constituted: “More than three-quarters of [the examined supply chains] entail substantial shortage risk.”¹¹ An antibiotics supply-shortage, by the definition of the Swedish Medical Products Agency, is present, when the marketing authorization holder cannot meet the needs for an antibiotic on a national scale. Between 2018 and 2024, the Swedish Medical Products Agency registered 337 antibiotics-shortages. As a small market with comparatively low usage, Sweden is also prioritized little by international suppliers.

In 2025, APL bought a penicillin plant in Strängnäs from the private company Meribel Pharma Solutions. Penicillins are among the most important antibiotics and are used to treat various bacterial infections.¹² The Swedish parliament allocated around 64 million euros for the acquisition.⁶

Problems with supply chains persist

Despite the purchase of the penicillin plant strengthening Sweden’s own production capacities, it does not make the country independent from global supply chains. For the APL-factories, too, need active ingredients and other preliminary products. Where they get them, cannot be traced.

The international interwovenness of Sweden’s supply with antibiotics is illustrated by an evaluation by Uppsala University. The researchers examined confidential registration data of the Swedish pharmaceutical office concerning 204 antibiotic preparations with 25 selected active ingredients which were sold in Sweden between 2013 and 2019. For 27% of the preparations, only European active agent producers were approved, 31% of the medicines came from producers in Europe and beyond, 40% came exclusively from manufacturers in China, India or other non-European countries and the remaining 2% were from producers in the US, respectively in the US and further countries.

The figures do not indicate production or delivery quantities, instead they refer to the registered active ingredient providers for every medicine. In the case of multiple such producers it stays unclear from which producer the agent was actually sourced: also, the origin of used raw materials and intermediates remains unknown.^{13,14}

It becomes apparent: the purchase of the plant strengthened domestic production, but it did not eliminate Sweden’s dependence from international suppliers.

Public – and also commercial

APL is rooted in the tradition of a welfare state, in which public healthcare provision had long been considered a common task. But Sweden, too, has opened more and more areas for competition and private providers.¹⁵ And alongside its public mandate, APL also develops and produces for private pharmaceutical and biotechnology companies. So, the work is supposed to be lucrative: APL states as its own goal that it aims “to be a competitive and profitable supplier.”¹⁶ The factory in Strängnäs, too, serves for the commissioned production of pharmaceutical products. (EF)

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Tim Joye

Photo: © Geneeskunde voor het Volk

RETHINKING EUROPE'S PHARMACEUTICAL SYSTEM

Why Europe needs its own Salk Institute

The European Salk Institute is the vision of a public alternative to the profit-oriented pharmaceutical industry. It aims to develop, produce and affordably provide urgently needed medication.

Tim Joye, could you outline the concept of a European Salk Institute?

For Jonas Salk, after whom the idea is named, patenting his polio vaccine was like trying to patent the sun. You cannot lock up something so vital for the sake of profit. Pharmaceuticals are not a luxury good and everyone has a right to health. The Salk Institute should have the capacity to

Tim Joye

Tim Joye is president of Médecine pour le Peuple (MPLP), a network of 11 multidisciplinary medical centres in Belgium. He works as a general practitioner at the clinic in Hoboken and coordinates the research department, where he helped develop the vision of a European Salk Institute.

develop, produce and distribute medicines, without the profit incentive which has so corrupted the private market. This is a complete shift away from the current framework, because it aims to restructure the market through its impact. An ambitious plan, without a doubt.

What are the fundamental objectives of the institute?

We are speaking about three separate aims. First, developing innovative medicines that meet the needs of the population, whether that means new antibiotics or affordable cancer medicines. This means financing the entire R&D cycle from start to finish, while at the same time creating a collective pool of knowledge that is open and transparent. Second, we need production facilities that meet the highest standards for working conditions and environmental impact, while guaranteeing a fair price for patients and European social security systems. And third, there is the joint procurement of medicines produced by private partners. Here, tenders can be used to ensure that these same principles are upheld.

What is wrong with the way pharmaceutical research priorities are set today, and what should guide them instead?

The criterion that reigns supreme today is profit maximalization. We know that this mindset has led the field astray. From pandemics we know are on the way to diseases of the poor, the neglect of the pharmaceutical industry is shocking. On the flip side, they invest millions into marketing and medicines that do not improve quality of life, but can be patented and monopolized for billions in profits because they demonstrate marginal gains in clinical trials. Public health needs to be the driving principle behind research agendas. There is no need to invent these criteria from scratch, the challenges our society will face are known: aging, antimicrobial resistance, access to affordable cancer treatments...

In this context, how could the “insulin problem” be addressed – that is, how could we prevent private companies from re-privatising knowledge generated in the public interest and using it for profit?

The ‘insulin problem’ shows why we need to set ambitious goals for research and development of the Salk Institute. When insulin was first discovered, it was patented with an open license that allowed equitable access. The patenting of innovations to delivery devices and manufacturing methods by private companies turned this life-saving discovery into a multi-billion-dollar profit machine. Our aim is to guarantee the affordability and availability of medicines. That entails building a collective pool

of knowledge, while simultaneously protecting it from monopolization by private companies. As long as monopoly-creating patents and private companies exist, Salk will have to compete with them, which is why it is critical to be ambitious about the scope of R&D funding. It is also why a flexible approach to intellectual property is necessary. Any data or technology needs to be fully accessible within the Institute’s knowledge hub. On the one hand, open licensing then allows production to be licensed to companies that guarantee affordability of the end product, as was the case for insulin in the beginning. On the other hand, joint procurement by Europe as a whole will guarantee that only useful innovations are reimbursed. We can choose not to buy a patented version of insulin if it does not offer health benefits compared to the generic.

Turning to the financial side: What level of funding would such a project require, and where could that funding come from?

In an article¹ we published in 2024, we made an effort to calculate what an annual budget might look like for the institute to significantly weigh in on the market. Taking the NIH as a benchmark, a European counterpart would have an annual budget of about 25-30 billion euros, of which 10% could be allocated to in-house research and the rest for extramural grants. Our analysis owes a lot to Professor Massimo Florio², who is an expert in this field. He estimated that an annual budget between 3.5 to 7 billion euros would suffice for a research portfolio that can deliver 80-150 innovative projects across 20 years. We are aiming for an organization that fundamentally transforms the market, not just corrects its flaws. It is clear that this will require some ambition. It is equally clear that these resources exist; we are already spending billions on both R&D and purchasing.

Pharmaceutical spending in the European Union is immense and rising. The problem is that very large portions of this money are disappearing into the pockets of shareholders or evaporating in the stock market. On the one hand, billions of euros of taxpayer money are spent on fundamental research that is later patented by private companies. Simultaneously, these patents allow companies to charge our social security systems exorbitant prices, which also come out of the taxpayers’ pockets. The public is duped twice! Not to mention the billions in tax

cuts and benefits that cushion the pharmaceutical industry from all financial risk. These are all resources that can be mobilized in a Europe that puts health over profits.

Some might consider the project overly ambitious or even somewhat naïve. At the same time, the Public Pharma for Europe coalition³ reflects growing momentum in Europe. What conditions are necessary to establish public pharmaceutical initiatives in Europe, and what key challenges would they face?

The Public Pharma coalition has indeed become a spring of hope, gathering many influential experts and organizations who share our vision of a pharmaceutical industry which serves the people and not the shareholder. Our alternative is a strong institutional player that can compete with the oligopolies in the sector. That is the counter-narrative we are building. Such a bold project needs broad public support to exist. The beauty of it is that an initiative in any of these areas can pave the way towards this greater project. Examples of public production or open licensing exist. The Drugs for Neglected Diseases initiative (DNDi) is well-known. In Belgium there are several research groups who have made open source medical imaging software. In Italy and Spain there are non-profits which have shouldered production of gene therapies after industry decided they were not 'commercially viable'. These bottom-up initiatives can serve to create momentum in the road towards the Salk Institute.



Jonas Salk on a U.S. postage stamp, 2006
Photo: © traveler116/iStock

The primary condition to realize our goal is a broad alliance of organizations who understand that leaving our health in the hands of shareholders is not an option. And I believe this is also the greatest challenge we are now facing, to build such an alliance. We need to bring together patients, researchers, workers in the pharmaceutical industry and healthcare to build trust – trust that the public alternative is realistic and necessary.

Thank you for the interview! (EF & MK)

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Public Pharma

A public pharmaceutical industry for a sustainable drug supply

High prices, recurring supply shortages and research prioritizing highly lucrative areas characterize today's pharmaceutical system. To ensure sustainable global access to vital medicines, vaccines, and tests, a fundamental change of course is needed. Around the concept of "public pharma", a global movement for a public pharmaceutical industry has therefore emerged. At its core, it aims to align research, production, and access to medicines with the actual public interest.

This publication provides an overview of the topic and explores individual aspects in greater depth using illustrative case studies. Furthermore, it analyzes why the current pharmaceutical system needs fundamental reforms and presents approaches that already contribute to a more sustainable, common good-oriented provision. The time for change is pressing: The human right to health is in acute danger worldwide.

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