Regulating by ranking? The access to medicine index and the 'will to perform'

Afshin Mehrpouya and **Rita Samiolo** consider the implications of using rankings for facilitating access to medicine

The problem of improving access to medicine in the 'global south' has long been a concern of the World Health Organization (WHO). In 1975, the WHO introduced the concept of 'essential drugs', followed in 1977 by a model list of drugs considered essential to public health.

The year 1994 marked the beginning of a new era. The ratification of the Trade-Related aspects of Intellectual Property Rights (TRIPS) agreement by the World Trade Organization (WTO) forced member countries to institute regulatory platforms for the protection of intellectual property. This led to the enforcement of intellectual property rights for patented pharmaceutical products in emerging markets, where generic copies of on- and off-patent drugs had proliferated. The new regime is deemed to have resulted in significant price increases and decreased supply. While most 'essential medicines' are now off-patent, patented products are regarded as indispensable for diseases such as HIV/AIDS, as new formulations are needed to replace existing ones against which the virus has developed resistance. Furthermore, new formulations of existing medicines are required to reflect disease demographics and natural environments – e.g. heat-resistant vaccines for countries with hot climates and no cold-supply chain. Finally, new medicines for the so-called Neglected Tropical Diseases are, as a consequence of TRIPS, under patent once they enter the market.

A surge of civil society activism followed the introduction of TRIPS. This resulted in litigation between pharmaceutical companies on the one hand and various non-governmental organizations (NGOs), southern governments such as India, and generics manufacturers on the other. Pharmaceutical companies' role in researching Neglected Tropical Diseases (for which their markets are frequently deemed unviable), in providing affordable prices for medicines, as well as their marketing and lobbying ethics in low and medium-income countries have since then become part of the 'access to medicine' debate.

It is in this environment that a new initiative, the Access to Medicine Index, was launched in 2008. Developed by a Dutch NGO, the Access to Medicine Foundation, this is a bi-annual ranking of the 20 largest pharmaceutical companies in the world regarding their policies and practices related to access to medicine (www.accesstomedicineindex.org). This ranking, now in its fourth iteration, has become a central technology in the access to medicine governance space. It has been endorsed by some of the most legitimate actors in this space, such as the World Health Organization and senior United Nations officials. Since 2009, it has received multi-year financing from the Bill and Melinda Gates Foundation and state development agencies of the UK and the Netherlands.

Rankings, such as the Access to Medicine Index, have proliferated in global governance. They aspire to achieve regulatory goals by 'moving' the market. They aim at creating reputational pressures on companies and enticing their 'will to perform' – to borrow an expression from the founder of the Access to Medicine Foundation.

What does regulation by ranking, especially in such a controversial field, entail?

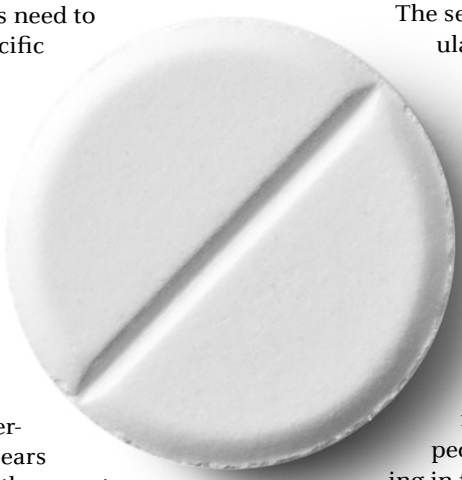
As a regulatory mechanism, rankings require the infrastructure to collect information about participating organizations. This usually involves a questionnaire and the development of a methodology for analysing such information, with the aim of turning non-standard quantitative and qualitative data into a set of comparable elements amenable to scoring and ranking. It is a complex technical task as participating organizations have different information systems, idiosyncratic business models and various degrees of enthusiasm and openness towards such exercises. More importantly, the choice of what to measure and, therefore, reward or punish, encompasses many possible ways of interpreting participating organizations' actions and policies.

In the case of the Access to Medicine Index, at stake in the definition of more than 100 indicators are wildly different interpretations of what access to medicine means, and thus different ways of representing what 'Big Pharma' ought to be doing to improve access. Indicators are defined in consultation with a stakeholder representative body, the Expert Review Committee, whose members are drawn from the pharmaceutical industry, generics companies, the WHO, NGOs, academia and investors. These represent opposing interests and can offer radically different perspectives on contested issues such as pricing, competition and patents. The Index methodology thus emerges as a difficult mediation effort in a highly contested space.

When a middle ground cannot be reached within the Expert Review Committee, the definition of measurement criteria is effectively handed over to the Access to Medicine Foundation and its analysts. The latter implicitly assume the role of mediators between the business case and the social case, seeking to act as neutral 'stakeholder collectors'. They are required to act scientifically – i.e. give substance to the Index's methodological aspirations

towards objectivity, reliability and replicability – but also to act neutrally – i.e. remain in the space of perceived stakeholder consensus. Having to walk the fine line between the technical and the political, analysts end up absorbing some of the conflicts and tensions at play. For the more controversial issues, the 'politics' of access to medicine is often shifted from an explicit space of confrontation and disagreement – the open fora of stakeholder consultation and expert review – to the more muted process of measurement.

What the collected data 'reveals' about companies is not self-evident. Analysts need to develop a specific professional vision – the ability to see meaningful events in the company data – so as to be able to score companies on a scale of 0 to 5. When most companies' performance appears too similar with respect to one indicator, variability – and thus the possibility to differentiate across companies – is introduced into the data by making the scoring criteria more and more detailed. The ability to develop a 'differential vision' provides the potential for 'moving the market' by incentivizing a race to the top. Analysts thus act as market makers by creating the conditions for companies to become comparable and, in principle, 'movable' along the ranks established by the Index methodology.



Regulating access to medicine by means of a ranking relies on two main factors. The first is the possibility of shifting some of the most controversial issues to the technical realm of analysis, where measurement choices can be sheltered from conflict and contestation. This, however, requires analysts to absorb the political conflict that cannot find resolution elsewhere. Such absorption takes the form of meetings during which analysts explore their attitudes towards access to medicine and learn to 'tame' possible sources of bias. Broken dialogue in the access to medicine forum thus is turned into an internal dialogue within the analyst professional self. The Access to Medicine Index emerges as a complex exercise in mediation, whereby political dialogue interrupted elsewhere can be resumed, but only in a muted way.

The second condition for regulating by ranking is the possibility of developing a differential vision of the market, i.e. of refining scoring criteria so as to create meaningful differentiation across companies that appear too similar. The conditions for enticing companies' 'will to perform' are thus maintained. However, especially for companies scoring in the middle of the ranking, this refinement of the scoring criteria results in the ranking capturing and amplifying differences that are at times quite marginal.

Far from being a simple representation of a market reality, ranking contributes to making such a market possible by means of its measurement choices. However, it also runs the risk of zooming in on marginal details at the expense of the bigger picture of what remains to be achieved in the field of access to medicine. Ranking has moved a market, once accused of being immobile, towards improving access. But this movement remains constrained by the need to reflect stakeholder consensus, and the often narrow margin separating companies from one another.

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