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EDITORIAL ANALYSIS

Patents Should Not Put Cancer Care Out of Reach

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Patents Should Not Put Cancer Care Out of Reach

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Every fact web-verified against primary sources

THE LIFT LINE

A patent is a bargain with society, not a licence to price the dying out of treatment.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Access to medicines sits at the intersection of health governance, intellectual property and India's global identity as the pharmacy of the developing world. When a new cancer drug carries a price tag of several lakh rupees a month, the question is no longer purely commercial. It becomes a question of the **right to health**, read into **Article 21** by the Supreme Court, and of how a state balances the private incentive to innovate against the public duty to keep citizens alive. This is exactly the kind of values-versus-institutions tension examiners love.

GS Paper 2: issues relating to health, the role of the state in ensuring access to medicines, and the interface between public health and international trade obligations. **GS Paper 3:** intellectual property rights, the innovation economy, and India's generic pharmaceutical industry as a strategic asset. For **Prelims**, hold the specifics: the **Patents Act, 1970**; **Section 3(d)** which bars ever-greening by refusing patents for minor modifications lacking enhanced efficacy, upheld in **Novartis AG v. Union of India (2013)** over the cancer drug **Glivec (imatinib)**; **compulsory licensing under Section 84**, first invoked in the **Natco v. Bayer (2012)** case over the kidney and liver cancer drug **Nexavar (sorafenib)**; the **TRIPS Agreement (1995)** of the WTO; and the **Doha Declaration on TRIPS and Public Health (2001)** affirming flexibilities. For **Mains**, this is a model answer on balancing competing public goods, where the mature position is neither anti-patent nor anti-access but a calibrated use of existing legal safeguards.

BACKGROUND AND CONTEXT

India's patent regime was rebuilt to meet WTO obligations. Until 2005 India granted only process patents on medicines, which let domestic firms reverse-engineer and produce cheap generics, turning the country into the supplier of affordable drugs for much of Africa and Asia. Joining the **TRIPS Agreement** required India to grant product patents from 2005. But Parliament wrote in safeguards. **Section 3(d)** was inserted to stop **ever-greening**, the practice of extending a monopoly by patenting trivial tweaks of a known molecule. The

Doha Declaration had already confirmed that TRIPS should be read in a manner supportive of public health, and that members retain the right to grant compulsory licences and to determine the grounds for them.

Cancer has sharpened this old debate. Newer targeted therapies and immunotherapies work, but their launch prices can exceed the annual income of most Indian households. With cancer incidence rising and out-of-pocket health spending still high, the affordability of patented oncology drugs has become a frontline public-health question rather than an abstract legal one.

THE CORE ARGUMENT / ISSUE

The monopoly problem in oncology

A patent grants a time-limited monopoly, and monopoly pricing is the point, since it rewards the risk of research. For most goods this is tolerable. For a cancer patient it can mean the difference between treatment and death. The market cannot self-correct here because demand is inelastic and the buyer is desperate. This is precisely why the law reserves safeguards for public health.

India's built-in safeguards

India does not need to break its patent commitments to protect patients. Its own statute already contains the tools. **Section 3(d)** keeps genuinely new inventions patentable while denying monopolies to recycled molecules. **Section 84** allows a compulsory licence three years after grant if the patented drug is not available at a reasonably affordable price, is not worked in India, or does not meet the reasonable requirements of the public.

The innovation counter-argument

Pharmaceutical firms argue that weak patent protection deters the investment needed for the next generation of therapies, and that compulsory licensing signals an unreliable market. This concern is real and must be answered, not dismissed. The correct reply is that safeguards are applied narrowly and transparently, on defined statutory grounds, so that genuine innovation is rewarded while abusive pricing and ever-greening are not.

SAFEGUARD	LEGAL BASIS	LANDMARK CASE	WHAT IT PREVENTS
Anti ever-greening	Section 3(d), Patents Act 1970	Novartis v. Union of India (2013), Glivec	Monopoly on minor modifications without enhanced efficacy
Compulsory licence	Section 84, Patents Act 1970	Natco v. Bayer (2012), Nexavar	Unaffordable pricing and non-working of a patent
Public-health flexibility	Doha Declaration (2001), TRIPS	Global norm	Reading TRIPS against access to medicines

HOW TO THINK ABOUT THIS (ANALYTICAL FRAME)

Treat a patent as a **conditional social contract**, not an absolute property right. Society grants a temporary monopoly in exchange for disclosure and eventual generic entry, on the assumption that the reward is proportionate to genuine invention. When a firm games the bargain by ever-greening, or prices a life-saving drug beyond public reach, the conditions of the contract are broken, and the state is entitled to use the remedies it reserved. The analytical move is to ask, in any IPR dispute, whether the monopoly is still serving its social purpose or has become extractive. That single test resolves most access-to-medicines questions and keeps you from the false binary of pro-patent versus anti-patent.

THE DIAGRAM IN WORDS

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Rising cancer burden + patented high-price therapy -> access gap for patients -> trigger legal safeguards (Section 3(d) blocks ever-greening + Section 84 compulsory licence for affordability) -> generic or licensed supply at lower price -> access restored while genuine innovation still patent-protected
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WAY FORWARD

1. **Use Section 3(d) rigorously.** Patent examiners should hold applicants to the enhanced-efficacy standard, so that only genuinely novel molecules earn a monopoly and recycled ones do not.
2. **Keep compulsory licensing credible and rule-bound.** Apply Section 84 on clear statutory grounds of affordability and working, with transparent royalty-setting, so it is a predictable safeguard rather than an arbitrary threat.
3. **Strengthen the generics ecosystem.** Support quality-assured domestic manufacturing and voluntary licensing pools so that cheaper versions reach patients quickly once a licence is granted.
4. **Invest in public procurement and price negotiation.** Bulk purchasing, patient-assistance tie-ups and inclusion of essential cancer drugs in public schemes can lower effective prices without touching the patent at all.

PYQ LINKAGE AND PRACTICE

This theme connects to UPSC questions on intellectual property and public health, and to GS2 questions on the role of the state in health. The 2019 Prelims tested TRIPS and patent concepts, and Mains has repeatedly asked about access to affordable healthcare. A candidate should be able to cite the Novartis and Natco cases as evidence that India can honour trade obligations and protect patients at once.

Practice question: "India's patent law contains its own answer to the tension between rewarding pharmaceutical innovation and ensuring access to life-saving medicines." Critically examine this statement with reference to Section 3(d) and compulsory licensing. (250 words, 15 marks)

Sources: The Indian Express, Office of the Controller General of Patents, Designs and Trade Marks

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