



## TRIPS and HIV/AIDS

You don't usually think of multinational corporations and the [World Trade Organization](#) as trying to restrict international competition, but in the case of intellectual property rights, that is just what they are doing. Attempts by the global pharmaceutical industry to stop developing countries from producing generic drugs for their citizens infected with HIV/AIDS is a disturbing illustration of this paradoxical battle, as well as an inspiring example of how collective action can work to counterbalance the dominance of corporate interests.

TRIPS, which stands for Trade-Related Aspects of Intellectual Property Rights, is an agreement under the purview of the WTO. It covers a wide range of subjects that relate to intellectual property, from copyrights and trademarks to pharmaceuticals. It stipulates that WTO member countries must provide [patent](#) protection for approved inventions for at least 20 years, severely restricting competition and granting monopoly power to the patent holder. This protection was a significant victory for pharmaceutical companies, who lobbied hard during the Uruguay Round of the GATT, which established the WTO, to get intellectual property rights enacted. Prior to this, many developing countries did not patent medicines at all, and domestic producers were free to make and market prescription drugs.

There are some exceptions written into the TRIPS agreement. In the event of national emergencies or other circumstances of "extreme urgency," or if the patent holder is practicing anti-competitive policies, countries can manufacture the drugs them-

selves without the permission of the patent owner (this is known as "compulsory licensing"). There is also nothing in the TRIPS agreement that expressly prohibits what is called "parallel imports," when one country purchases drugs from another country that imports the drug at a lower price, rather than importing from the pharmaceutical company itself.

The TRIPS agreement does not specify what constitutes a national emergency, but it is clear that drug companies consider compulsory licensing a major threat their patent-protected profitability. And the stakes are really high. Only four companies dominate the pharmaceutical industry: Merck, Pfizer, Glaxo SmithKline and Eli Lilly, and their profits are huge. The *New England Journal of Medicine* described the rate of return on assets (the profit rate) of the pharmaceutical industry to be the highest of any other industry.

The TRIPS agreement comes at time when the developing world is being challenged by the plague of HIV and AIDS. Eleven million people in poor countries will die of infectious diseases this year, and half of them will be children under age five. Just over one quarter, 2.6 million people, will die from HIV/AIDS. Most of these people live in Africa: of the world's population living with HIV, 70% of adults and 80% of children live in Africa, and more than 3/4 of the people who have died of AIDS are from Africa (20 million). But fewer than 25,000, or one-tenth of 1%, receive the life-saving antiretroviral therapies that are standard issue in developed countries. It is taking a tremendous toll. In the year 2010,

## Regional HIV/AIDS, end of 2000

Region	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate*
<b>Sub-Saharan Africa</b>	25.3 million	3.8 million	8.8%
<b>North Africa &amp; Middle East</b>	400,000	80,000	0.2%
<b>South &amp; South-East Asia</b>	5.8 million	780,000	0.56%
<b>East Asia &amp; Pacific</b>	640,000	130,000	0.07%
<b>Latin America</b>	1.4 million	150,000	0.5%
<b>Caribbean</b>	390,000	60,000	2.3%
<b>Eastern Europe &amp; Central Asia</b>	700,000	250,000	0.35%
<b>Western Europe</b>	540,000	30,000	0.24%
<b>North America</b>	920,000	45,000	0.6%
<b>Australia &amp; New Zealand</b>	15,000	500	0.13%
<b>TOTAL</b>	<b>36.1 million</b>	<b>5.3 million</b>	<b>1.1%</b>

\* The proportion of adults (15 to 49 years of age) living with HIV/AIDS.

Source: UNAIDS and WHO. 2000. "AIDS epidemic update: December 2000," p. 5.

South Africa, one of the richer countries on the continent, will be almost one-tenth poorer in terms of GDP than if AIDS had never existed. And HIV/AIDS is becoming more serious in other parts of the world that cannot afford public health interventions as well. India has four million infected, but it could have five times that many. The Caribbean has the second-highest rate of infection after sub-Saharan Africa. In Eastern Europe and the former Soviet Union, the number of infected nearly doubled in the last year. (See the table below for a regional portrait of HIV/AIDS.)

But some developing countries are fighting this global health crisis and winning, thanks largely to their decision to stand up to the global pharmaceutical industry.

### ***Brazil***

Brazil is Latin America's largest and most populous nation. In 1997, using the TRIPS compulsory licensing loophole in the case of national emergency, Brazil began to produce generic AIDS medicines and distribute them for free. Today it is estimated that 580,000 Brazilians, out of a population of 167 million, have HIV. When the virus first surfaced in Brazil two decades ago, it was estimated that the infected population would be 1.2 million by now, but infection rates have returned to 1995 levels. Over the past five years, AIDS-related deaths have plummeted by half, and each AIDS patient is only one-quarter as likely to be hospitalized as before. A program that was originally criticized due to Brazil's lack of medical infrastructure and the

government's reputation for corruption and inefficiency is now widely acknowledged as a great success. Brazil has offered to transfer its technology and provide training in how to treat patients to other countries that want to provide these services to patients for free.

Moreover, Brazil's domestic production has driven prices down: since 1996, the price of AIDS drugs manufactured only by multinationals has declined a mere 9%, but the cost of medications that must compete with Brazil's domestic production has declined by 79%. A typical treatment of antiretroviral drugs, the medicines known in the U.S. as AIDS cocktails, costs Brazil \$3,000 a year to manufacture, and could drop to as low as \$700 a year or less. In the U.S., similar treatment ranges between \$10,000 and \$15,000.

### **India**

Before joining the WTO, India allowed patents only for manufacturing processes, and it made 70% of its own drugs. Cipla, India's largest domestic drug manufacturer, has offered to sell generic versions of patented HIV/AIDS medicines at 5 to 10 cents on the dollar as a global public service, supported by their manufacturing counterparts in Thailand and groups like Doctors Without Borders.

These efforts have been met with strong resistance from U.S. trade officials working on behalf of the pharmaceutical industry, which pours big money into U.S. politics. Pharmaceutical manufacturers give money to both political parties, contributions that totaled \$23 million in the last election cycle according to the Center for Responsive Politics, with 69% of these contributions going to the Republican Party. Pharmaceutical manufacturers also spend \$75 million on lobbying every year. Many developing countries have been put on the [U.S. Trade Representative's](#) Special 301 Watch List because of pharmaceutical patent disagreements. Getting on the list is a precursor to trade sanctions, it warns you that the U.S. government has their eye on you. But being on the list can be costly in itself, as it can strongly discourage foreign investment, and pits a country's business sector against generic production because businesses are afraid of trade retaliation.

Consider the case of South Africa, which in 1997 passed a law that enabled them to engage in compulsory licensing and parallel importing to get cheap AIDS drugs. Even though the Clinton Administration acknowledged that what South Africa had done was legal under the WTO, they still exerted a lot of pressure on the South African government. Friends of drug companies in the U.S. Congress passed a requirement that the State Department report on Washington's efforts to stop South Africa before it could receive American aid. U.S. trade officials pressuring South Africa admitted to being unaware of the dimension of the health crisis. It was not until a combination of AIDS and anti-globalization activists began heckling Al Gore's Presidential Campaign that the Clinton Administration backed off and said it would no longer challenge countries issuing compulsory licenses under WTO rules; the Bush Administration recently said it would maintain Clinton's policy. Public pressure has also helped South Africa in other ways. A lawsuit brought by 39 foreign drug manufacturers was recently filed in South African court to stop the country from compulsory licensing and parallel importing of AIDS drugs. The case was dropped amid much international criticism.

Developing countries are not yet in the clear in terms of the U.S. government's defense of the pharmaceutical industry. The U.S. has taken Brazil to the WTO Dispute Settlement Body for its compulsory licensing practices, claiming that they violate the non-discrimination clause of TRIPS. They argue that Brazil's law discriminates against imports by allowing the government to license a drug if it is not being manufactured in Brazil within three years of its introduction.

Trying to make an end run around their bad public image, in early 2000 a group of six major pharmaceutical companies (Bristol-Myers, Glaxo, Merck, Boehringer, Roche, and Pfizer) approached the United Nations to propose a collaborative initiative. They proposed that they would commit to discounts on AIDS medicines to poor countries on the condition that the agreement reinforced protection of industry patents. The deal that was eventually announced on May 11, 2000 has been widely criticized as containing little of value, and many insist



that the U.N. was co-opted by the big drug companies. According to the initiative, discounts are to be negotiated drug by drug, firm by firm, and country by country with no commitment to bring drugs to significant numbers of the dying. It has been estimated that a only few hundred thousand of the close to 34 million people infected with HIV in the developing world would benefit.

The main issue for the pharmaceuticals here was to protect the principle of intellectual property rights by heading off compulsory licensing, a practice that directly challenges the right of patent holders to garner monopoly profits.

Why do we need the type of intellectual property rights protected by TRIPS, anyway? The argument most often used by drug companies is that patents protect their investments in research and development (R&D), and that jeopardizing those investments by allowing developing countries to ignore patents would pose a serious danger to future research of life-saving drugs. Sounds reasonable, but the evidence is weak. According to Oxfam, only 10% of pharmaceutical R&D is devoted to diseases that afflict 90% of the world's population; most R&D is spent on health issues suffered in the developed world like lowering cholesterol and addressing impotence. And drug manufacturers typically spend twice as much on marketing and administration as they do

on R&D. Not to mention the fact that a substantial proportion of R&D is in fact subsidized by governments.

Moreover, it does not appear that the drug companies are in any danger of losing money if the developing world continues to produce drugs. According to IMS Health, which supplies market data to the industry, 4/5 of all pharmaceutical revenue, and an even higher proportion of profits, comes from

just seven countries in North America, Europe, and Japan; all of Africa provides only 1% of the drug industry's revenue. According to *Forbes* magazine, after putting \$21 billion into R&D, the 10 largest U.S. drug makers had \$100 billion more in sales than manufacturing costs. And herein lies the rub: Although compulsory licensing in Africa would do little to profit, it could put downward pressure on global prices and the ability of the drug companies to maintain astronomically high markups in the developed world.

Another defense put forward by drug companies is that antiretrovirals involve complex dosage regimens, and they must be taken correctly or we run the risk of creating more virulent strains of HIV. So they must maintain strict control over drug production and distribution to protect the population at large. But evidence from Brazil's success, discussed above, challenges this assertion. A 1999 survey of 1,000 AIDS patients in Sao Paulo found that 69% took their medications correctly 80% of the time. A study in San Diego showed that 72% of patients took their medications correctly 80% of the time. Clearly, the two are comparable and shows that programs in developing countries can work if they're done correctly, and can even be a basis for improving the overall public health delivery system.

Those who argue against TRIPS point out that it discourages competition and the development of local producers, keeping prices unnecessarily high as monopolies tend to do. Even just the credible threat of generic competition can help keep prices down, as has been the case in Brazil. Others point out abuse of the patent system itself, arguing that 20 years is too long for patent protection, and amounts to the unfair establishment of monopolies in what is reputed to be a system of free competition. Moreover, running a patent office is expensive, perhaps too expensive for developing countries, some of whom do not even have a patent review process. (Patents are awarded on a national basis, so firms must register their patent with each country.) For example, the U.S. spends \$1 billion annually on its patent and trademark office, but the quality of U.S. patent examinations is actually very poor. According to one study of patents litigated to judgment, only 54% were found to be valid.

Partly as a result of pressure from African countries, in June 2001 the WTO Council on TRIPS will hold a special discussion on intellectual property and drug access. Since the case in South Africa was dropped, there is a sense that the balance of power may have shifted away from drug companies and towards developing countries. But it remains to be seen whether TRIPS will ultimately put public health before corporate monopoly rights. One thing is for sure, it has put the WTO in the position of making certain types of competition sanctionable, an ironic but telling use of the global trading system to protect corporate profit.

#### Sources:

- Stephen Buckley. "Brazil Becomes Model in Fight Against AIDS." *Washington Post*, September 17, 2000, p. A22.
- Tom Buerkle. "Dilemma of Cheaper Drugs." *The International Herald Tribune*, March 19, 2001.
- Larry Elliott. "Evil triumphs in a sick society." *The Guardian*, February 12, 2001.
- Barton Gellman. "An Unequal Calculus of Life and Death." *The Washington Post*, December 27, 2000, p. A01.
- Barton Gellman. "A Turning Point That Left Millions Behind." *The Washington Post*, December 28, 2000, p. A01.
- Jon Jeter. "Trial Opens in South Africa AIDS Drug Suit." *The Washington Post*, March 6, 2001.
- James Love. "Access to Medicine and Compliance with the WTO TRIPS Accord: Models for State Practice in Developing Countries." Paper for the UNDP.
- Nick Mathiason. "South Africa fights Aids drug apartheid." *The Observer*, January 14, 2001.
- Tina Rosenberg. "Look at Brazil." *The New York Times Magazine*, January 28, 2001.
- UNAIDS and the World Health Organization. 2000. "AIDS epidemic update: December 2000."
- WTO. 2001. TRIPS and Pharmaceutical Patents Fact Sheet.

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