Access to medicines and the right to health and life

Access to medicines is a cornerstone to the realization of the right to health and life. The following is a statement presented by Martin Khor, Executive Director of the South Centre, during the 2015 Social Forum of the United Nations Human Rights Council which took place from 18 to 20 February 2015 in the Palais des Nations, Geneva, Switzerland.

By Martin Khor

Access to medicines, even if a person is too poor to afford it, is a cornerstone to the realization of the right to health and life. There has been significant progress in new and better medicines. However prices of the medicines are often priced so high so as to be out of reach of the poor or even the middle classes in many countries, not only in developing but also in developed countries.

A major reason for this is the monopoly granted to drug companies through patents, which prevents competition. Sometimes the prices are so astronomical so as to make super profits for the companies. The latest example is the new drug for hepatitis C, sofosbuvir, which is sold for USD84,000 for a 12 week course, or USD1,000 a pill. Profits for the company Gilead have run at many billions of dollars already. Though the company has now offered that some poorer countries can have access to generic versions at low prices, the majority of people in the world, in developed countries and middle income developing countries, cannot have this access. There are 170 million people living with hepatitis C worldwide, and around 350,000 deaths every year. What has happened to their right to health and life?

The global IPR regime has to be reviewed. The TRIPS agreement and public health WTO ministerial declaration of 2001 have been positive but inadequate. There should be an option for countries, or at least developing countries, to opt for an exemption to patents for medicines and other essential health technologies.

Meanwhile, countries should be encouraged to make use of TRIPS flexibilities, which are part and parcel of the global and national IPR regime. These include the policy space to determine which applications are eligible for patents, for the non-grant of patent for frivolous changes or second use, the use of safety data for approval of generics, pre grant opposition, the use of compulsory license and government use orders. These enable the making and use of generic medicines, which together with regulation on prices, can enable access to medicines at affordable prices.

Developing countries should master the principles and use of TRIPS flexibilities, and developed country governments should not place pressure on those countries that make use of the right to use TRIPS flexibilities.

There are new threats and challenges to access to medicines, as well as opportunities.

A major opportunity is the significant progress in universal health coverage as a principle adopted by WHO, WHA and the SDGs. This principle recognizes states' responsibility to provide or arrange for health services for all. The issue is how to make this a reality.

The challenge to this is the cost to government of providing health care including medicines, when the prices of many brand name medicines are so high and governments cannot provide them at this cost. All the more then is the need for generics and for the use of TRIPS flexibilities. Otherwise UHC cannot be attained.

The new threats include:

(1) investment treaties and bilateral and regional FTAs. These remove many of the TRIPS flexibilities for countries that subscribe to these treaties as they contain TRIPS plus provisions including data exclusivity, prolonging patent term, and in the investor-state dispute system which threatens the use of compulsory license and other TRIPS flexibilities.

(2) Reduced government revenue due to recessionary conditions and austerity policies, sometimes imposed through conditions for extending loans.

(3) Conditions that prevent the establishment, survival or thriving of generic companies.

(4) The emergence of new diseases and epidemics makes the access of medicines an even more acute issue. For example, ebola vaccines and medicines are likely to be patented. Will this prevent access, just as patented drugs prevented access with regard to avian flu some years ago and sparked a major global controversy?

(5) Antibiotic resistance poses another challenge. New medicines are needed. However if the same R and D model is followed, the new antibiotics will be patented and access to them will be limited. Thus only a few will have access to the new life saving drugs for resistant TB, AIDS, pneumonia, skin and stomach ailments etc.

We therefore also need a new R and D model in which public funding supports R and D for drug discovery including for neglected diseases of poor countries, and these new drugs should not be patented, or else the patent should be owned by the public fund, which allows licenses freely for all companies to produce.

Therefore, to realize access to medicines and the right to health and life:

1. Measures should be taken to enable countries to make use of TRIPS flexibilities. There should be no pressure on countries that exercise these flexibilities.
2. LDCs whose exemption from TRIPS implementation for medicines is expiring in 2016 should be allowed renewal of this exemption for as long as they are LDCs.
3. This year, 20 years after TRIPS was established, there should be consideration for allowing exemption for medicines and health technologies, at least for developing countries. 75% of the world's poor live in middle income countries, thus the medicines exemption for LDCs should be extended to other developing countries.
4. Investment treaties that threaten the right to health should be reviewed. Countries that have signed on should consider amending the treaties or changing the model to one that explicitly allows governments to pursue the right to health and access to medicines, without threat of being brought to court and sued.
5. FTAs should not contain TRIPS-plus provisions or other elements such as the investor-state dispute system, that adversely affect access to medicine and the right to health. There should be a general exception for public health measures including tobacco control.
6. Policies that governments pursue to counter recession or extend their loans, should not include measures that affect the right to health and access to medicines.
7. Conditions should be created or further developed to enable the establishment, survival and thriving of generic medicines and their producers.

8. All patients should have access to new medicines developed for new and emerging diseases.
9. In the growing battle against anti-microbial resistance, priority must be given to access to existing medicines as well as the new medicines that combat resistant diseases.
10. An R and D model should be prioritized in which there is sufficient public funding and the outcome of research is thus not patented or else the patent is freely available to producers.
11. Financial and technological assistance should be provided to developing countries to enable them to implement universal health coverage policies and the health related SDGs.

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