Trade, drugs, and health-care services

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In the early 1990s, a subset of the health sector—patented drugs—burst quite unexpectedly into the international trade debate. The ongoing trade negotiations of the Uruguay Round were in disarray, and support from sectors that relied on the protection of intellectual property rights became essential to move them forward.[1] Indeed, the Uruguay Round Agreement was signed in 1994 only because it included a then much praised Trade-Related Intellectual Property Rights (TRIPs) agreement.

Between 1994 and the 2001 Doha Ministerial of the World Trade Organization (WTO), the spread of AIDS reached pandemic proportions. Research had yielded a cocktail therapeutic of drugs, but in 2001 a typical treatment cost US$12 000 a year per person—a sum far out of reach for most people with AIDS in developing countries. This imbalance fuelled a debate about access to essential medicines so acrimonious that it came close to derailing the Doha Ministerial.[2,3] A solution was reached only 2 years later, and only 2 weeks before the 2003 Cancún WTO Ministerial.

WTO and enforcement of intellectual property rights

The crisis raises the following question: is the WTO the best place to enforce intellectual property rights protection? From an economic point of view, freer trade is attractive because it offers gains to all trading partners by reducing the domestic price of the goods and services they import. The TRIPs agreement cannot guarantee such a positive outcome. Many developing countries—especially the poorest ones—will not be able to contribute to the development of major drugs (hence benefit from TRIPs-related revenues) for a long time to come. Meanwhile drug prices will increase in these developing countries since patents grant time-limited monopolies (20 years under TRIPs) to the innovators. (Patents attempt to strike a balance between higher prices and more innovations.[4,5]) For many less-developed countries, innovation gains could never fully compensate for the intellectual property rights monopoly-related losses.

That the WTO is not the best place to enforce intellectual property rights is reinforced by the fact that pharmaceutical companies' research is driven by rich-country demand, not by the diseases that impose the heaviest health burdens on the developing world (malaria, tuberculosis, diarrhoea). Ideally,[6] it would have been better to design a more flexible intellectual property rights protection regime that would: (i) limit the TRIPs agreement to developed and emerging economies; (ii) encourage developing countries to enforce property rights in a more progressive and adapted way with the help of other institutions (such as the World Intellectual Property Organization, WIPO); and (iii) subsidise research into drugs to tackle diseases of prime interest for the developing world, especially the poorest ones, through initiatives such as the Millennium Development Goals.

Having said the above, eliminating the TRIPs agreement altogether is inconceivable. Not only are some developing countries (such as Brazil and India) witnessing the rapid emergence of strong domestic drug producers, but in addition, intellectual property rights protection may offer gains to the less-developed world in other domains, such as traditional knowledge or genetic resources.[7] Progress could thus be achieved only from whatever flexibility could be found within the TRIPs agreement. In fact, between the Doha and Cancún Ministerials, the negotiators' efforts consisted of reaching an approximation of the ideal solution by using the flexibilities embedded in the TRIPs provisions by the Uruguay Round negotiators.

The WTO solution to the crisis

The WTO solution to the issue of access to essential medicines relied on two decisions.[8] First, the least-developed countries (a subset of the poorest countries) are not obliged to implement, apply, or enforce the TRIPS obligations on patents before 2016, instead of 2005. Second, trade negotiators clarified the role of compulsory licences by which a government can authorise the use of a patented invention by producers other than the right-holder, especially in a national emergency.[9] The crux of the access to essential medicines crisis was due to the fact that, under TRIPs, products produced under a compulsory license were to

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be used predominantly for the domestic market of the WTO member authorising the licence. This factor left developing countries that lacked domestic production capacity—by definition, a large group that includes the poorest countries—with no solution. Thus, negotiators agreed that patented drugs could be produced by a compulsory licensee exclusively for export into countries without adequate domestic drug manufacturing capacities.

This flexibility constitutes a straightforward interpretation of the TRIPs agreement. Why then did it take 2 years for negotiators to achieve such an outcome? The answer lies in the fact that these TRIPs flexibilities were rejected by some of the holders of intellectual property rights.[10] What was really at stake during the controversy was every country's ability to actually make use of the TRIPS flexibilities in light of political pressures (especially but not exclusively coming from the USA) not to do so. Intellectual-property-rights holders worry that products under compulsory licences could leak into markets outside the least-developed countries, including their own. They are also concerned about competition from generic drug producers and, in fact, some developed countries (Canada, the European Union, and Norway) are in the process of introducing changes to their laws to enable their domestic generic industry to export to the developing world.

As a result, so many conditions have been attached to the WTO solution to ensure that the flexibility granted is to protect public health (and not to pursue industrial and commercial policy objectives) that some observers doubt that the solution can be effectively implemented. However, unravelling this solution would carry a political price tag far too high—and bilateral trade agreements offer a cheap alternative to eroding the WTO solution.

Freer trade in health-care services

Recent years have witnessed the emergence of a lively, yet limited, trade in health-care services. Patients are increasingly going abroad in search of adequate health care, including elective surgery and long-term care. Nurses are supplying their services in countries other than their own through migration or scheduled visits, while doctors consult their clients or colleagues with telemedicine. An increasingly large number of health-care organisations (private and public) are actively operating in several countries at once. All these changes are occurring in both private and publicly funded health care even if, for the time being, trade in health care tends to be concentrated in privately funded ancillary services (such as dentistry and cosmetic surgery).

Rich and developing countries alike are participating in this freer trade, with some parts of the developing world (India, Brazil, Philippines, Thailand, South Africa) exporting quite actively. Such freer trade has provided gains for the consumers of health-care services.[11] For

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instance, poor Mexicans who live near the Mexico-USA border can buy health insurance from Mexican subsidiaries of US insurers, thereby benefiting both from basic medical services in Mexico, and US services for more serious health problems. The Philippines are developing a systematic policy of dispatching qualified nurses abroad who then send huge remittances back to their homeland. In some instances, the emergence of this trade has been so strong and rapid that it has created adjustment problems within the domestic industry, such as in Thailand where the fast growth of health care/resort packages for foreigners has amplified the existing gap between the two-tiered (public/private) system.

These changes have been significant enough to permeate the WTO negotiations.[12] Some members have declared a strong interest in negotiating on health-care services, while others remain vehemently opposed. Once again, one should ask whether the WTO is the best organisation to deal with these issues. Here, the answer is undoubtedly yes—consumers' gains are there. However, the fact that these services often imply labour flows also raises the politically sensitive issue about the difference between labour movement and migration, which is hard to tackle without disagreements in such a large forum as the WTO.[13]

Bilateral trade agreements: Dr Jekyll or Mr Hyde?

In health-care services, the WTO might ultimately be the best place to multilateralise and secure agreements intitially negotiated and implemented on a bilateral (Japan-Philippines, Mexico-US) or plurilateral (within

the European Union) basis. Bilateral trade agreements could be the best initial instrument, in particular because they can more easily and precisely address complex domestic health-care regulations than can WTO.

In sharp contrast are the TRIPs cases where bilateral trade agreements create a great danger.[14] The agreements between the USA, on the one hand, and Morocco or Australia, on the other hand, include provisions stronger than those contained in the WTO TRIPs agreement—imposing additional limitations on the use of compulsory licences, extending the effective term of intellectual property rights protection for pharmaceutical products or the scope of patent protection to plants and animals—and de facto could make the use of WTO flexibilities more difficult.

Trade and aid for development

The health sector provides a key illustration of the need to combine trade and aid for development. For instance, in the poorest countries, more flexibility in TRIPs provisions should be complemented by aid in the form of subsidised purchases of essential medicines. Even generic drugs offered at marginal cost remain prohibitively expensive in these countries: in 2003, a generic package of AIDS drugs costs about $200 annually, roughly 30–40% of the gross domestic product per person in many poor countries severely affected by the AIDS epidemic. Similarly, freer trade than at present in health-care services would be greatly amplified by better infrastructures. As usual, freer trade is not a panacea; yet very little can be achieved without freer trade.

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P A Messerlin co-chairs the UN Millennium Development Goals Project Task Force on Trade and Finance.

Conflict of interest statement

I declare that I have no conflict of interest.

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