How TRIPS are building enhanced inequalities in access to care: the case of HIV/AIDS drugs

Benjamin Coriat (Paris Nord University)

and

Fabienne Orsi (University of Aix-Marseille II)

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Abstract

In 1995, the TRIPS agreement established so-called "minimum standards" for the protection of intellectual property rights, making mandatory the patentability of pharmaceutical molecules, and introducing a minimum 20-years patent protection period for drugs. The implementation of these standards at the global level represented the enforcement, on behalf of the WTO, of IP international standards largely based on those established in the most advanced countries. Compliance with this new IP regimen for southern countries was envisaged under two different deadlines: 2005 for developing countries and 2011 for least-developed countries.

Focusing on access to HIV/AIDS treatments in DC's, the objective of the paper is to shed some lights on the inequalities in access to drugs created by the TRIPS agreement.

The paper starts by recalling that the patenting of pharmaceutical molecules is an old and still controversial question even in developed countries. In most of them patents on pharmaceutical molecules were not introduced before the 1960's, and often much later on (Swiss 1977, Finland 1992, …). As regards DC's before the TRIPS agreement, international treaties recognized the right to each country to design and implement the type of IP system suited to its level of economic development. As a consequence most DCs dispensed themselves with any form of IP protection for drugs. By exploiting their rights to learn by "imitating" and "copying", many developing countries established local industries producing low-cost generic drugs (and/or imported these drugs) , as a way to ensure access to treatment for the poorer segments of their HIV/AIDS populations.

The TRIPS have put an end to this situation, at a time when the worldwide explosion of the HIV/AIDS created more than ever the need of cheep drugs and treatments, especially in DC's The second and third part of the paper presents the consequences of the TRIPS agreement as regards access to drugs in DC's. We distinguish two periods (1996-2005 and post 2005) From 1996 to 2005 (before the deadline imposed to DC to comply with TRIPS requirements), India in particular (exploiting her right to copy until the 2005 deadline), has played an exceptional role, becoming the largest manufacturer of low-cost generic drugs worldwide. The supply of generic drugs by Indian manufacturer at low costs (140 $ compared to 10 000 $ per person/year for the same ARV patented cocktail), opened the possibility to deliver treatments to patients in southern countries. Even if only a small percentage of people in need had access to ARV treatments, the period is characterized by the launching of the first programs of fight against the pandemic in many DC's

After 2005 the situation has changed dramatically. Most newer-generation drugs (now required for efficient treatments), are barred from being manufactured generically by Indian companies. As a consequence the prohibitive prices of newer first and second-line regimens have created a watershed in relation to the prices of earlier first-line treatments. The public health programs built during the previous period (and massively based on generic drugs), are now under serious threats.

We conclude by stressing how the enforcement of the TRIPS agreement by creating enormous barriers to generic competition have contributed to enhance north/south inequalities