

TAKING STOCK: AIDS, TRIPS AND GLOBAL HEALTH AFTER DOHA

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**Doha Plus 10: The future agenda of public
health, innovation and trade**

SPEECH

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Taking stock: AIDS, TRIPS and global health after Doha

Allow me to begin by thanking my friend Pascal Lamy and the Graduate Institute for bringing us together today to begin discussions on one of the most timely and topical issues of the AIDS response.

Today, 10 years after DOHA, is our opportunity to have a serious discussion—to take stock of what TRIPS has brought to the global public health debate, and how it has helped us to transform, or not. This is also a key opportunity to think about what should come next. AIDS is a good entry point for this discussion. It shows us the possibilities of TRIPS, but also the limitations. On this, we have to be very honest.

Two days ago, UNAIDS launched the 2011 World AIDS Day Report in Germany. One of the most important findings is that we are reducing AIDS mortality worldwide. Not only in the developed world, but also in the developing world, we are seeing a clear decline in the number of people who are dying from AIDS-related causes.

HIV has transformed from a death sentence to a chronic condition in many parts of the world today. This is a remarkable public health achievement.

We have to remember, in 2001 when the Doha Declaration was adopted, we were at the same time negotiating the Declaration of Commitment on HIV/AIDS in the General Assembly. People were telling us that treatment could not be given to poor countries—that they could not even use it properly. It was too costly. In those days, we had only 300,000 people on treatment, and most of those people were in high- and middle-income countries. Fewer than 50,000 were in Africa. Today, we are talking about almost 7 million people on treatment. We managed to increase the scale and quicken the pace when we pushed forward the debate around universal access.

We began to talk about universal access not just as an absolute number, but about how it can be used to advance the debate around social justice, around the redistribution of opportunity and around reduce the cost of treatment. We talked about how universal access

Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.

can narrow the gap between people who have and people who do not have. And that truly changed the nature of the response to HIV.

In 2001, the cost of treatment was around US\$15,000 per person per year. Today, it is around US\$80 to \$120—a 99% reduction. The debate on drug prices was opened. We managed to engage pharmaceutical firms. We managed to create space to stimulate competition, and to use the flexibilities that were provided by TRIPS.

We have to recognize how important Doha was as a platform for progress against HIV, and has promoted the use of TRIPS flexibilities to increase generic competition and lower prices in many parts of the world. We know of course the experience of Brazil, which has become a model not only for treatment access and national ownership, but also for South-South cooperation. And we know the experience of India, which produces almost 80% of the drugs available to people living with HIV today.

TRIPS flexibilities not being fully exploited

It is critical that we spend some time looking at what has happened since Doha, especially with regard to TRIPS. The UNAIDS report I am launching today gives concrete examples of how countries have used flexibilities to promote generic competition, but it also shows that there are many who are not using them.

In 22 countries in Africa, there are domestic provisions that allow for parallel importation. Thirty-nine countries provide for some form of compulsory licensing in their domestic laws. But despite these provisions, only Rwanda has used the import-export mechanism. Zimbabwe is the only country in Africa that has actually applied compulsory licensing for antiretroviral drugs. Meanwhile, other countries—not only Brazil, but also Thailand, Malaysia and others—have significantly lowered costs for specific drugs by using compulsory licensing.

The evidence is that when it is well done, the savings can be enormous. In the case of Brazil, we estimate that the government's use of TRIPS flexibilities has saved approximately US\$1.2 billion in ARV costs, allowing them, of course, to increase coverage considerably.

But the experiences in many other countries and regions are not as impressive. So we need to ask, if all these provisions exist, and the majority of people in these countries still lack access to ARV treatment, why are we not making sure that those countries have the capacity to better use them? It is an issue of how to create a new type of partnership, with a different framework, that will help countries better benefit.

Certainly, we still have key challenges in providing affordable treatment. Today, second-line treatments are selling at three times the price of first-line treatments. This is very serious. When I said that we have almost 7 million people on treatment, you have to understand that almost 96% of people in the developing world are still on first-line regimens. In the coming years, most of them will need to move to second-line, and that will be costly. I am not even talking about third-line, which is almost 20 times more expensive than first line treatment—and that is using the lowest priced third-line drugs available.

Encouraging competition is essential

We must make sure that countries use the TRIPS flexibilities to encourage generic manufacturers to remain in the market, and that they continue to invest in the production and the supply of new first-line treatment as well as second- and third-line. This is critical if we want to leverage this opportunity to reduce the price for the poor.

Let me say that the next phase of the AIDS response is ensuring innovation—this is critical. When we look at the big picture—not just of AIDS, but the future of global health—we must be aware that the challenge is not to reach millions of people—we need to reach billions. So we need to think differently. We cannot reach billions without innovation. And it has to come from developing countries.

I am always trying to challenge our leaders in Africa that we need a knowledge-based economy. We cannot just be participants in an idea. We need to produce our own ideas, and we need to improve our competencies so that we not only can partner with drug producers, but we can also produce our own drugs that are not under patent to others.

Innovation will help us achieve simplification of all aspects of HIV treatment. It will facilitate the achievement of universal access. It will allow us to pursue new types of treatment—what we have been calling Treatment 2.0.

I think we also need new incentives to work better with people who are producing medicines. We are seeing new momentum being created, such as the Medicines Patent Pool—which is a new way to go, but we need to clarify the mechanism for scaling up without killing competition.

There are four major areas where we can move forward:

We must help more countries follow the example of the Indian Patent Law, and have TRIPS flexibilities streamlined in their patent law to facilitate use. We need to make more strategic use of our partners in civil society, like MSF and ITPC, to keep the pressure on governments to resist bad trade agreements and the limiting of TRIPs flexibilities. We need to leverage innovative mechanisms to deal with intellectual property and market dynamics.

And we must continue to use the AIDS movement as a force for ensuring that trade and innovation are tools to promote global health and human dignity.

Thank you.

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