been turned away from India, where it was originally scheduled to be dismantled, because of local concerns about risk from asbestos ship insulation.[8] Workers who remove asbestos need training, high levels of personal protection, and close environmental monitoring. Disposal of unneeded materials containing asbestos while protecting the environment can be a daunting and expensive challenge.

Lin and colleagues' findings highlight the tremendous current opportunity to blunt a future epidemic of asbestos-related deaths. Countries with the least historical usage can maintain their favoured status if they decide soon to restrict or eliminate importation and use. Future costs of health care, lost productivity, and human suffering, and the great economic costs of managing asbestos-contaminated waste, can be avoided. To paraphrase George Santayana: "Those who ignore history are doomed to repeat it." We hope the lesson from Lin's research is not lost on those who stand to benefit most.

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The views in this Comment are solely mine and do not necessarily represent the views of the US Centers for Disease Control. I declare that I have no conflict of interest.

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WHO must defend patients' interests, not industry

The printed journal includes an image merely for illustration

Reuters

Is WHO's Director-General, Margaret Chan, more concerned about the needs of patients or the interests of industry? Addressing an audience in Bangkok in February, she stressed the need to negotiate with drug companies over access to medicines, and that the use of compulsory licensing to import and manufacture generic versions of patented drugs must be "balanced".[1]

Her statement was in reference to the Thai Government's recent issuing of compulsory licences for efavirenz, lopinavir/ritonavir, and clopidogrel. Thailand is one of the few developing countries that have achieved universal access to antiretrovirals, but access to efavirenz (needed by around 15% of people on treatment) and lopinavir/ritonavir (for the increasing number of people who need second-line) are limited because of high price.

There are several reasons why Chan's comments are misplaced. First, the Thai Government does not need to be advised to negotiate: it has been in regular contact with the industry over high prices of its drugs in Thailand, but these negotiations have led nowhere. The best price for originator's efavirenz is still twice the price available from Indian generic sources (US$500 per patient a year *vs* $224). The best offer for originator's lopinavir/ritonavir is $2000 per patient a year, five times more than WHO's estimate of manufacturing costs.[2] The Thai Ministry of Health estimates that the price of clopidogrel would fall by over 90% if made generically. These are substantial price differences in a country where the average annual wage is $1400 a year.

Second, direct negotiations with companies are not as successful as Chan thinks. She cited Brazil as a positive example where negotiations with drug companies have led to price reductions. However, the prices negotiated by Brazil for antiretrovirals are up to four times more expensive than prices available on the international market, and treatment costs are rising. In 2003, three patented drugs—lopinavir/ritonavir, nelfinavir, and efavirenz—took up 63% of the total antiretrovirals budget. In 2005, imports accounted for 80% of Government expenditures on antiretroviral drugs.[3] Company deals have also stunted the development of local generic manufacturing capacity, which is reflected by the fact that no new generic AIDS drug has been produced in Brazil since 2002.

Third, it is up to a government to decide when to issue a compulsory licence. World Trade Organization agreements nowhere state that negotiations are a precondition to use of a compulsory licence by a government,[4] and even the US Government is not questioning the legality of the Thai compulsory licence.[5]

The need for "balance" presumably refers to industry's claim that patents are required to reimburse the costs of innovation. We cannot say precisely how much it costs to research and develop these drugs, but we do know that they have already made billions of dollars: last year alone sales of efavirenz, were $791 million,[6] while sales for lopinavir/ritonavir were over $1·1 billion.[7]

The US Government and the multinational drug industry have put pressure on the Thai Government over its intellectual property laws since 1985, and as a result Thailand has implemented patent protection sooner and stronger than required by the World Trade Agreements.[8] During this time, past WHO Director-Generals were silent over the need to find a balance to protect public health. We do not believe it is the role of the Director-General of WHO to be protecting the interests of industry the moment there is a challenge—a legitimate and legal challenge—to their drug monopolies.

WHO is well aware of the high cost of new drugs for Thailand. A recent WHO evaluation[9] projected that second-line therapy for a quarter of all HIV-infected patients will be absorbing three-quarters of the treatment budget by 2020, and the cost of antivirals with second-line regimens could reach $500 million a year if current prices remain. In response to these rising drug costs, the World Bank has recommended that Thailand should use compulsory licensing.[10]

Improving access to expensive medicines is not just an issue for people with HIV/AIDS. The Thai Minister of Public Health recently announced that he is considering issuing compulsory licences for up to 11 more AIDS, cancer, heart and cardiovascular, and neuropathic drugs and antibiotics.[11]

Not surprisingly, the drug industry is pressuring the Thai Government to reverse its position. Abbott Laboratories, which resisted all efforts by Government and health groups to negotiate an affordable price for lopinavir/ritonavir, has taken steps that show little regard for public health in Thailand. The company withdrew all pending drug-registration dossiers and announced that it will not register any new drugs in Thailand until the Government reverse its decision to issue compulsory licences.[12]

Thailand, indeed all developing countries, need WHO to put patients first, and encourage and support member states to use flexibilities in patent laws to improve access to drugs. In a recent letter to the Minister, Chan clarified that WHO unequivocally supports the use of compulsory licensing.[13] This is a welcome clarification that should be followed up by WHO's active technical and political support for Thailand's efforts. In particular, WHO should denounce the actions of Abbott. Protecting the high price of one new drug by withholding access to all others is an unacceptable and unethical practice that no-one concerned about public health should stay silent about.

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We declare that we have no conflict of interest.

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