Health and human rights

The Global Health Fund: moral imperative or industry subsidy?

Last month's G8 Summit in Genoa, Italy, was described by many as a war zone. 100 000 demonstrators gathered in the city, among whom a few intended to cause trouble, and peaceful marches quickly degenerated into fierce clashes between demonstrators and riot police.

The G8 response to this public unrest was to focus attention on the newly established Global Fund for Health. The fund has been established as a source of money for prevention, treatment, and research activities for three of the less-developed world's biggest killers: AIDS, tuberculosis, and malaria.

The UN has calculated that up to US$10 billion is needed annually to fight AIDS alone, but by the end of the summit the fund stood at a paltry $1·3 billion. That is the amount sub-Saharan Africa will pay in 6 weeks' debt repayments. Furthermore, it has been stressed that substantial investment in health systems will be needed to enable poor countries to increase prevention, treatment, and research activities.[1] This investment will require far more resources than have so far been committed. It is lamentable, but not surprising, that the world's rich governments cannot come up with enough money to tackle such an urgent issue. Their response was to label the fund a public-private partnership, calling upon multinationals to fill the funding gap.

There have been exchanges between the USA and the European Union (EU) about how this limited amount of money will be spent. The USA, backing its pharmaceutical industry, wants the money to buy brand-name drugs. The EU says that the fund should not become just another wealthy customer for the pharmaceutical industries. Médecins Sans Frontières, Oxfam, and others believe that if the purpose of the fund is to save lives, and not to give taxpayers' money to shareholders, then it should always be spent on the most affordable medicines and other health commodities. In the case of AIDS, triple-therapy costs five times less from generic-drug companies in India than pharmaceutical companies in the west.

To obtain and sustain an equitable pricing system for medicines in less-developed countries, a combination of mutually supportive strategies is required.[2] Generic competition is so far the only proven way to bring drug prices down. In Brazil the price of AIDS drugs fell by 82% over 5 years thanks to such competition. Equitable pricing requires an interpretation of the World Trade Organisation TRIPS (trade-related aspects of intellectual property rights) agreement that prioritises public health. Countries should produce or import generic drugs through compulsory licensing, or parallel import patented products at the lowest price offered on the world market. Members of the WTO are increasingly agreed on the need to make full use of these safeguards. A key challenge will be to put them into action.

Lower prices can also be achieved by supporting the local production of drugs through voluntary licensing and technology transfer. This strategy is long-term, sustainable, and will also stimulate economic development. The final G8 communiqué was a compromise between the US and EU positions. It acknowledged the importance of TRIPS safeguards, but went on to thank the pharmaceutical industry for their efforts at reducing their drug prices, and provided reassurance that drug patents are important because they fuel innovation. This may be true, but the current patent system has resulted in AIDS drugs that have been unaffordable for 95% of those in need, and has "fuelled the innovation" of virtually no new drugs for tuberculosis and malaria in the past 30 years.

Without basic commitments on how funds are to be spent, who makes the decisions, and a policy of purchasing medicines at the lowest possible cost, it will be a long time before the fund will have any substantial impact on diseases that kill 7 million people every year.

1 Brugha R, Walt G. A global health fund: a leap of faith? *BMJ* 2001; **323:** 152–54.
2 Médecins Sans Frontières. Pills and pocketbooks: equity pricing of essential medicines in developing countries. Geneva: MSF, May, 2001. www.accessmed-msf.org

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Inappropriate drug donations: the need for reforms

Individuals and organisations tend to respond to humanitarian emergencies with an urgent desire to help those in need. The media often highlight shortages of medicines, and donating medicines can seem a tangible way to express concern and solidarity. Drug donations do play an important part in humanitarian relief efforts, but they are not always the most effective way to help. After an earthquake, the first needs are usually shelter and earth-moving equipment. In refugee settings, priorities are clean water, sanitation, shelter, food, and vaccines. The requirement for drugs is determined with a comprehensive assessment of health problems.

Surplus drugs from hospitals and pharmacies in donor countries are rarely what is most needed in emergency settings. If the medical needs of the affected population are not clearly specified, responses from hospitals and pharmacies are unlikely to be helpful. Surplus drugs often include free samples or drugs returned by patients or health professionals, such as cardiovascular drugs, gastrointestinal drugs, hormones, and anti-rheumatic remedies. Some drugs have reached or are near their expiry date.

Antimalarials and vitamin A are commonly needed in an emergency, but are unlikely to be among the medicines donated by western hospitals. In 1991, Pharmaciens Sans Frontières found that only 20% of 4 million kg of drugs collected from 4000 pharmacies in France for international aid programmes could be used—the rest had to be burnt.

Guidelines for drug donations were produced by several organisations during the 1980s in response to inappropriate donations in emergency situations. They formed the basis for internationally endorsed drug donation guidelines.[1] The 12 articles of these guidelines are based on a set of