

Empty Shelves**As U.S. Balks on Medicine Deal,
African Patients Feel the Pain**

**Big Drug Makers, Protecting
Their Patents, Seek Limits
To a Global Trade Accord**

Searching for Insulin in Chad

By **ROGER THUROW**
And **SCOTT MILLER**

N'DJAMENA, Chad—At the central hospital in this decrepit capital, the lone cardiologist writes prescription after prescription for medicine to relieve hypertension. But he acknowledges that few of his patients will ever fill his orders.

"They often can't find the medicine in Chad, and if they do, they can't afford it," says Dr. Mouanodji Mbaissouroum.

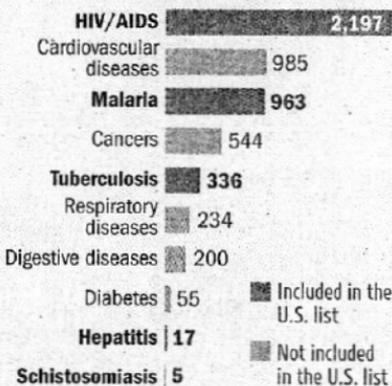
By now, Dr. Mbaissouroum and many of his colleagues throughout the developing world had hoped that relief would be on the way for the chronic affliction of unavailable and unaffordable drugs. Wealthier countries, where the drugs are produced and patented, promised 18 months ago at global trade talks in Doha, Qatar, to loosen patent restrictions in order to ease shortages and reduce prices. It was just after Sept. 11, 2001, and the U.S. led the rhetorical charge, eager to demonstrate its desire to battle suffering among the world's poor, while mounting a war on terrorism.

But last December, when all of the other 143 countries in the World Trade Organization had lined up behind a new plan on the trade of medicines, the U.S. blocked the proposal. The Bush administration, under heavy lobbying from a pharmaceutical industry seeking to limit the scope of the deal, endorsed a list of some 20 infectious diseases that it was willing to address. These included HIV/AIDS, malaria, tuberculosis, typhus, haemorrhagic fever and others categorized as epidemics in developing countries—but that was it. Drug manufacturers feared that without the limitation, the deal could lead to a broader undermining of their lucrative patent rights.

Poor nations were outraged. Dr. Mbaissouroum and other doctors here point out that they treat more patients, combined, for heart-related problems, diabetes, cancer and chronic respiratory diseases—which aren't on the U.S.-backed list—than

Selective Treatment

Deaths by cause in Africa,
2001 estimates, in thousands.



Source: World Health Organization

for AIDS. Many AIDS sufferers, they say, don't seek formal treatment out of ignorance or fear of stigma. Malaria kills one million Africans each year. Yet nearly twice as many, combined, die of heart or respiratory ailments, diabetes and cancer, according to the World Health Organization.

In the crowded diabetes ward here, a floor above the cardiology wing, Bechir Soumaine is recovering after several days without insulin, which he couldn't find in any local pharmacies. "People in the developed world think AIDS and malaria and communicable diseases are the biggest problems in Africa," says Dr. Mbaissouroum. "But we also suffer the same illnesses as rich people do."

Fifteen months before Doha became the central command post for the U.S. campaign to oust Saddam Hussein, it was the stage for a mission to effect potentially even bigger change: liberalizing global trade for the benefit of the developing world. While the military mission has been largely achieved, the grandly named Doha Development Round of trade talks has deteriorated into a major letdown for those it was supposed to help.

"We're disappointed, extremely frustrated and very concerned that this round of negotiations won't achieve the vision it set out to achieve," says Faizel Ismail, South Africa's trade representative in Geneva.

Asked to explain the U.S. position,
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Deputy Trade Representative Peter Allgeier cites the importance of zeroing in on AIDS and other epidemics: "As agreed by ministers in Doha, the WTO's efforts must focus on helping the poorest countries have access to medicines to fight infectious epidemics like HIV/AIDS, tuberculosis and malaria and those that may arise in the future." He adds that it is crucial not to stray from that focus by emphasizing other diseases, such as cancer and heart ailments. "We think the WTO needs to keep its eye on the ball to fulfill the Doha mandate," Mr. Allgeier says.

Summit Turmoil

The clamor for action has grown in recent days, as President Bush and the heads of the other largest industrialized countries, known as the G-8, have gathered in Evian, France, for their annual economic summit, which concludes tomorrow. Thousands of protesters, marching from Geneva toward Evian on Sunday, carried placards proclaiming "People before profit." The group Doctors Without Borders, pushing its campaign for cheap and accessible medicines, fervently handed out "Too poor to pay" stickers. At the WTO headquarters in Geneva, before it was ringed by police in riot gear over the weekend, demonstrators scrawled graffiti on the surrounding stone walls: "WTO kills" and "No justice, no peace."

Since the breakdown in December, there has been no action on the medicines stalemate. Neither has there been much movement on scaling back the agriculture subsidies that keep U.S. and European Union farmers in business. By encouraging surplus production that drives down world prices, the farm subsidies undermine the economies of many agricultural-based developing countries.

U.S. Trade Representative Robert Zoellick and Pascal Lamy, his EU counterpart, said earlier this spring that they wanted to start by finding an easier target and had decided to join forces on the relatively attainable goal of reducing tariffs on manufactured goods. Focusing their efforts on that, they said, might create some momentum at the WTO that could spill over into other areas, such as medicines or agriculture.

The explosive spread of AIDS in Africa has drawn international attention to the issue of access to patented medicines readily available in the West but scarce and prohibitively expensive in most developing countries. At Doha, trade ministers agreed that poor countries should be able to override patent protections and

use cheaper generic copies of drugs to attack mass health problems. Mr. Zoellick repeatedly stressed the need to reach out to struggling nations. "One of our primary objectives in launching a new global negotiation is to use trade and openness to bring new opportunities and new hope to the poorest among us," he said in a speech to the Council on Foreign Relations in October 2001.

But the Doha agreement didn't spell out how poor countries, with no capability to manufacture generic drugs of their own, could import the generics from a third country. The pact also didn't specify precisely which diseases it covered. The key language referred to "public-health problems afflicting many developing and least developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics."

The developing countries interpreted this as covering any disease they would identify as a public-health problem. But as the round-the-clock talks neared a final deal last December, U.S. negotiators argued that the patent exception should apply only to epidemics such as AIDS, tuberculosis and malaria.

Drug companies, led by their trade group, the Pharmaceutical Research and Manufacturers of America, mounted an 11th-hour lobbying blitz aimed at the White House and members of Congress. The industry had spent more than \$50 million to help Republicans gain control of Congress in November 2002.

About three dozen lawmakers signed individual and group letters beseeching Mr. Zoellick to limit the scope of the deal. Chief executives of 19 drug companies signed a separate letter to the trade representative. And the White House kept "in very close contact" with Mr. Zoellick, as is standard practice in such negotiations, an administration spokeswoman said.

The drug industry fears that relaxing patents beyond those for a limited list of epidemics would set a precedent leading to much broader erosion of their intellectual-property rights. That could spark an open season on lucrative drugs of little relevance to African public-health crises, the industry says, specifically citing Pfizer Inc.'s impotence remedy, Viagra, and products designed to prevent baldness. Without the exclusive right to produce innovative drugs—and collect commensurate profits—manufacturers say they won't have enough incentive to research new treatments. In the long run, that will undercut medical science and harm those who suffer, both rich and poor, the companies add.

"We care a lot about people having

access to our medicines," Raymond V. Gilmartin, Merck & Co.'s chairman and chief executive, said at a European Commission conference in Brussels in April. He pointed to Merck's distribution of reduced-cost drugs in the developing world, including antiretroviral medicines for HIV/AIDS and treatments for river blindness, an affliction transmitted by flies that breed on water. "Many of the medicines that have come from Merck laboratories have changed the way diseases are treated and changed millions of lives," the executive said. But Mr. Gilmartin also said that the original broad Doha declaration could lead to future pressure to relax patent protection of other products.

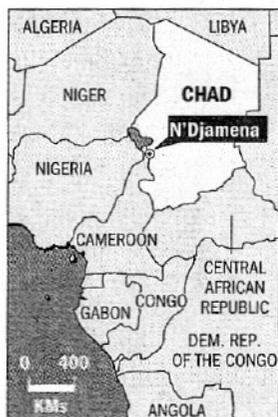
U.S. trade representatives also bristle at the perception that they are keeping drugs out of the hands of those who need but can't afford them. At the Brussels conference, Grant Aldonas, under secretary for international trade at the U.S. Department of Commerce, deflected questions on the topic, stressing that drug prices are only a small part of the health problem facing developing countries. More important than prices, he said, are ineffective distribution systems and endemic corruption in developing countries, which make it hard for the needy to get their hands on any medicine that does arrive from abroad. "It's not just about intellectual property," he said.

The U.S. tried to counter international critics late last year by announcing a temporary moratorium on export laws governing patented drugs for poor nations facing certain epidemics. And, several weeks later, in his State of the Union address, President Bush pledged that the U.S. would spend \$15 billion over five years to fight AIDS around the world. The Bush plan, focused largely on African and Caribbean countries, aims to provide care for those already infected with the disease, as well as bolster programs designed to prevent its spread.

Representatives of African countries praise the U.S. AIDS money and the temporary export-law moratorium, but they question why similar steps aren't taken for other diseases that are big killers. And, they ask, what about diseases that materialize in the future and medical breakthroughs? If new cures are patented and not included on the U.S.-favored list, they will be largely out of reach to the sick of Africa.

"The development of science is so great, we must be up to date," says Dr. Mbaissouroum, the Chad cardiologist.

Chad, one of the world's poorest countries, where the vast majority of the population lives on less than \$1 a day, displays all the ills of African health systems: little capacity to manufacture its own drugs, broken-down distribution networks, no reliable record-keeping to gauge medical needs and a lack of money to import medicine.



Feel the Pain

While the government has a list of over 400 drugs it considers essential for treating its citizens, it can't afford many of them, even in generic versions. Last year, according to the local WHO office, the Chad government relied on \$2.3 million in funding from the EU and the World Bank to buy medicine for the country's eight million people.

Shortages are common. Often, Chad patients have to cross into neighboring countries, such as Cameroon, to find the drugs they need. And when they do, they often find they can't afford them there.

Doctor's Dilemma

Consider Dr. Mbaissouroum's dilemma: For hypertension, he usually prescribes one of two drugs which sporadically make their way into the country. One, Loxen, sold by Switzerland's Novartis AG and patented in Europe, costs the equivalent of about \$25 for a box of 60 tablets. He prescribes one or two tablets a day, so the box can last for one or two months. Or he prescribes a generic ver-

sion of the drug alphas-methyl-dopa that costs about the same: \$8 for a box of 20 tablets. He prescribes several tablets a day, so this box lasts only one week. Most of the patients prefer the \$8 box because it costs them less on the day of purchase, even though it lasts for a shorter time.

"They can't afford a second box, so they interrupt their treatment," the doctor says.

Mr. Soumaine, the diabetic, often interrupts his treatment, too, because insulin supplies in Chad are spotty. Some pharmacies lack refrigerators to store it, so they keep a low supply. Other times, it isn't available at all. Most injected insulin is no longer under patent. But potential new treatments that are currently being researched and could be of particular benefit to Africans with diabetes, such as inhaled or oral insulin, would probably be patented if they ever come on the market.

For 16 years, Mr. Soumaine has battled diabetes, taking insulin whenever he could to control his blood-sugar level. When he has a job—most recently he managed inventory for a French contractor in Chad—Mr. Soumaine can afford the

monthly insulin purchases: \$12 in local pharmacies, \$25 over the border in Cameroon. But now that he has been out of work for eight months, the 42-year-old father of eight children says, "When I need more insulin, I rush to my parents or other relatives for money. It's embarrassing."

Two months ago, he traveled eight hours by car to Moundou, the nation's commercial hub, to look for a job. The search dragged on, and he ran out of insulin. There was none to be found in Moundou, he says. Weak and woozy, he was rushed back to N'Djamena, to the diabetes ward at the central hospital.

There, a medical student found that Mr. Soumaine's blood-sugar level was severely elevated. The patient was stabilized with insulin from the hospital's emergency supply while, for two days, friends and relatives scoured N'Djamena for insulin. Finally, they bought some in Cameroon.

Preparing to leave the hospital, Mr. Soumaine says he is certain he'll be back. "As a diabetic in Chad," he says, "every day I don't know if I'll die."

—Tom Hamburger
contributed to this article.