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COMMENTARY

Curing the Diseases of Poverty

By FRANKLIN CUDJOE
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ACCRA, Ghana -- The World Health Organization will discuss this week the problems facing the world's poor. Many of the technocrats gathering in Geneva for the Intergovernmental Working Group on public health, innovation and property rights believe that eliminating drug patents will usher in a new era of global health and prosperity. They blame intellectual property laws for high drug prices and limited research and development into cures for the "diseases of poverty" -- illnesses that disproportionally affect the poor, such as AIDS, tuberculosis and malaria.

Unfortunately for us in the poorest nations, these health activists are missing the forest for the trees. Inadequate infrastructure, not price, is the chief obstacle blocking access of high-quality medicine to poor countries.

Imported drugs often sit for months in Africa's dirty, non-air-conditioned storage facilities -- either losing quality or expiring before reaching patients. Hospitals lack doctors, nurses, equipment and sometimes even electricity to effectively administer available medication. Roads are often in disrepair, making it particularly difficult to reach rural populations, where disease rates are the highest.

Malaria is a perfect example. In the 1990s, this infectious disease surged in sub-Saharan Africa as the parasites causing the illness became resistant to the most effective medications at that time. In 2001, the Swiss drug maker Novartis signed a contract with WHO to provide African patients with Coartem, its blockbuster antimalarial combination therapy, at production cost.

But demand was low because most African countries said they simply did not have the money to purchase the drug even at production cost. Consequently, Novartis was forced to close a production facility and destroy expired stock, incurring substantial financial losses in the process.

Even when pharmaceutical companies offered drugs for free, as Pfizer and GlaxoSmithKline have done in the past with drugs to treat trachoma and malaria, respectively, African countries still had severe problems in storing the drugs and distributing them. Poor roads, dilapidated health centers and inadequate medical personnel to administer the right prescriptions all stood in the way of helping patients. The tools to cure malaria were ready -- we in Africa were not.

If the West is any guide, better health systems come with economic development and higher standards of living. Both are frequently stifled in poor countries by destructive policies and home-grown corruption. Import taxes and tariffs on lifesaving drugs, for example, can be severe. Brazil, currently leading the global crusade to break patents, levies a 30% tariff on all imported medicines. Kenya and Ghana slap tariffs of 37.8% and 33%, respectively, on all imported medicine, ultimately doubling drug prices under their national health schemes when retail costs are factored in. The paradox here is that Kenya is the main African advocate for breaking patents of essential drugs.

Many health activists, however, ignore these realities and instead focus their attention (and ire) on Western pharmaceutical firms, applauding nations that issue patent suspensions on drugs.

Last year, the Thai military government declared that it could not afford branded drugs to treat its citizens. So it issued compulsory licenses, or patent suspensions, for two AIDS medications and one heart drug and began producing copies locally. Though the quality of the drugs was unknown, the move was hailed by activists as a victory for "patients over patents."

But the generals weren't really worried about patients. If public-health concerns had been the prime motivation, the Thai government wouldn't have refused the massive price reductions the patent holders had offered. Even more tellingly, the government rejected the opportunity to use money from the U.N.-sponsored Global Fund to Fight AIDS, Tuberculosis and Malaria to purchase WHO-certified generics.

Far from a noble act, Thailand's compulsory licensing was a bald power play to beef up local manufacturing and generate revenues for a corrupt state. Unfortunately for Thai AIDS patients, producing the drugs locally has proved prohibitively expensive and has sharply limited their supply.

What's more, few generics and locally produced copycat drugs are tested and certified by respected regulatory authorities. Low-quality pharmaceuticals can expose viruses, bacteria and parasites to substandard doses of an active ingredient, breeding the bug's resistance in the process. This can doom an entire class of drugs. The poor quality of Thailand's copycat antiretroviral drug caused a rise in resistant AIDS viruses two years ago.

Another cautionary tale comes from India. Under pressure from antipatent activists, the WHO in 2004 green-lighted without testing an antiretroviral generic produced by Ranbaxy, an Indian company. The Geneva-based organization then had to quickly withdraw its approval again when Ranbaxy failed to provide adequate safety data.

By most estimates, it costs Western pharmaceutical companies around $800 million to develop a new drug and bring it to the market. The risk of losing a product through compulsory licensing will only discourage investment in future research.

Yet antipatent activists, with their myopic fixation on price, are relentlessly bullying bureaucrats to follow their advice. Let's hope the WHO won't succumb to the misconception that compulsory license can cure Africa's health problems. Instead, economic development remains the continent's best hope for eradicating the diseases of poverty.

Mr. Cudjoe is executive director of the Imani Center for Policy and Education.