

The Strength of Industry Interests in Shaping Global Health Policies on Access to Tuberculosis Medication

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The United Nations' Covenant on Economic, Social and Cultural Rights, adopted in 1966, represents the first international rights-based approach to the control of communicable diseases. Article 12 of the Covenant affirms that State Parties to the Covenant must take steps necessary for "the prevention, treatment and control of epidemic, occupational and other diseases" (ICESCR, 1966). Article 12 clearly establishes infectious disease governance as a public good and a fundamental right. 160 countries had ratified the ICESCR as of April 2010 (Schrecker et al., 2010: 1521). While the ICESCR is a remarkable document and represents a landmark human rights framework, its emphasis on a State's responsibility for the public health of its citizens becomes problematic in the face of a globalised world grappling with infectious disease. There is a disparity between the scale of the problem -- that is, global -- and the governance mechanisms to address the problem -- that is, national (Smith, 2009: 126).

A political economy approach to examining the governance of infectious disease involves a consideration of what scholar Susan Strange labels "the significance of the state-firm dimension" (Strange, 1992). This significance is crucial in reflecting on the public health community where "collective actions in response [to the challenges of globalisation for public health] have been influenced by how these perspectives privilege certain interests, institutions and ideas" (Lee, 2009: 37). The paradox between the primacy of health as a human right as articulated by the United Nations in their ICESCR and the powerful hegemony of commercial interests in the global health industry has been recognised in global health literature – and some scholars argue that "the domination of commercial interests is being challenged by social ones" (Cohen-Kohler, 2009: 189). Unfortunately, an examination of the global governance of communicable diseases paints a somewhat bleaker picture in which health industry interests dominate.

Tuberculosis is a particularly poignant and effective lens through which to examine the politics and economics at work in the interactions of global governance mechanisms and the global health industry. The disease is an immense public health menace – one in seven people die from tuberculosis (Selgelid, 2008: 10). The strong connection between tuberculosis and inequality is essentially uncontested (Suk et al., 2009) and societal factors certainly play a crucial role in determining whether a person infected with *M. Tuberculosis* becomes affected by an active infection; nonetheless, *M. Tuberculosis* is a microbe. It is a disease with “a known causal agent, pathogenesis, mode of transmission and predisposing factors, as well as an effective cure” (Verma et al., 2004: 1). Tuberculosis is an airborne pathogen and is contagious (Farmer, 2005: 119). Our globalised reality obliges international bodies to manage tuberculosis. That the reduction of poverty would benefit tuberculosis prevalence rates is not denied; however, the global governance community must recognise that pharmacological interventions are a necessary component to addressing tuberculosis on a global scale.

As a communicable disease, tuberculosis urges the global community to act expediently because of its ability to become multidrug or even extremely-drug-resistant. MDR-TB is a result of inadequate drug therapy – patients either do not comply with treatment and cease taking their medicines before the course of therapy is completed, or physicians provide incorrect or insufficient drugs either because of misdiagnosis or the unavailability of appropriate drugs (Bayer and Dupuis: 1995: 310). Treatment of MDR-TB takes about two years to complete as opposed to the six month treatment period involved with treating the typical drug-responsive strains of tuberculosis (Farmer, 2005: 118). Furthermore, MDR-TB is 100 times more expensive to treat than drug-responsive tuberculosis, which only costs between \$10 and \$20 to treat (Selgelid, 2008: 12). Alarmingly, as of 2005, estimates indicated that one in five new reported cases of tuberculosis was classified as drug-resistant (Farmer, 2005: 127). XDR-TB is another growing cause for alarm among the global health community – treatment can cost up to \$500,000 and scholars have noted that “it remains to be

seen, but the emergence and spread of XDR-TB may turn out to be as, or more, significant than AIDS” (Selgelid: 2008: 13).

The first anti-tuberculosis drugs were introduced in 1946 and are still in use today (Bayer & Dupuis, 1995: 309). The most powerful combination of drugs – isoniazid and rifampin – are recommended to treat drug-responsive tuberculosis under the DOTS system; MDR-TB patients do not respond to either of these drugs (Farmer, 2005: 180). Because of the pressing nature of the rise of MDR-TB, one might assume that there has been significant drug research and development in that area; but, between 1975 and 1999, “of 1393 new chemical entities marketed, only 13 were for tropical disease and 3 were for tuberculosis” (Trouiller et al., 2002: 2189). Furthermore, there is currently only one available preventative vaccine for tuberculosis, the BCG vaccine, and it was invented in France in 1921 (Franco-Paredes et al., 2005: 94). The BCG vaccine does not prevent tuberculosis in adults and therefore has enjoyed little success in reducing the global burden of the disease (Kaufmann et al., 2010: 2111). The BCG vaccine, like the drugs to treat drug-susceptible tuberculosis, is a cost effective intervention, costing only \$0.10-\$0.20 per dose (Kaufmann et al., 2010: 2110). That cost effective interventions are continually advanced by global health governance institutions despite their inability to control the spread of MDR-TB points to the strength of the global health industry and of the prevailing neoliberal market approach to healthcare.

A representative of the pharmaceutical industry, in a speech to the Washington-based think tank the American Enterprise Institute, attributes this lack of innovation to increased market regulations and the 2001 WTO Declaration on the TRIPS Agreement and Public Health (Taurel, 2005). He lists market-based pricing and intellectual property protection as “pre-conditions for innovation” and passionately inveighs against “healthcare systems around the world who are...[waging] a worldwide campaign against pharmaceutical innovation” (Taurel, 2005: 326). The pharmaceutical industry is quick to point out the high costs of research and development in lobbying for increased patent protection and less market regulation – the industry states that the cost of developing a new drug for the market is \$500 million (Henry & Lexchin, 2002: 1593). Indeed, the pharmaceutical

industry invests incredible amounts of money in drug research and development – in 1999 it invested an estimated \$35.3 billion, however, only about 10% of this was spent on infectious diseases (Trouiller et al., 2002: 2189). Furthermore, former World Bank chief economist Joseph Stiglitz explains that “drug companies spend more on advertising and marketing than on research, more on research and lifestyle drugs than on lifesaving drugs, and almost nothing on diseases that affect developing countries only” (Stiglitz, 2006: 1279). The industry’s argument that they could not remain profitable if the global community were to enforce pricing restrictions or lower levels of patent protection are questionable given their position as the most profitable industry in the business sector with an average of 16.2% profit – as a point of comparison, the financial industry enjoys a profit margin of about 11% (Henry & Lexchin, 2002: 1591).

The establishment of the Global Fund to Fight AIDS, Tuberculosis, and Malaria is the global governance community’s attempt to manage the spread of tuberculosis. The brain child of the 2000 G8 summit in Okinawa, Japan, and mandated by a 2001 United Nations Special Session on AIDS, the Global Fund started its funding work in January of 2002 and today describes itself as the main source of financing for programmes to fight AIDS, tuberculosis and malaria (Brown, 2009: 170). As the self-described “main source of financing” and as the arguably most visible international response to tuberculosis control, the Global Fund deserves further examination when considering the context of global tuberculosis management.

The Global Fund, as established by the United Nations, is a public-private funding foundation with a multisectoral decision-making board (Brown, 2009: 171). The Global Fund is funded through voluntary replenishments of donor bodies -- these donors are mostly States, but also include private corporations, and initiatives such as “Product RED” and “Comic Relief” (Global Fund, 2011). Pharmaceutical companies also donate drugs to the Global Fund on an ad hoc, one-off basis (Bluestone et al., 2002: 7). The Global Fund disburses its funds and its donated drugs to recipients who have, through the Fund’s required Country Coordinating Mechanism comprising multisector representatives, completed successful applications detailing their planned tuberculosis interventions

(Brugha et al., 2004). Grant recipients must use the money provided by the Global Fund to purchase anti-tuberculosis drugs from a list of pre-approved providers to ensure quality (Global Fund, 2009: 16).

The Global Fund has had successes – UN Secretary-General Ban Ki-moon recently applauded the Fund for saving “close to 5 million lives...in just seven years” and went on to state that “very few initiatives can make such a claim” (United Nations, 2010). This is all true. However, the fundamental nature of the Global Fund implores us to examine the structural power of industry at work in controlling the global conversation about communicable disease, particularly tuberculosis. It is a financing mechanism, above all, and provides funds to successful applicants so that they might afford the appropriate drugs to manage tuberculosis within their particular context – and the Global Fund gathers its resources from voluntary contributions by its member States and other organisations and from drug donations by the pharmaceutical industry. The Global Fund’s very nature suggests that providing treatment for tuberculosis patients is more a charitable cause than a justice issue. The implicit ideology that comprises the Global Fund’s foundations is that the pharmaceutical industry should be left to self-regulate on issues of access to medicines. The most optimistic interpretation of the Global Fund is that it is a groundbreaking and innovative public-private-partnership that has managed to save millions of lives – the least optimistic is that it has been so influenced by market and industry interests that it manages to maintain the high cost of essential medicines while simultaneously publicising the pharmaceutical industry’s good corporate social responsibility practices.

There is unquestionably a disparity between the human rights approach to health espoused by such documents as the ICESCR and current global governance mechanisms for managing tuberculosis and other communicable diseases. Some have argued that international governance mechanisms lack the architecture to enforce the human rights norms it claims to embrace (Fidler, 2003: 289). It has also been pointed out that “governments can and do oblige industry to do necessary research in other sectors (Trouiller et al., 2002: 2193) and that it is possible to

acknowledge the profit motives of the pharmaceutical industry but to also reasonably “limit profits in the context of public health emergencies” (Gupta et al., 2001: 1050). UN Special Rapporteur Paul Hunt suggested external mechanisms to regulate pharmaceutical pricing in 2008 and major international nongovernmental organisations such as Oxfam have called for global regulations to reduce drugs costs (Bluestone et al., 2002). These exhortations have not led to the development of stronger governance mechanisms for managing access to treatment for victims of communicable diseases.

Margaret Chan, WHO Director-General, in her opening remarks at a WHO and WTO joint symposium on drug pricing and procurement practices, spoke of the ethical imperative to enhance access to essential medicines for the poor; but, she concluded her speech by explaining that the pharmaceutical industry is “profit-driven, and not a philanthropist...or humanitarian enterprise” and that price reductions should come from more efficient procurement procedures (WTO, 2010). There was no mention in her speech of the need for greater regulation of the pharmaceutical industry or of controlling drug costs. This speech is indicative of the global governance stance on managing tuberculosis – it speaks its positions through silences. The absence of governance mechanisms is in and of itself a governance mechanism. It is a mechanism that leaves the issues of access to essential drugs in the hands of industry concerns. The involvement of the global health industry on the global level plays a key role in the formation of mechanisms that tackle communicable diseases to the detriment of victims of all infectious diseases. In the case of tuberculosis, the effects of the ascendancy of the market-concerned global health industry may prove to be catastrophic.

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