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World trade, the poor and swine flu

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In the last edition of this Journal Anant Phadke provided readers with the dreadful story of the death of Rida Sheikh from the H1N1 flu virus (1). Moving from this local and most concerning incident to the international arena reveals further matters worthy of consideration in the context of pandemic influenza. In 2005 the World Health Assembly adopted revised International Health Regulations. The purpose of these Regulations is to prevent the international spread of disease while avoiding unnecessary interference with international traffic and trade (2). According to the Regulations countries are obliged to develop certain minimum public health capacities for the detection, assessment and reporting of infectious disease outbreaks. Member States are urged to support developing countries in this regard. While it is unlikely that Member States will privilege the interests of developing countries, the question of what constitutes "unnecessary interference" with international traffic and trade and how this issue ought to be considered in the context of a threat to "global" public health seems not to have been the subject of conspicuous debate.

Similar issues were of concern to the rulers of the European populus during the13th and 14th centuries. Their regulatory systems were directed towards limiting the impact of the plague on trade and controlling the rampaging poor once the rich had fled the confines of their cities. Armed militia were employed to put down rebellions of the poor and to stop them from pillaging the property left behind by the rich. Quarantine including house arrest was ordered. Plague victims and their carers could be sent to pest houses, hospitals such as there were, and monasteries. Schools were closed and religious assemblies banned. Goods thought to be contaminated were confiscated and destroyed. Travellers were banned. Cordons sanitaire were established and specified travel routes mandated. Information was exchanged between health authorities.

In early 2009 the H1N1 flu virus was described as the heir to the so-called Spanish Flu that had led to the death of millions at the end of the First World War. That flu virus spread quickly and had been capable of causing death within 24 hours of otherwise healthy young men and women. Governments expressed concern over how this new flu pandemic was to be managed. On April 29, 2009, the *New York Times* reported Dr Michael T Osterholm, director of the Center for Infectious Disease Research and Policy at the University of Minnesota, as saying that closing borders is dangerous because many goods needed in a pandemic are made abroad. After making reference to masks, gowns and gloves, and the raw materials to make drugs, he continued, "Our global just-in-time economy means we are dependent on others." Much of our food is from overseas. "A Kellogg's Nutri-Grain bar has ingredients from nine countries in it." On April 30, 2009 the Kellogg company and its subsidiaries reported a solid first quarter operating profit $529 million(3).

While most of us could do without Nutri-Grain bars if the choice is between the bar and contracting the H1N1 flu, legitimate questions may be raised about the privileging of the current international trade regime and the extent to which developing states should be supported so that they might have available what is needed during periods of national emergency (and otherwise). In this context it seems industrialised countries would like to have their cake and eat it too, having constructed world trade law so that their domestic producers and manufacturers have unfettered access to international markets but evincing limited

concern when the threat to health is faced by others and is accompanied by risks to export income. For example, World Trade Organisation members cannot agree to an amendment to the Agreement on Trade Related Intellectual Property Rights proposed in 2005 intended to improve global access to patented drugs. This amendment enables countries with the ability to manufacture patented drugs to export these products under a compulsory licence in order to protect public health in another country in the "event of national emergency or other circumstances of extreme urgency". A number of stringent conditions must be met before such a licence can be relied upon. This being so there has been only one instance of reliance on this mechanism in the form of two shipments of drugs from Canada to Rwanda. The deadline for this amendment to be agreed by Member countries has now been extended by two years to 2011.

Furthermore over the last couple of years generic drugs made in India intended for use in developing countries have been repeatedly seized in European ports. Customs officers have relied upon a European Commission regulation directed towards goods suspected of infringing intellectual property rights to support the seizures. India has argued that this regulation is inconsistent with the Agreement on Trade Related Intellectual Property Rights, yet it is unlikely to be repealed by the EC. India has asserted that the seizures have an adverse systemic impact on:

(i) the principle of universal access to medicines,
(ii) national public health budgets,
(iii) legitimate trade of generic medicines,
(iv) South-South commerce,
(v) use of TRIPS flexibilities, and also
(vi) seriously impair the efforts of civil society organisations engaged in providing medicines and improving public health in the least developed parts of the world (4).

The failure to reach agreement on the international regulation of agricultural trade during the Doha Round because current rules gravely disadvantage developing countries further reinforces the notion that the protection of trade, as currently constructed, should be accorded less weight in the health/trade balance.

An editorial in the *Lancet* quoted an estimate predicting that 96% of the deaths in the next global influenza pandemic would occur in low and middle income settings with displaced populations at particular risk (5).Sangeeta Shashikant of the Third World Network, which campaigns for better drug access for the poor, announced in a media release that "advance purchase agreements" for flu vaccines and other deals that secure medicines for wealthy governments could bleed the global supply chain of effective medicines. During an earlier outbreak of avian influenza, Indonesia sensibly stated that it would not provide its virus samples without an assurance that States unable to afford the vaccines developed in consequence of Indonesia's assistance would be provided with them (6). Indonesia was subjected to international criticism for insisting upon this as a condition of its cooperation.

The WHO Director-General has called for international solidarity to provide fair and equitable access to flu vaccines. WHO states that it has helped secure donations of about 200 million doses for 95 low and middle income countries and aims to provide these countries with enough vaccine to immunise at least 10% of their populations (7). However there is no doubt that geopolitical issues will figure in decisions regarding which countries are provided with assistance and by whom. There is also no doubt that the countries with most to fear are the countries who are least likely to receive the assistance they need, countries already dealing with AIDS, tuberculosis, pneumonia, malaria, diarrhoea and other diseases, the names of which those of us living in economically wealthier countries would not recognise. The distribution of disposable masks, a popular measure in some countries, is an unthinkable in countries where uniform access to clean water and soap is a distant dream. How is the most fundamental preventive measure of hand washing to be recommended in these circumstances?

So while developed countries attempt to protect their export earnings and selectively decide which countries other than themselves might benefit from drug stockpiles and future vaccine development, little is done to strengthen the capacity of developing countries to detect, manage and treat outbreaks of infectious disease. This remains so even though it is very well known that diseases like influenza do not respect borders, especially in an age where international travel occurs with a frequency never imagined possible. While our pharmaceutical remedies may have improved, not much else has altered in the way that we deal with infectious plagues like pandemic influenza. The rich protect their interests while the poor are controlled.

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