

COUNTRY EXPERIENCES IN USING TRIPS SAFEGUARDS

This note provides a brief overview of countries' experiences in using the safeguard mechanisms available in the TRIPS Agreement to protect public health and access to medicines. It is written in response to requests to share such experiences.

COMPULSORY LICENSING IN DEVELOPING COUNTRIES

While the TRIPS Agreement contains several safeguard mechanisms, probably the most important one is compulsory licensing. A compulsory license (CL) is a license granted by the government to allow the use of a patented invention, without the permission of the patent holder. Virtually all patent laws contain provisions for compulsory licensing, and compulsory licensing is allowed under TRIPS. A CL allows the production, import, sale and use of generic products before expiry of the patent. A special case of compulsory licensing is "government use" (or a CL for public non-commercial use), i.e. when a government itself uses, or authorizes a third party to use, a patented invention for government purposes, without the permission of the patent holder.

In the past five years, several developing countries have issued compulsory licences in order to increase access to medicines¹.

MALAYSIA

In November 2002, after efforts to negotiate price reductions had failed, the Ministry of Health (MoH) of Malaysia proposed the use of "government rights" to the Cabinet. In January 2003, upon receiving approval, the MoH applied to the Ministry of Domestic Trade and Consumer Affairs (custodian of the Patents Act) for an authorization to import generic versions of patented antiretrovirals (ARVs). In spite of the Cabinet approval, the authorization was opposed by some other government agencies, citing concerns that it would deter foreign investors.

On 29 October 2003, however, the authorization for the exploitation of a patented invention on behalf of the government (government use authorization) was issued. It allowed a local company to import didanosine tablets, zidovudine tablets and a fixed-dose combination (FDC) of didanosine+zidovudine from a generic manufacturer in India.

The authorization was valid for two years. It required that the medicines be labelled with the words "Ministry of Health Malaysia" and imposed several other conditions, including a

maximum price and a requirement that royalties be paid to the patent holder(s) within two months of importation of each successive batch. While the authorization did not specify the royalty rate, the MoH offered the patent holders 4% royalties. The patent holders however showed little interest in accepting or negotiating the proposed remuneration.

Following the government use authorization, the patent holders reportedly reduced their prices by 50-80%. However, treatment costs were still lower when using generics, and the number of patients treated with (generic) ARVs in the public sector more than doubled.

In reaction to the government use authorization, one of the patent holders filed a lawsuit –which, however, was never activated– while complaints were received at some Malaysian embassies.

On 1 November 2005, the authorization expired. It was not renewed, since price reductions offered by the patent holders were considered satisfactory.

ZIMBABWE

On 8 April 2003, Zimbabwe issued a CL for all HIV and AIDS-related medicines. The licence was issued after a period of emergency on HIV/AIDS was declared. The declaration of emergency was issued in accordance with Zimbabwe's own national law; it is not a TRIPS requirement (see box 1). The CL allows a local company, Varichem Pharmaceuticals Ltd, to produce ARVs or HIV/AIDS-related medicines during the emergency period. The licence requires the company to supply three quarters of its production to state-owned health institutions and specifies that the medicines produced under the licence will be subject to price controls.

Varichem reportedly launched its first ARV in Zimbabwe in October 2003, and has since launched several other ARVs. It supplies to both the government and private sector.

Box 1: The "emergency myth"

There is a widespread misunderstanding that TRIPS allows for compulsory licensing only when there is an emergency. This is not correct; TRIPS leaves countries free to decide the grounds, or reasons, for issuing a compulsory license. TRIPS does however impose a number of conditions.

One of those conditions is that there should first be an effort to obtain a voluntary license from the patent holder. This particular condition is waived in three cases: i) when there is an emergency, or in case of "other circumstances of extreme urgency"; ii) in case of public non-commercial use (or government use); or iii) when the compulsory license is granted to remedy anti-competitive behaviour.

¹ The examples listed in this briefing note do not represent a complete or comprehensive list.

ZAMBIA

On 29 September 2004, Zambia issued a CL to allow a domestic company to manufacture a FDC of lamivudine+stavudine+nevirapine. The CL prohibits export, and specifies that the total amount of royalties payable to the patent holder(s) shall not exceed 2.5% of the turnover of the product.

INDONESIA

On 5 October 2004, a presidential decree was issued in Indonesia authorizing the Minister of Health to appoint a manufacturer to exploit patents on lamivudine and nevirapine on behalf of the government. The decree specifies a royalty rate of 0.5% of the net (generic) sales price. The authorization lasts for seven years (nevirapine) and eight years (lamivudine), i.e. for the remaining patent term. In March 2007, the decree was amended to include efavirenz. The decree was issued –and amended– in a low key manner, and does not appear to have attracted any criticism.

THAILAND

In the late 1990s, the Government Pharmaceutical Organization (GPO) started producing generic versions of ARVs that were not patented in Thailand, or for which the Thai patent had expired. One important drug, didanosine (ddI), was under patent in Thailand; however, the patent only applied to ddI tablets. Hence in January 2000, the GPO started producing ddI powder; the powder form, while not as convenient or as accurate a dosage form as tablets, did not infringe the patent.

Subsequently, in October 2002, following a challenge by people living with HIV/AIDS, Thailand's Central Intellectual Property and International Trade Court ruled that the ddI patent was only valid for tablets containing 5-100 mg ddI. This ruling allowed generic manufacturers, such as the GPO, to produce ddI tablets outside that dosage range (e.g. tablets containing 125 mg ddI).

Thailand issued its first CL in November 2006, for efavirenz. About two months later, the first consignment of generic efavirenz was imported from India², at half the original price. In January 2007, two more CLs were issued, for lopinavir/ritonavir and for a cardiovascular drug, clopidogrel. This was the first time a developing country used compulsory licensing in relation to a non-communicable disease.

Thailand's actions were widely reported in national and international media, and drew mixed reactions. Notably the inclusion of a cardiovascular drug generated controversy³. One of the affected companies withdrew seven pending applications for registration of new drugs in Thailand, thus effectively withholding them from the Thai market⁴. Meanwhile the United States Trade Representative referred to these CLs when adding Thailand to its "priority watch list" of countries whose level of intellectual property protection and/or enforcement it considers to be inadequate⁵, while at the same time acknowledging that Thailand had the right to issue compulsory licenses.

² Generic efavirenz is being imported, at least initially. Meanwhile national companies have started preparations for local production.

³ The TRIPS Agreement does not limit compulsory licensing to particular products or to products for certain diseases.

⁴ On 25 May 2007, Abbott announced it had resumed efforts to register one of the products (the heat-stable version of lopinavir/ritonavir).

⁵ Countries on this list are the focus of increased US attention. If they do not attempt to address the policies/actions at issue, they may be marked as "Priority Country", which may, eventually, lead to trade sanctions.

Box 2: Authorizing "government use"

Procedures for issuing a compulsory license vary among countries. In Indonesia, government use has to be authorized by presidential decree. In Malaysia, the Minister of Domestic Trade and Consumer Affairs has the authority to do so, while in Thailand "any ministry, bureau or department of the government" has this authority.

These differences are caused by differences in the national laws; TRIPS does not specify at what level a compulsory license/government use can or should be authorized.

In January 2008, the Ministry of Public Health of Thailand endorsed government use of patents on several cancer medicines.

BRAZIL

Brazil, like Thailand, has a government-owned company that produces generic versions of certain ARVs, which are not under patent in Brazil. In addition, Brazil has used the fact that it is capable of producing generic versions of crucial HIV drugs, and that it would be willing to issue a CL if necessary, to negotiate substantial price discounts for those drugs that are patented. For several years, this strategy was quite successful, and Brazil did not actually have to issue a CL.

However, on 24 April 2007, the Minister of Health passed Decree n° 866, declaring that efavirenz would be eligible for compulsory licensing for public non-commercial purposes. This was followed, on 4 May 2007, by the issuing of a CL for public non-commercial use of efavirenz. The CL is valid for a period of five years, and specifies a royalty rate of 1.5%.

This action was taken after price negotiations with the patent owner, begun in 2006, failed. The time lag between the passing of Decree n° 866 and the issuing of the CL was intended to allow the patent owner to submit a better price offer. Reportedly, a 30% price reduction was proposed, which however was considered insufficient, since the patent holder had offered a significantly lower price to Thailand.

Following the issuing of the CL, the first consignment of generic efavirenz was imported² on 2 July 2007, at a price reduction of 65-70% (depending on dosage).

The decision to issue a CL has been criticised, among others, by the patent holder, citing it would have a negative impact on Brazil's ability to attract inward investment.

COMPULSORY LICENSING IN DEVELOPED COUNTRIES

Compulsory licences have also been used in developed countries. Some examples are listed below¹.

CANADA

Before it acceded to the North-American Free Trade Agreement (NAFTA) in 1992⁶, Canada made extensive use of compulsory licensing to promote the public interest; thus, between 1969 and 1992, there were 1 030 applications to import or manufacture

⁶ NAFTA is a pre-TRIPS trade agreement, but contains provisions on intellectual property rights that are very similar to those in TRIPS.

medicines under such licences, of which 613 were granted⁷. From 1970 to 1978, 142 CLs were issued on 47 prescription drugs. Prices of generic versions were 20-60% below the original price, depending on the number of competitors.⁸

UNITED STATES OF AMERICA

Unlike most other countries, the United States of America has never enacted a law that generally authorizes compulsory licensing of patents in the public interest. However, “the United States Government has broad powers to seize and use any invention protected by privately owned patents, subject to the payment of reasonable and entire compensation, and it makes extensive use of this power.”⁷ Compulsory licences are also granted in cases of antitrust violations. In the United States, any department of the federal government can use or authorize “government use” of a patent. The United States government does not have to negotiate first, and neither the government nor its contractors can be sued for infringement; the patent holder’s only remedy is to seek compensation.

While the majority of compulsory licences in the United States are not for pharmaceuticals, the possibility of using this mechanism has been contemplated seriously for ciprofloxacin, in the wake of the 2001 anthrax scare.

Examples related to medical devices include a compulsory license on intellectual property related to drug-eluting stents with a rapid exchange delivery system (granted in 2005), and on

patents directed to guiding-catheters for performing angioplasty (granted in 2006).

COMPULSORY LICENSING UNDER THE WTO “30 AUGUST DECISION”

The WTO’s decision of 30 August 2003⁹ sets up a system that allows production of a pharmaceutical product under a compulsory license for export to a country that lacks domestic manufacturing capacity, provided certain procedures are followed¹⁰.

CANADA AND RWANDA

In July 2007, Rwanda notified the WTO secretariat of its intention to import 260 000 packs of a FDC of zidovudine+ lamivudine+nevirapine from Apotex, a generic manufacturer in Canada. This is the first attempt to make use of this system. The notification states that Rwanda reserves the right to modify the quantity as necessary. It furthermore states that Rwanda will make use of its right, as a least-developed country, not to enforce any patent rights that may have been granted with regard to this product.

Following this request, the Canadian Commissioner of Patents granted, in September 2007, a CL to Apotex, allowing Apotex to manufacture the concerned product exclusively for export to Rwanda. This CL is valid for a period of two years.

Summary Table: Examples of compulsory licenses by/for developing countries¹

Date	Country	Type	Product	Duration	Royalties
April 2003	Zimbabwe	CL	all HIV/AIDS-related medicines	not indicated	not indicated
Oct. 2003	Malaysia	GU	- didanosine - zidovudine - FDC didanosine+zidovudine	2 years	not indicated
Sept. 2004	Zambia	CL	FDC of lamivudine+ stavudine+nevirapine	until notification of expiry of the compulsory licence	2.5%
Oct. 2004	Indonesia	GU	- lamivudine - nevirapine	7-8 years (remaining patent term)	0.5%
Nov. 2006	Thailand	GU	efavirenz	until 31 December 2011	0.5%
Jan. 2007	Thailand	GU	lopinavir/ritonavir	until 31 January 2012	0.5%
Jan. 2007	Thailand	GU	clopidogrel	patent expiry or no longer needed	0.5%
March 2007	Indonesia	GU	efavirenz	until 07 August 2013	0.5%
May 2007	Brazil	GU	efavirenz	5 years	1.5%
Sept. 2007	Canada for export to Rwanda	CL	FDC of lamivudine+ zidovudine+nevirapine	2 years	2%
Jan. 2008	Thailand	GU	several cancer drugs	patent expiry or no longer needed	3-5%

CL = compulsory license; GU = government use (CL for public non-commercial use).

⁷ ICTSD/UNCTAD, 2003. *Non-voluntary licensing of patented inventions: historical perspective, legal framework under TRIPS, and an overview of the practice in Canada and the USA.*

⁸ Lexchin, J. Pharmaceuticals, patents, and politics: Canada and Bill C-22. *Int J Health Serv.* 1993; 23(1): 147-160.

⁹ WTO document WT/L/450.

¹⁰ For more information, see documents 1 and 3 in the further reading section (at the end of this briefing note).

OTHER TRIPS FLEXIBILITIES

Compulsory licensing, and other safeguards such as parallel importation, are important mechanisms that allow governments to protect the public health interest after a patent has been granted (i.e. these are “post-grant” safeguards). However, some countries have focused on using “pre-grant” flexibilities instead. Pre-grant flexibilities seek to ensure that patents are not granted unnecessarily (e.g. when a country has no obligation to grant patents, or when an invention does not deserve a patent). Examples of pre-grant flexibilities include pre-grant opposition (see example of India below) and the right to define the standards for patentability.

CAMBODIA

Cambodia enacted a TRIPS-compliant patent law in 2003, and joined the WTO in October 2004. Under the Doha Declaration on the TRIPS Agreement and Public Health, Cambodia and other least-developed WTO Member States have the right to postpone the implementation of patents for pharmaceuticals until 2016. Cambodia has made use of this right by explicitly incorporating it in its patent law (see box 3).

Box 3: Article 136 of Cambodia’s Law on Patents

“The pharmaceutical products mentioned in the Article 4 of this Law shall be excluded from patent protection until January 01, 2016, according to the Declaration on Agreement on Trade-Related Aspects of Intellectual Property Rights and Public Health of the Ministerial Conference of World Trade Organization dated November 14, 2001 in Doha of Qatar.”

INDIA

In March 2006, a coalition of public-interest groups filed an opposition against GlaxoSmithKline (GSK)’s application for a patent on Combivir (a FDC of zidovudine+lamivudine). Referring to section 3(d) of India’s Patents Act (see box 4), they argued that “a combination of two drugs in one pill is not considered an invention under Indian patent law”¹¹; therefore no patent should be granted. Following the filing of the pre-grant opposition and public protests, in June 2006, GSK announced the withdrawal of pending patent applications for a FDC of zidovudine+lamivudine in India (as well as Thailand).

In 1998, Novartis filed a patent application for the beta crystalline form of imatinib mesylate (Gleevec), an anti-cancer drug. The application was opposed by several Indian generic manufacturers as well as a cancer patient group, who alleged, among others things, that the claimed invention was not patentable under section 3(d) of the Patent (Amendment) Act 2005. According to the opponents, Gleevec is a polymorph form of imatinib mesylate; section 3(d) considers polymorphs to be the same substance unless they differ significantly in properties with regard to efficacy – which they held was not the case. The patent office rejected the application, and the patent was not granted in India.

Novartis challenged the decision to reject the patent application in Court¹². Moreover, in a separate court case, the company

Box 4: Section 3(d) of India’s Patents Act (2005)

“The following are not inventions within the meaning of this Act, - [...]”

(d) the mere discovery of a new form of a known substance which does not result in the enhancement of the known efficacy of that substance or the mere discovery of any new property or new use for a known substance or of the mere use of a known process, machine or apparatus unless such known process results in a new product or employs at least one new reactant.

Explanation – For the purposes of this clause, salts, esters, ethers, polymorphs, metabolites, pure form, particle size, isomers, mixtures of isomers, complexes, combinations and other derivatives of known substance shall be considered to be the same substance, unless they differ significantly in properties with regard to efficacy.”

challenged the relevant section (section 3(d)) of the Patents Act under both the Indian Constitution and the TRIPS Agreement.

The Chennai High Court found that the concerned article did not run counter to the Indian Constitution, and dismissed the second challenge, on the ground that it has no jurisdiction to decide compliance with TRIPS.

COMPETITION LAW

Another important mechanism to protect access to medicines is competition law (or anti-trust law). The examples below briefly illustrate this.

SOUTH AFRICA

In September 2002, several people living with HIV/AIDS and a nongovernmental organization filed a complaint with the Competition Commission of South Africa against GlaxoSmithKline and Boehringer Ingelheim. According to one of the complainants, the complaint was filed after a campaign that lasted nearly four years, requesting pharmaceutical companies to issue unconditional voluntary licences, against a fair royalty rate of 4-5%. Since companies failed to respond, “now we are asking the Competition Commission to investigate the complaint and to refer it to the Competition Tribunal”¹³.

The case was settled on 9 December 2003. Boehringer Ingelheim agreed to offer licences for nevirapine to Aspen Pharmacare Holdings Ltd and to two other appropriate “entities”. According to the settlement, these licences would allow supply to both the public and private sectors, permit export to other sub-Saharan African countries and carry a maximum royalty rate of 5%. A very similar settlement was concluded with GlaxoSmithKline for zidovudine and lamivudine.

Since receiving these licences, Aspen has obtained WHO prequalification for several of its products. Its prices for the public sector are competitive; in March 2005, the company was granted a significant share of the South African government’s ARV tender.

¹¹ Pepper, D. “Patently unfair”. *Fortune Magazine*, 18 Sept. 2006.

¹² In April 2007, the case was transferred to the Intellectual Property Appellate Board. As of 29 February 2008, it is still pending.

¹³ Treatment Action Campaign. Statement on Excessive Pricing Complaint to Competition Commission. 19 Sept. 2002.

ITALY

In March 2007, the Italian Competition Authority ordered Merck & Co. Inc. to provide free licences for the manufacture and sale in Italy of the active ingredient finasteride (used in the treatment of prostate hypertrophy) and related generic drugs. In an earlier investigation in 2005, the Competition Authority had already obliged Merck to grant licenses for its antibiotic combination imipenem+cilastatin, in order to rectify alleged abuse of a dominant market position, while in February 2006 its investigations led GSK to license its migraine drug sumatriptan succinate.

LESSONS

Some preliminary conclusions and lessons can be drawn from these experiences. These include:

- compulsory licensing can be used, and has been used, to protect public health, in developed and developing countries;

- while the number of instances of compulsory licensing by developing countries is relatively limited, those experiences show that compulsory licensing/government use can be an effective mechanism;
- a compulsory license, or a “credible threat” to issue one, can be instrumental in obtaining price reductions from the patent holder;
- various “pre-grant” flexibilities can play a complementary role in safeguarding access to medicines. In addition, the role of competition law could be explored further.

This underscores the need for incorporating workable provisions for compulsory licensing and government use, as well as other (pre-grant) safeguards, in national laws. Yet even though compulsory licensing is allowed under TRIPS, some developing countries have experienced criticism and/or pressure when using this safeguard mechanism¹⁴ – thus there appears to be a need to safeguard the safeguards.

REFERENCES AND FURTHER READING

1. WHO. *Implementation of the WTO General Council Decision on Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*. Geneva: WHO, 2004.
2. UNDP/WHO. *Remuneration guidelines for non-voluntary use of a patent on medical technologies*. Geneva: WHO, 2005.
3. WTO. *Frequently Asked Questions: compulsory licensing of pharmaceuticals and TRIPS*. Geneva: WTO, 2006. Available at http://www.wto.org/english/tratop_e/trips_e/public_health_faq_e.htm
4. South Centre/WHO. *The use of flexibilities in TRIPS by developing countries: can they promote access to medicines?* Geneva: South Centre/WHO, 2006.
5. Third World Network. *Malaysia's Experience in Increasing Access to Antiretroviral Drugs: Exercising the “Government Use” Option*. Penang: Third World Network, 2006.
6. ICTSD/UNCTAD/WHO. *Guidelines for the examination of pharmaceutical patents: developing a public health perspective*. Working paper. Geneva: ICTSD/UNCTAD/WHO, 2007.

¹⁴ However, no country has had its decision to issue a compulsory license challenged at the WTO Dispute Settlement Body, which would be the appropriate forum for dealing with actions that contravene the TRIPS Agreement.