GLOBAL HEALTH LAW

WORKING SESSION

Tuesday, 9 August 2016, 9.00am

Chair: Professor Dapo Akande (UK)

The Chair introduced the three panellists – Professor Frederick Abbott, Co-Chair of the Committee, Dr Ruth Atherton, member of the Committee, and Dr Xavier Seuba, Co-Rapporteur of the Committee.

The Chair informed attendees that the first report of the Committee was available online from the ILA website.

Professor Frederick Abbott (US) introduced himself and welcomed attendees.

Professor Abbott started his presentation by referring to the mandate of the Committee. He mentioned that the main objective of the Committee was to bring forward international health law as a field of international law.

He then laid out some points on the breadth and complexity of the field. First of all, the protection and promotion of health encompassed a wide range of subject matter, including:

- the establishment and functioning of national healthcare systems
- mechanisms for the production and distribution of health goods and services, including cross-border movement
- innovation and access to health-related technologies
- preparation for, and responses to, health emergencies
- the impact of environmental degradation and climate change
- disparate treatment of groups.

Few areas were as heavily regulated as healthcare, as exemplified by the following:

- implementation of national healthcare schemes, including access to goods and services, insurance and reimbursement
- approval of new health technologies, including medicines
- regulation of production and distribution, including approval of manufacturing facilities, supply chain, prescribing and pricing
- regulation of professional services, including cross-border provision
- innovation and transfer of technology, including patents and regulatory market exclusivity, and related competitive market aspects
- the systems of regulation are interrelated.

With regards to the nexus between trade and public health, the following points were made:

- The establishment of the WTO and the adoption of the TRIPS Agreement represented a "sea change" in the international regulation of public health. Before then, half of the countries in the world exempted pharmaceuticals from patenting, whereas afterwards, it basically is a given that patent protection would be provided.

- Authority to make rules directly affecting important health interests were moved from the international organisation regulating health (WHO) to the international organisation primarily devoted to promoting mercantile interests (WTO).
- Trade negotiations since the formation of the WTO, including preferential trade agreements, had an increased focus on restricting public health flexibilities (as exemplified by the recent Trans-Pacific Partnership Agreement (TPP). Rules on the extension of market exclusivity to biologic drugs was the most contentious element of the TPP negotiations
- Other key aspects included investor-State dispute settlement and intervention in public health formularies/reimbursement determinations.

Professor Abbott informed attendees that the Committee had initially decided to focus on four subject matter tracks, namely:

- legal issues surrounding access to research materials, including biological materials and results of clinical research
- legal issues surrounding access to essential medicines
- legal issues surrounding tensions between trade/investment agreements and global public health
- State obligations in the field of health and links with human rights law, including non-communicable diseases and sustainable development.

The first major activity of the Committee was to co-organise a multi-stakeholder meeting on global health security in Geneva in February 2015 in the midst of the West African Ebola crisis. The Committee managed to bring to the table all the relevant actors, including Médecins Sans Frontières (MSF), WHO, people involved in the development of new vaccines, and an array of organisations working to put together a response to the crisis. The idea was to come up with potential changes to the legal framework that might be beneficial in light of the crisis and with a view to future events.

Professor Abbott proceeded to address a few highlights of the meeting. There was a strong consensus on the fact that the top priority for improving responsiveness was to invest in building up national healthcare systems (surveillance, response, training of personnel). There was a critical need to accelerate research and development as well as approval pathways for new vaccines and treatments. There was a critical need to improve the management of crisis intervention services. In this regard, Professor Abbott pointed to the fact that MSF had to ask the US military to intervene and provide on-the-ground support and intervention. He noted that it was not a question of money (MSF is a well-funded organisation); rather, the problem was that there were insufficient trained people and there was no organisation that could build hospitals, train staff and protect them. It was difficult to coordinate the interactions between, and transition from, military authorities to civil authorities. WHO was not specifically a on-the-ground response organisation, and had very limited staff for that.

Other highlights included the need to integrate work of international organisations and NGOs, without establishing new international organisations. Moreover, it was acknowledged that the recent Zika outbreak represented the latest challenge to the emergency response system, and would certainly not be the last.

The second major activity of the Committee was participation in the process of the High Level Panel on Access to Medicines (HLP), which had been appointed by the UN Secretary

General in November 2015. The HLP called for submissions, and members of Committee prepared two submissions:

- access to essential medicines authored by Ellen ’t Hoen, Professor Brigit Toebes and Professor Abbott (as well as by Katrina Perehudoff, who is not a Committee member)
- Framework Convention on Pharmaceutical Innovation and Related Protocols authored by Xavier Seuba

Professor Abbott noted that the number of submissions received exceeded expectations. Both submissions authored by members of the Committee were selected for presentation at HLP hearings in London. Professor Abbott then proceeded to summarise the first submission on access to essential medicines, as set out in the Committee’s first report.

Professor Abbott noted that the process of the HLP had been fascinating, and pointed to the fact that not only developing countries struggled with the issues. For example, the Netherlands made a very detailed presentation about the challenges the country faced with regards to access to essential medicines, its pharmaceutical budget, and its aging population. He noted that there were many submissions related to the need to prioritise the right to health as a human right.

Professor Abbott ended his presentation by informing attendees that Committee members had expressed interest in formulating a draft resolution for adoption by the ILA based on the anticipated HLP report. However, as of 8 August 2016, the report had not been issued.

The Chair opened the floor for questions on Professor Abbott’s presentation.

Mr Steven van Hoogstraten (Netherlands) asked if a draft of the HLP report was available.

Professor Abbott responded that there was no draft available, but that both submissions made by Committee members were available on the ILA website.

Mr Dipak Bhattacharyya (India) noted that 70% of the Indian population did not have access to any essential medicines due to high prices. Furthermore, there was no reference to alternative medicines. He mentioned that there should be more discussion on alternative medicines in the global health scenario. He asked the panellist whether there were any concerted efforts to address these issues. He noted that high prices set by patent holders was preventing the general public from accessing medicines. Any report or presentation of the Committee should take these issues into account. Mr Bhattacharyya also expressed concern at the lack of representation from China on the Committee.

Professor Abbott noted that most of the work of the Committee so far had been directed at improving accessibility to medicines. He pointed to the fact that the Committee’s primary submission precisely addressed this issue. He also pointed to the fact that the Indian government allocated a very low proportion of its budget to assure accessibility of medicines (less than almost every other country in comparable circumstances). Therefore, one could not talk about what was going on in India without talking about governmental budgeting priorities. While the domestic pharmaceutical industry in India had been very successful, there had not been much effort in channelling those medicines to the wider Indian population as compared to exporting them. India was a very complex picture and there was a lot of work to be done.

Professor Abbott added that a lot of attention was being paid to the topic of alternative medicines. For example, in China, 25% of the medicines budget went to providing these types of medicines (traditional Chinese medicines). The Committee had not been very much involved in this topic, but was aware of its importance.

Mr Xavier Seuba (Spain) noted that, in the 2000s, the WHO organised an event on the topic of alternative medicines and promoted the adoption of national policies on traditional medicines. Admittedly, there had been little research on this, particularly from a legal perspective. The topic had not yet received the attention of the legal community.

Mr Bhattacharyya referred to the fact that India had an infant mortality rate of 25% as evidence that these issues were very pressuring for the country.

Dr Ruth Atherton (US) thanked Mr Bhattacharyya for raising important questions. She then proceeded to give a presentation on the legal issues surrounding access to research materials, including biological materials, and the results of clinical research.

To begin with, Dr Atherton offered a definition of global health research materials as pathogens (viruses, bacteria, microorganisms that cause disease) and clinical materials (human biological samples such as blood or tissues). She then explained why access was needed. The primary goal of global health research was to bring medicines, vaccines and diagnostics to people in need. Access to these research materials was a critical step in the process of developing new therapeutics.

She gave the example of the early work of Edward Jenner in England in inoculating a child against smallpox by collecting samples of fluid from cowpox lesions, which set the stage for all vaccinations worldwide. That work involved access to pathogens (cowpox and smallpox) and access to clinical material (the milk-maid who had contracted cowpox and the child who was inoculated). Dr Atherton showed how the importance of access began at the fundamental level of access to the pathogens and clinical materials to develop new therapies and vaccines.

Today, higher standards existed, a global desire for information and material sharing to allow access was widely increased, and a complex array of considerations – including pricing and stakeholder incentives – arose for global product development.

Dr Atherton referred to the way in which the Ebola crisis highlighted continuing gaps in access to medicines and vaccines, particularly for those who were more vulnerable. Unfortunately, product development timelines were not aligned with the needs of patients and communities undergoing a crisis. Product development needed to be optimised for the needs of the patient. The uncertain legal situation involving the pathogens and clinical materials needed for new therapeutics, vaccines and diagnostics led to an unpredictability as to whether and how these materials would be shared.

Dr Atherton then discussed the question of how these research materials were to be used. To illustrate she referred to “development phases” for medicines and vaccines, which began with the discovery in order to identify the target molecules that have the potential to lead to future products. This was followed by extensive study of the molecules with the highest potential in animals and in-vitro models during the pre-clinical phase. If this was successful, candidates could progress into clinical development, where they were analysed for safety and efficacy. These studies were done in humans, beginning with health volunteers typically and progressing into appropriate patient populations. Trials became increasingly costly as they

progressed. The goal was to prove to regulatory agencies that a marketing approval was justified, that the product was safe and effective, and that the risk-benefit analysis tipped towards the patient. Along the way, patient samples were collected and helped in identifying the causes, manifestations and incidences of these diseases. Both types of materials could be used in aspects of product development. While timelines varied and costs were debated, it was generally understood that this process could take a decade and cost hundreds of millions of dollars.

Dr Atherton next addressed the relationship between the stakeholders and the regulatory and legal framework for both pathogens and clinical materials. With regard to pathogens, there were two important frameworks – one that was very broad, and one that was specific to a single pathogen. The *Convention on Biological Diversity* (CBD) was based on the principle of sovereignty over genetic material and provided for access to that material on terms mutually agreed by States Parties. Genetic material was defined to mean "any material of plant, animal, microbial or other origin containing a functional units of heredity" (Art 2). A principal objective was to fight bio-piracy. There was also the *Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization*, which further implemented details of the CBD. On the other end of the spectrum was the Pandemic Influenza Preparedness Framework. This was a specific non-binding framework that provided for the sharing of viruses and contemplated the role of private companies, academics and laboratories in addition to States.

With regard to clinical materials, there were international principles including the *Declaration of Helsinki* and the International Council for Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use. Both of these processes were broadly accepted, but human subject research was regulated nationally. By way of illustration, the International Compilation of Human Research Standards enumerated over 1,000 laws, regulations and guidelines that govern the topic in 120 countries. Differences in these regulations created highly complex legal and operational problems for multijurisdictional trials concerning the subsequent sharing and use of materials. Materials need to be transported from the site of collection to the site of research. Here, one must examine the role of bio-risk, bio-safety and bio-security. In this context, bio-terrorism and bio-security could not be overlooked. The first synthetic polio virus was reported to be made in 2002, and subsequent laws enacted in the US banned the synthesis, use, transfer or possession of smallpox virus with penalties up to life imprisonment. Similarly, a WHO advisory group recommended that re-creation of the polio virus should be prohibited. Legal prohibitions might not achieve avoidance of intentional bio-terrorism attacks. This must be part of the access considerations of the Committee.

Finally, Dr Atherton referred to other considerations that needed to be taken into account, including the broad spectrum of stakeholders that were needed to develop important therapeutics. Academics, clinical researchers, States, NGOs, funders, intergovernmental organisations each played a role in product development. Creating an environment that encouraged sharing and distribution must take into account existing incentives and disincentives beyond legal considerations. Dr Atherton concluded by noting that, while the focus of her presentation did not allow for a full analysis of various factors – including cost and timelines, liabilities inhibiting the development of medicines, and prices that must be balanced to allow product accessibility – these factors must not be overlooked.

The Chair opened the floor for questions on Dr Atherton's presentation.

Mr Bhattacharyya noted that patients were being used as guinea pigs for the trials of international pharmaceutical companies. This harmful syndrome on the underdeveloped masses happened a lot, especially in India. In the previous two years in India, trials had been put forward without notifying patients of harmful side effects. The world was focused too much on the Zika virus while India battled with dengue fever. Every day, 105 individuals died from dengue fever. There should be a watch dog to monitor occurrences of epidemics in other areas of the world. Mr Bhattacharyya agreed with Dr Atherton about access.

Dr Atherton thanked Mr Bhattacharyya for his intervention. She acknowledged that she did not give enough attention in her presentation to the issue of informed consent, and acknowledged the expertise of Mr Bhattacharyya on this issue. Informed consent was one of the most critical principles of medicine and became particularly important in the context of a vulnerable populations. The compilation of laws referred to in her presentation was largely driven by the complexities and importance of informed consent. The laws around clinical trials had evolved to ensure protection of the patient. So it was disheartening to hear that this was potentially not occurring in the way that all of us would like to see done.

Dr Atherton noted that the focus of her work was to look upstream at the creation of medicines. She acknowledged that, once the regulatory approval was received, the hard work began.

With regards to dengue fever, Dr Atherton noted that it was something of which she was well aware in her role at the Bill & Melinda Gates Foundation. There were organisations trying to eliminate dengue fever. Obviously, neglected tropical diseases were a critical part of access, and medicines needed to be provided to treat patients in need.

Dr Seuba reacted to the issue of informed consent. Informed consent was a customary rule of international law, finding expression in the Nuremburg trials and in international treaties. The Committee would find sources of international health law in various places (including the WHO and WTO). Some of these sources were probably too old, while pharmaceutical standards had evolved into a very important source. There were now more sophisticated rules to apply in the context of clinical trials.

Dr Atherton noted the intersection between technology and informed consent, particularly in that it was becoming more common for consent to be videotaped or recorded in some electronic manner. There were only a few jurisdictions that had jurisprudence on the matter. The interaction was an important and developing area to monitor.

Dr Seuba presented on two parts of the report that he had authored. The first concerned the submission to the HLP on the adoption of a Framework Convention on Pharmaceutical Innovation. The second concerned international standard-setting in the area of pharmaceuticals. He noted that the HLP submission allowed the Committee to reflect on the broader relationship between public international law and innovation, more particularly pharmaceutical innovation.

The HLP submission advocating the adoption of a Framework Convention on Pharmaceutical Innovation conveyed the following:

- It highlighted the various legal regimes influencing innovation – it responded to the multifaceted nature of pharmaceutical innovation and identified a mechanism to

facilitate international coordination and also to foster legal development or international normative action.

- It argued that the relationship between innovation and public international law went beyond intellectual property. Norms found in several international legal regimes impacted on pharmaceutical innovation, including international human rights law, international health law, and international economic law.

Dr Seuba noted that it was not easy to draw up the proposal in a single document as it identified topics that related to very different areas. The objectives of the proposal outlined the following:

- the Convention would facilitate the adoption of clear principles and basic understandings, enable and promote the development of complex legal tools, and prompt the cooperation of diverse stakeholders
- like in other areas of public international law where framework conventions had been developed, the proposal would facilitate the codification of fundamental principles and reach consensus on central points in the fraemwork convention, and address complex topics and more technical areas in specific and independent instruments (protocols)

Dr Seuba noted that there were a number of pillars in the proposed Framework Convention, namely:

- human rights basis for international normative action in the area of health innovation
- recognition of health innovation as a common interest of the mankind
- definition of pharmaceutical innovation as the introduction of new products and processes that create value for health
- identification of relevant stakeholders, a coordination mechanism, and areas of further normative action in additional protocols

Dr Seuba explained to attendees the different kinds of protocols, as outlined in the report.

Dr Seuba mentioned that there was an intense relation between public international law and pharmaceutical innovation, which was reflected in this report. Both the normative technique and mechanism to develop the proposal were typical of public international law. Moreover, at least eight international organisations or programs were relevant for the purposes of the adoption of the new regime.

Dr Seuba explained the special relevance of WTO law to the proposal. In this regard, he noted that TRIPS was relevant to IP management, the General Agreement on Trade in Services (GATS) was relevant to facilitating the international mobility of scientists, the Agreement on Subsidies and Countervailing Measures (ASCM) was relevant to the acceptability of subsidies in health-related areas, and agreement on Technical Barriers to Trade (TBT) was relevant to conditions for drug development.

Dr Seuba noted that the international structure and adoption process could not happen without the support of stakeholders. The success of an initiative of this caliber required broad international support, including:

- States with research-based economies, emerging economies, as well as countries with pressing health needs
- international organisations

- companies supplying different segments of the pharmaceutical market
- scientists
- non-governmental health organisations

The Framework Convention would be negotiated by means of international conferences. Previous partial attempts would be the source and point of departure. A light coordination mechanism would be in charge of monitoring the action of concerned stakeholders.

The Chair opened the floor for questions on Dr Seuba's presentation. He kickstarted discussions by querying the interaction between the Framework Convention and existing areas of law. Dr Seuba's presentation noted that proposal would in part clarify certain matters in the WTO agreements, but the Chair queried whether legally this would actually work. One of the aims of the proposal was presumably to take some of this discussion outside existing mechanisms and to put it into the new mechanism. However, unless all WTO members were to become party to the proposed Framework Convention, there would be a potential conflict between these existing treaties and the Framework Convention and protocols. Then the question would be the extent to which the WTO dispute settlement system and other systems would be able to take these protocols into account in interpreting the WTO agreements.

Dr Seuba responded that he had given some thought to this issue. He thought that the protocols would be the right place to reach compromise by participating member states to precisely address these type of issues in the context of relevant institutions and organisations. He thought that it was perfectly possible to achieve this objective. The other response was that having on board the relevant organisations was the best way to distribute these functions. The idea was to coordinate existing mechanisms and organisations that so far addressed health related issues.

Mr van Hoogstraten queried the problem that the proposed Framework Convention would actually be solving. Why create a whole new structure with 190 countries if there was an existing structure and the only problem was with coordination.

Dr Seuba agreed that coordination was a problem but that it was not the only problem. Existing organisations had a clear mandate to carry out specific tasks. Having a common document identifying clear principles and clear objectives would facilitate responding to the health needs and innovation-related concerns.

Professor Locknie Hsu (Singapore) intervened with two questions for the panel. The first concerned managing corruption with respect to pharmaceutical innovation; the second concerned the use of sovereign wealth funds for funding.

Professor Abbott responded that, while the proposed Framework Convention did not address corruption, the Committee did have a strong interest in competition law and competition law principles. The Committee had been looking closely at procurement clauses and practices, and noted that one key element globally in reducing costs and improving supply chains was to increase transparency in procurement processes. This was something that would be incorporated more directly into the Committee's inquiry, and was work that the UN Development Programme was doing on the ground right now.

With respect to the second question, Professor Abbott was not sure whether the Committee had specifically reflected on a potential role of sovereign wealth funds. These funds could be looked at in terms of contributions to reforms and innovation processes and whether that

could fit into some type of delinkage proposal or factored in to push-pull mechanisms in the development of new medicines. Professor Abbott posited that in Singapore, a lot of biotech innovation was being funded by sovereign wealth funds.

Dr Seuba mentioned that sovereign patent funds were a new and contentious tool that was being used by States such as China, Singapore and France. The Committee had not yet researched this area from a legal point of view because it was still a new initiative.

Professor Abbott asked Professor Hsu to unpack her question on sovereign wealth funds, and whether she had something specific in mind.

Professor Hsu responded by noting that the Norwegian sovereign wealth model worked well for Norway. This model might assist the Committee in getting new stakeholders to fund expensive research.

Professor Abbott thanked Professor Hsu for this suggestion.

Dr Atherton cited an example of funds in Japan that specifically targeted global health innovation. Where innovators were partnering with industries in States, it allowed them to access a variety of sovereign funds or co-funding for global health. There were a few models out there that were starting to take hold, so it is something to monitor with interest.

Professor Abbott observed that much of the public private partnership (PPP) funding was coming from development funds, such as the Dutch development fund and the British development fund. Those are contributions made without an expectation of return on investment. In the Middle East, a number of wealthy governments are investing in health, the funds for which were coming from sovereign wealth funds

Dr Atherton thought that some of these funds were looking at specific returns and criteria for returns so they were operated more as a venture capital style investment as opposed to PPP, which tended to be more grant like.

Mr Bhattacharyya (India) suggested having a country specific protocol rather than a general protocol. India had the biggest corruption in the healthcare over the past three years. In the last two years, its rural health funds from WHO, UN and other rich countries had been defalcated. Things were going beyond imagination. Where was this money going? There should be a system in place that monitored how the money was being spent. The Committee should push for more transparency as the underprivileged were suffering from the mismanagement of funds.

Dr Seuba thanked Mr Bhattacharyya for his intervention, and suggested that it might be useful to have a bilateral treaty, for example, between India and the US. South to south initiatives took place, but the ideal situation would be a global convention.

Professor Abbott responded to Mr Bhattacharyya by adding that the Committee could highlight this as a general problem in the hope that pointing it out would help those in the country to put pressure on government to address the issue. From the outside, it was very difficult to know what one would suggest that would help address and identify the problem. The World Bank did a large scale study on the issue in India. What the Committee could do to help from the outside was a very good question, and one on which further reflection was needed.

Dr Seuba continued with his presentation on the second part of the report that he authored – international standard-setting in the area of pharmaceuticals. In parallel to the debate relating to innovation and access, there was another scientifically complex debate touching upon the quality, safety and efficacy (QSE) of medicines. Whereas the former frequently focused on IP, the latter essentially related to technical standards. Marketing authorisation of medicines depended on the satisfaction of standards of national and international origin. QSE of medicines was certified through laboratory tests and clinical trials on animals and persons as well as the fulfillment of manufacturing, distribution and management standards.

Dr Seuba noted that, in the area of international harmonisation, we find the harmonisation of pharmaceutical nomenclatures, the standardisation of pharmaceutical compositions, the adoption of harmonised guidelines relating to activities in the preclinical, clinical, production and distribution phases of the medicines chain, and the harmonisation of documentation submitted for pharmaceutical registration. The purpose of international harmonisation in this field was to:

- avoid the repetition of tests already carried out, or the conduct of tests very similar to others already carried out
- accelerate the entry of products into the market
- avoid the creation of entry barriers to foreign competitors.

Dr Seuba then referred to the public institutional dimension of international harmonisation, referring to the international standard-setting organisations referred to in Part VII of the report, including the development of the International Council for Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH).

Dr Seuba explained the relevance of the WTO Agreement on Technical Barriers to Trade, as set out in Part VII of the report.

Dr Seuba also mentioned some controversy associated with ICH, namely:

- the risk that the ICH process results in excessively demanding standards
- the risk that the ICH blocks debate on presently contentius scientific issues
- conflict or missmatch with human rights and ethical standards (as drawn out in Part VII of the report).

Dr Seuba added that the ICH must be praised for the adoption of high quality standards, but added that its membership and external participation should be broadened. Other countries should become full members, associations of patients and consumers should join as observers, as should generic manufacturers' associations.

Dr Seuba finished his presentation by questioning the role of the WHO, in view of Art 2(u) of its Constitution, which provides that WHO's functions included the development, establishment and promotion of international standards with respect to food, biological, pharmaceutical and similar products.

Professor Abbott thanked the chair for facilitating the session. He then referred to the beginning of his presentation, where we identified four basic thematic areas which included access to research materials, access to essential medicines, tenstions with trade/investment agreements, and links with human rights law. The Committee had made good progress in each of these areas. Of course, with this Committee and with the ILA in general there was a

resource limitation. Global public health was a huge area with hundreds of subtopics, of which many were highly specialised. The Committee only had 14 members, and there were limitations on how much they could do. For the moment, our mission was to move each of this areas forward progressively, while addressing the systemic impact of climate change on the environment and the potential for degradation of public health.

The Chair thanked attendees for their participation.

Reporters: Lucia Berro and Faith Olaseinde