The debate on intellectual property protection and medicines for the poor countries is part of a general debate on "how much" intellectual protection there should be and whether it should have been built into the World Trade Organization. But it raises some issues specific to medicines, of course.

The argument for intellectual property protection (IPP) is that, since it costs money to invent knowledge, and that the widespread diffusion of knowledge once secured is desirable, we have here the economist's tradeoff: more IPP means more knowledge but it also reduces diffusion. The social optimum lies somewhere in the middle, as often. Few economists believe that the 20-year patent length agreed upon at the conclusion of the Uruguay Round at Marrakesh in 1995 is anything but excessive from this viewpoint. Yet the pro-IPP lobbies, among whom the drug companies were vociferous, used their political muscle to have this agreement.

In fact, most poor countries, which were not enthusiastic about IPP just as the United States had been historically when it was a user rather than a producer of know-how, objected to having IPP, via the Trade related Intellectual Property (TRIPs) agreement into the WTO. IPP is not a "trade" issue; and the WTO ought to be about lowering trade barriers and tackling market access problems that will often go beyond border measures to "internal" regulations: a thorny issue. TRIMs is by contrast only about royalty collection. It was put into the WTO by considerable lobbying pressure in the United States in particular, so as to make the use of trade sanctions against user countries who used knowledge without paying royalty. It turned the WTO therefore into a royalty-collection agency! To the chagrin of the poor countries today, the result has been the proliferation of yet other lobbies, such as labour unions, who would like to have their

own agendas built into the WTO, to follow in the path of the IPP lobbies. The poor countries therefore see the WTO as increasingly the target of Western lobbies that would capture the WTO to their own advantage, using the specious arguments that their causes have to do with trade in some intrinsic way: all courtesy of the IPP lobbies, drug companies included.

But one must say that the very premise that drug companies are seriously handicapped in their R&D by the lack of IPP in the poor countries is flawed. Poor countries have need, but no effective demand. There is little money to be made to recover normal profits on your invented drugs if you think of poor country markets. To see why the drug companies nonetheless see IPP in the poor countries as a money-spinner, it is necessary to distinguish between two types of diseases: those, such as malaria, which are primarily in the poor countries and those, such as AIDS, which afflict all.

For the former, evidently IPP cannot assure any decent return because the poor countries cannot pay. So, we have several ways of getting drugs invented for them by using public and quasi-public moneys to mobilize scientists (and firms) to address the task. In the old days, you had institutions like the Institute for Tropical Medicine in England. The Nobel laureate Normal Borlaug was financed by Foundation moneys to help invent the new seeds that made the Green revolution. Michael Kramer of Harvard University has proposed the setting up of guaranteed remunerative prices for invented vaccines. All of these are variations on the use of public moneys; IPP has no role to play in this, the only, solution to the invention of poor-country-specific drugs.

But everything changes when drugs to fight diseases that cut across the rich and poor nations are at stake. Here, the drug companies make moneys in the rich country

markets; IPP there is clearly something they value. But then they see piffling effective demand for drugs in the poor countries. So, their strategy is to sell there, producing at very low marginal costs and then charging the little that these poor markets will bear. But they would like to raise that return as much as they can by increasing effective demand by using aid moneys addressed to health programs, so that the excess of what they will charge over their marginal cost is increased, raising profitability in the poor country markets. Medical economists have known for years that medical groups, for instance, favour insurance schemes that improve the patients' ability to pay as under insurance programs such as Blue Cross and Blue Shield in the US, but oppose insurance schemes like the NHS of England which reduce instead the returns to doctors.

Where IPP in the poor countries comes into play is when they want to shut off the more advanced of the poor countries, such as India and Brazil, coming into Botswana and Gabon and providing, with their generic copies, the same drugs at low prices that effectively put a cap on how far the drug companies can raise their prices. So, they would like to stop Indias and Brazils through IPP applied there; and they prefer also restrictions on whether the Indias and Brazils can export to the poor countries.

What about "parallel imports"? I.e. should the drug companies be allowed to segment rich and poor country markets for such drugs, preventing the importation of lower-priced drugs sold by them in the poor countries? The answer has to a resounding yes. If there were no such segmentation, the poor and the rich countries would be a single market and the prices charged to the poor countries would rise. The segmentation enables them instead to secure low prices from the drug companies. This is something that the

rich-country NGOs must also understand. There are often paradoxical ways to effectively help the poor; this is one of them.

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