Conclusion

We have made the mightiest industry in the world shake in its boots!
—Zackie Achmat, Treatment Action Campaign

The turn of the twenty-first century featured some very positive news in HIV/AIDS treatment.\(^1\) Recently discovered antiretroviral medicines (ARVs) had been proven to be hugely effective in combatting the virus. In fact, ARVs were so potent that their impact on patients was known as the Lazarus effect: people with AIDS were literally rising from what all had presumed would be their deathbeds.\(^2\) Suddenly, HIV/AIDS was transformed from a death sentence into a chronic but manageable disease—for those who could afford the medicine.\(^3\)

But that miracle medicine was protected by patents held by multinational pharmaceutical companies, despite the fact that government-supported scientists played the key roles in discovering the drugs and developing their potential for use in HIV/AIDS therapy.\(^4\) The price of the ARVs established by the companies was over $1,000 per month, prohibitively expensive for patients and governments in low-income countries.\(^5\) As is typically the case with patent-protected medicines, that price tag bore no
resemblance to the production cost of the medicines, which was barely over $1 per daily dose.\textsuperscript{6}

By 2000, ARV treatment had become widely available across North American and Europe, but just 1 of every 1,000 Africans infected with HIV had access to the medicines.\textsuperscript{7} The impact of this lack of treatment was staggering: more than 2 million Africans were dying from AIDS each year.\textsuperscript{8}

South Africa was particularly hard hit, with the prevalence of HIV as high as 25 percent among women of childbearing age.\textsuperscript{9} In 2000, more South Africans died in their thirties and forties than did in their sixties and seventies.\textsuperscript{10} In neighboring Zimbabwe, morgues began staying open twenty-four hours a day to receive the bodies that were being brought in at all hours.\textsuperscript{11} Yet, largely due to the monopoly pricing of the medicines, the conventional wisdom was that it was not going to be possible to treat HIV in the developing world. “It’s so politically incorrect to say, but we may have to sit by and just see these millions of people die,” an unnamed global health official told the \textit{Washington Post} in early 2001.\textsuperscript{12}

I am sad to say that I had my own experience doing just that. Shortly after the turn of the century, I visited Moi Teaching and Referral Hospital in Eldoret, Kenya. Although some HIV/AIDS medicine was then being provided to a few individuals in the area, the medicine was limited to those whose disease had not advanced. That meant that the women I met at the hospital were going to die without ARV treatment.\textsuperscript{13}

One woman, Theresa,\textsuperscript{14} lay huddled under a thin blanket in a bed on Ward One of the hospital, a bed she shared with another woman whose feet lay by Theresa’s head. She looked up vacantly at the doctors and medical students surrounding her. Theresa was so thin—\textit{wasted} was the term the Kenyan medical student used when reading aloud from his examination notes—that her eyes seemed to bulge out from above her sunken cheeks. The medical student read on. Theresa had had a persistent cough for four years. Her breathing was rapid but shallow. Her mouth and throat were choked with a white fungus that made it appear Theresa had been chewing cotton—it was oral thrush, an indicator of late-stage HIV. Theresa’s breathing was so labored because she also had pneumocystis carinii pneumonia, one of the most common and serious infections for people with HIV. The medical student closed by reciting the social history.
Theresa was a twenty-eight-year-old widow with three children at home, the youngest just three years old.

Theresa had plenty of company on the ward. Women lay two or even three to a bed, flies alighting on their heads. We stepped around a woman curled up on the bare floor, clutching herself and moaning. We saw Elizabeth, who had arms the circumference of a broom handle. Janet was in a coma, Beatrice had skin lesions.

Alice had not been tested yet, but she showed signs of late-stage HIV and had lost her husband to the disease a few years before. As we stood by her bedside, I was bumped in my hip. I turned to see an attendant trying to maneuver a rickety aluminum cart past me. On the cart was a small body under a stained blanket. For all these patients, that would be their fate soon enough. It was a horrifying scene, and one being reproduced thousands of times a day across the African continent.

Against this grim backdrop, a small South African group calling itself the Treatment Action Campaign (TAC) was formed. Its first effort, on Human Rights Day in 1998, consisted of ten people fasting in front of St. George's Cathedral in Cape Town, asking passersby to sign a petition demanding the government provide medicine for pregnant women with HIV/AIDS. But even though TAC had humble beginnings, it possessed excellent organizational genes. Several of its founding members had been active in the anti-apartheid movement, and the group had received training from ACT-UP and other veterans of the passionate, dramatic U.S.-based AIDS treatment campaign of the 1980s and 1990s.

One of the lessons TAC learned from the U.S. activists was the strategy of treatment literacy, in which HIV-vulnerable people in South Africa trained their colleagues in the science and politics of HIV. That training empowered previously marginalized South Africans to mobilize in ambitious campaigns built around direct action, political pressure, and litigation. As TAC co-founder Mark Heywood described it, “People with AIDS ceased being silent victims and became political agitators for their human rights to treatment.” The role of the patient-activist moved the medicines issue from an abstract discussion of intellectual property laws to a human rights question. As one HIV-positive TAC activist said at a filmed protest event, “You are denying me drugs. Look me in the face and tell me to die.”
TAC soon launched a campaign of civil disobedience, illegally but openly importing a generic version of the AIDS medicine fluconazole. Activists brought the drugs from Thailand, where generic versions cost less than 10 percent of the price charged in South Africa by the patent-holder Pfizer. TAC also proved to be effective at combining legal challenges with the power of mass mobilization. When lawyers argued against the high prices charged for patented medicines or pushed for ramped-up government programming, the courtrooms were packed and the streets outside were filled with thousands of singing, chanting demonstrators. Activists also conducted “die-ins,” and even filed charges of culpable homicide against the minister of health.

The face of TAC was its co-founder, Zackie Achmat, who was HIV-positive but refused to take ARVs until they were widely available to the poor of the country. As a result, Achmat suffered through life-threatening lung infections, but he stuck to his vow even after South African President Nelson Mandela personally begged him to take the medicines. Achmat and other TAC activists wore t-shirts with the words “HIV-Positive” in large block letters on the front. The shirts were created after Gugu Dlamini, an AIDS activist, was beaten and stoned to death after revealing her disease status on a radio show. Based loosely on the apocryphal story of the king of Denmark wearing a yellow star in solidarity with Jews during the Nazi occupation, the “HIV-Positive” shirt was worn by individuals irrespective of their status. In December 2002, Mandela wore the shirt during a visit to an AIDS clinic.

When the International AIDS Conference was held in Durban in July 2000, TAC led over 6,000 protestors in a march to the site of the opening ceremonies. The conference hall pulsed with the sound of drums and singing, and a small HIV-positive boy named Nkosi Johnson gave a moving talk. He died the next year at age twelve, without having received ARV treatment.

At those same ceremonies, Edwin Cameron, an HIV-positive South African High Court justice, also spoke to the crowd, laying out the moral imperative. “Those of us who live affluent lives, well attended by medical care and treatment, should not ask how Germans or white South Africans could tolerate living in proximity to moral evil. We do so ourselves today, in proximity to the impending illness and death of many millions of people with AIDS,” Cameron said. “Available treatments are denied...
to those who need them for the sake of aggregating corporate wealth for shareholders who by African standards are unimaginably affluent." 

These demonstrations and speeches were widely covered in national and international media. Feeling the pressure building, the pharmaceutical companies decided to go on the offensive. Thirty-nine multinational drug companies filed suit to stop the implementation of the South African Medicines and Related Substances Control Amendment Act, a law that opened the door for international importation of generic medicines. Simultaneously with the pharmaceutical lawsuit, the U.S. trade representative accused the South African government of violating international intellectual property laws, placing the country on a watch list that suspended some trade advantages. The United States also filed a formal complaint against the government of Brazil. Citing the Brazilian constitutional right to health, activists there had successfully pushed for a government program that domestically manufactured generic AIDS medicines.

All the while, the pharmaceutical corporations continued to dismiss the possibility of scaling up HIV/AIDS treatment in the developing world. “Trying to put that much money into the system is like pushing on a string,” the Pfizer CEO said in 2001. “We couldn’t spend that much money if we had it.” As part of its public relations response, pharmaceutical corporations also claimed that generic medicines were of poor quality and that ARVs would not work for Africans.

TAC and global AIDS treatment activists kept up their efforts. Al Gore, U.S. vice president and 2000 presidential candidate, had been an enthusiastic supporter of the tactics of the pharmaceutical industry in resisting access to generic ARVs. So, employing the classic “name and shame” tactic of human rights advocacy, activists relentlessly heckled Gore at his public appearances. They even interrupted his official presidential campaign announcement, chanting “Gore’s Greed Kills” and passing out fliers saying “Vice President Gore Doing Drug Company Dirty Work.”

Other demonstrations targeted U.S. Trade Representative Charlene Barshefsky, who was leading the push for sanctions against South Africa and Brazil. The international media began following the story, bringing unwanted attention to the Clinton-Gore administration. Finally, reportedly at the urging of Vice President Gore, President Clinton issued a May 2000 Executive Order pledging that the U.S. trade representative
would not interfere with the efforts by African nations to obtain cheaper AIDS medicines.\textsuperscript{37}

Nevertheless, the lawsuit by the pharmaceutical companies continued, so the activists now focused their attention on the corporations. On March 5, 2001, the day that oral arguments began on the South African lawsuit, TAC led a Global Day of Action against the corporations. Marchers in major cities carried signs saying, “Stop Medical Apartheid.” Others convened mock court hearings in front of the offices of GlaxoSmithKline and Bristol Myers Squibb, finding the companies guilty of murder by blocking affordable drugs. The activists said the corporations had blood on their hands and relabeled them “GlobalSerialKillers” and “Big Murder Syndicate.”\textsuperscript{38}

Finally, drug company executives admitted that the activist campaign was causing “a public relations disaster” for the industry.\textsuperscript{39} Six weeks after the Global Day of Action, the companies dropped their lawsuit, even agreeing to pay the legal fees of the South African government.\textsuperscript{40} The United States soon withdrew all its punitive measures against South Africa and Brazil.\textsuperscript{41}

In November 2001, in the time-honored tradition of the letter of the law following dutifully behind the demands of effective grassroots activism, governments at the WTO Ministerial Conference adopted the Doha Declaration on TRIPS and Public Health. The Doha Declaration affirmed that the TRIPS agreement must be interpreted “in a manner supportive of WTO members’ right to protect public health and, in particular, to promote access to medicines for all.”\textsuperscript{42} The Doha Declaration sent a powerful message, one heard by fifty-plus developing countries that have since taken advantage of TRIPS flexibilities to bypass the patent system to procure lower-cost generic AIDS medicines for their populations.\textsuperscript{43} As one activist put it, the signs once carried by access-to-medicine protesters had been transcribed right into the text of the Doha Declaration.\textsuperscript{44}

Continued legal challenges and protests by TAC led the drug companies to allow generic manufacturing of their patented AIDS drugs in South Africa and allowed the government to create a broad HIV/AIDS treatment plan.\textsuperscript{45} Demonstrations continued across the world, including body bags being delivered to the White House in Washington, DC, on World AIDS
Day while celebrities and evangelical Christians lobbied President George
W. Bush to expand treatment.46

With the introduction of generics, the ARV prices in Africa fell by as much as 99 percent. In 2002, the United Nations created the Global Fund to Fight AIDS, Tuberculosis and Malaria, and in 2003, Bush announced the President’s Emergency Plan for AIDS Relief (PEPFAR).47

The HIV/AIDS treatment picture had changed quickly and dramatically. In 1999, just 20,000 South Africans were on ARVs; today, nearly 3 million are.48 Globally, PEPFAR and the Global Fund provide ARV treatment for nearly 16 million people.49

After the pharmaceutical industry dropped its South African lawsuit, Zachie Achmat, the TAC leader, told a cheering crowd outside the courtroom, “We have made the mightiest industry in the world shake in its boots!”50 He was right. Evaluated by the scope of the challenge it faced, the powerful resistance it encountered, and the impact it had on millions of lives, the campaign for access to HIV/AIDS medicines was not just the most successful health rights campaign in history—it is one of the most successful human rights campaigns of any kind. And it provides a model for modern-day advocacy for access to essential medicines.

Pushing for change will not be easy. As the HIV/AIDS treatment activists learned, efforts to enforce the human right to essential medicines face the determined resistance of one of the most powerful and profitable industries in the world. We have already seen (chapter 7) that the pharmaceutical industry devotes a significant chunk of its blockbuster revenues to political lobbying, campaign contributions, and marketing of its overall image, all toward the goal of creating the system that provides its corporations with monopoly profits on necessary medicines.

We have seen that those corporate lobbying efforts paid off in the lead-up to the TRIPS Agreement, as the industry-supporting U.S. government used sticks-and-carrots advocacy to pressure nations that were concerned about access to medicines.51 The same leverage was employed after TRIPS was signed, pushing many countries to adopt patent-protecting medicine laws even earlier than TRIPS forced them to do so.52 Now that the global patent regime is in place, this same approach is the template for the efforts by the pharmaceutical industry to preserve it.
A recurring target for those pro-monopoly patent efforts is India, home to the generic drug industry that makes the country the “pharmacy of the developing world.” The U.S. government and pharmaceutical manufacturers have filed lawsuits and pulled the levers of global trade to undermine India’s access-to-medicine measures.53 Over two hundred members of the U.S. Congress have written to express opposition to generic drug manufacturing in India, and the pharmaceutical industry and other U.S. business groups created a pro-patent coalition, the Alliance for Fair Trade with India.54 In 2016, criticizing what it called the weak protection of patent rights by India, PhRMA asked the United States to keep India on a priority watch list that could pave the way for trade sanctions. In its request, PhRMA openly admitted to concerns that India’s reluctance to facilitate patent monopolies on essential medicines could serve as a model for other nations.55

The U.S. trade representative assented to the PhRMA request, keeping India on the watch list; recall (chapter 17) that this designation indicates the country in question has “serious intellectual property rights deficiencies” that require trade scrutiny.56 The ratcheting up of pressure on India had its desired effect: soon after the watch list decision, the Indian patent office reversed a decision that had denied the U.S. drug manufacturer Gilead a patent in its hepatitis C medicine, an about-face that advocates say was a response to the badgering the Indian government was enduring on all sides.57

Across the globe, the pharmaceutical industry keeps a close eye on any proposal that may interfere with its patent monopolies. When a threat is identified, the industry strikes. Pharmaceutical corporations vigorously opposed an indefinite extension at the World Trade Organization of exemptions from medicine patent rules for the poorest countries, lobbied hard against a proposed World Health Organization agreement to support medical research and development, and spent over $126 million resisting a California initiative that would have required drug cost transparency.58 In opposition to proposals to allow the Medicare program to negotiate drug prices, pharma corporations have published newspaper ads that portray a concerned elderly woman being told “you could lose access to medicines you need.”59 As the National Association of Medicaid Directors said in 2015, “The pharmaceutical industry is the third rail of politics and if you go against them they will cut you off at the knees.”60
The industry even harshly criticized the TPP measure that would have created the controversial mandate of data exclusivity for biologic drugs. The TPP provisions represented a historic extension of monopoly medicine rights, but the companies wanted even more, complaining that the additional monopoly period of five to eight years was not long enough. These are all quite public efforts, but the pharmaceutical corporations do not limit themselves to above-ground advocacy. As I have discussed (chapter 4), the industry funds patient groups that then lobby for extended patents. Sometimes, large corporations simply buy the generic companies that otherwise might have offered more affordable medicines.

Yet, try as they might, pharmaceutical corporations have not been able to silence the voices of the access-to-medicine advocates. That was certainly true in the historic turn-of-the-twenty-first-century HIV/AIDS treatment campaign, and it has been the case ever since. There are several examples from which activists can draw inspiration:

- In 2007, when the U.S. government and the drug corporation Abbott resisted plans by the Thai government to allow the manufacturing of generic second-line ARV drugs to treat HIV/AIDS, advocacy groups pushed back harder, including a threat to boycott Abbott products. The company eventually dropped its patented price to below the generic price. Thai activists also persuaded their government to create a national HIV/AIDS treatment plan, helped scuttle a proposed United States-Thailand trade agreement that would have included damaging medicine patent protections, and convinced their government to allow the manufacturing of four patented cancer medicines in generic form.
- Activists in Chile have resisted patent-sheltering trade deals and successfully pushed for a Congressional resolution demanding generic licensing of essential medicines.
- Following up on the dramatically successful campaign that led to the dismissal of the pharmaceutical industry lawsuit in 2001, South Africans continued to use civil disobedience, mass protests, and litigation to force the pharmaceutical corporations to allow the generic manufacture of affordable HIV/AIDS medicines.
- Colombian activists have won Congressional endorsement for their demands for generic cancer medicines, and a Kenyan coalition persuaded its parliament to allow greater generic drug access.
• Court victories that expanded medicine access, usually buttressed by significant advocacy outside the legal system, have been won in Peru, Argentina, Venezuela, Colombia, Costa Rica, and Kenya. A study of over 1,000 access-to-medicine lawsuits filed in southern Brazil found that the litigation served as an effective grassroots tool for the poor.

A recent and powerful advocacy success story can be found in the spirited responses by global activists to the prospect of a sweeping pro-patent Trans-Pacific Partnership Agreement. In 2013, José Luis Silva, then the trade minister of Peru, responding to activist outrage, said that proposed intellectual property terms, especially medicine patent rules, elevated the interests of U.S. corporations over the needs of Peruvian citizens. Silva called for Peru to “not go one millimeter beyond what was already negotiated” on medicine access issues in past agreements. Australian access-to-medicine organizations pushed their government to publicly promise that no TPP provisions were acceptable if they undermined the popular pharmaceutical price control program of the country. The Malaysian prime minister condemned any trade agreement restrictions on government efforts to provide affordable medicine as “imping(ing) on fundamentally the sovereign right of the country to make regulation and policy.” Similar TPP concerns were expressed by current or former officials in Singapore, New Zealand, Chile, and Canada.

It turns out that all these public statements were the reflection of a dynamic that was being played out even more intensely in the private TPP negotiations. Multiple individuals familiar with the five-plus years of negotiations confirmed that the U.S. proposals to extend medicine monopolies had been opposed by nearly all the other participating nations, with the sometimes exception of Japan. The U.S. publication Politico reported that the draft TPP intellectual property chapter as of May 11, 2015, was a ninety-page document “cluttered with objections from other TPP nations” to U.S.-drafted protections for pharmaceutical companies. Negotiators from the TPP nations besides the U.S., supported by global health activists, pushed back hard against extensions to monopoly patent protections.

The result of this resistance was that the U.S. and the pharmaceutical industry, accustomed to getting their way with pro-patent provisions in prior trade agreements, could not achieve their TPP goal of twelve years of data exclusivity for monopoly protection for biologic drugs, forcing an industry-resisted compromise of five to eight years of data exclusivity.
Even with that concession to access-to-medicine arguments, the agreement signed in 2015 by trade ministers still faced real difficulties in getting the necessary legislative approval in several countries, including the United States. Ultimately, the deal collapsed in January 2017, when newly-elected U.S. President Donald Trump formally withdrew from the agreement. Many problematic aspects of the TPP spurred determined global opposition, including provisions that would have been harmful for workers and the environment. But the TPP’s demise was caused in significant part by what one account called “a small, international group of affordable-medicine advocates” that relentlessly demonstrated in the streets, recruited expert and politically-powerful opposition to the deal, and traveled the globe to button-hole the TPP negotiators and elected officials.

The United States, despite being home to the government that pushes the medicine monopoly agenda on the world stage, is also the site of a growing medicines-access advocacy movement. Accounts of the U.S. withdrawal from the TPP said the agreement had become “politically toxic” for members of both major political parties in the United States, a toxicity medicines-access advocates helped create. When the Obama administration argued for historic levels of intellectual property protection at the TPP negotiating table, U.S.-based economists, elected officials, and presidential candidates, all informed by activist research and fueled by activist demonstrations, raised their voices in opposition to the TPP. The powerful AARP (formerly the American Association of Retired Persons) and the largest U.S. nurses’ union were among many health organizations in the United States arguing that TPP provisions could have limited future efforts to control domestic drug prices in programs such as Medicare and Medicaid.

The AARP, along with the California Nurses Association, also supported the November 2016 California ballot initiative designed to lower the prices that the state agencies pay for medicine, one of several state-level initiatives whose aim was reducing drug prices. The California proposal, which was ultimately defeated after the pharmaceutical industry devoted $126 million to campaign against it, called for state agencies to pay no more for medicines than the cost paid by the U.S. Veterans Administration. (The ability of the Veterans Administration to negotiate the prices it pays for the drugs it purchases and to restrict its formulary, freedoms
denied the Medicare program, have led to the administration paying an estimated 40 percent less for drugs than Medicare plans do.\(^87\)"

Other activism has come in response to the high price set by Gilead for its hepatitis C medicines, including a “Gilead Greed Kills!” advocacy campaign. That campaign conducted demonstrations in front of the company headquarters in Foster City, California, highlighted by a hearse and a plane flying overhead with the campaign message.\(^88\) This kind of activism, along with lawsuits and media coverage, have led to increased government and private-insurer coverage of the hepatitis C medicines, despite their enormous expense.\(^89\)

During the 2016 Democratic and Republican Party conventions, access-to-medicine activists staged a mock tug-of-war and took out full-page newspaper ads featuring a character named Big Pharma Bro; the aim was to demonstrate the overall support of the pharmaceutical corporate agenda by both parties.\(^90\) I have already mentioned (chapters 2 and 4) that the 450 percent increase in the price of the allergy shot EpiPen, a product that enjoyed a market monopoly, triggered what USA Today called a “firestorm” of controversy and angry condemnations from lawmakers and patients.\(^91\) Access-to-medicine advocates have disrupted congressional hearings, filed U.S. lawsuits, sent public letters decrying the prices of patented medicines, and supported local and state initiatives demanding negotiated drug prices and cost transparency.\(^92\)

Healthcare providers often play important roles in that advocacy. In 2016, a physician wrote a column in the Los Angeles Times that began, “The drug companies are ripping us off, pill by pill, shot by shot. Instead of working to earn reasonable returns by relieving our suffering and saving lives, they now focus on profits above all.”\(^93\) That same year, another physician wrote in the Salt Lake Tribune, “Evil in medicine is often linked with the past practices of blood-letting, lobotomies and arsenic treatments. Now we can add to these atrocities another evil, that of killing people by preventing their needed, life-sustaining treatments.”\(^94\)

Faith-based groups are advancing a similarly morality-based argument against medicine monopoly pricing. “The field is tilted toward the powers that be rather than the power of God’s people,” stated one coalition letter in opposition to the TPP. “Our faith organizations serve those living in poverty in every country in the world and stand witness to the pain that bad trade policies inflict on communities, particularly developing
countries.” An interfaith investor coalition is pushing shareholder resolutions to force the pharma corporations to justify their price increases. In recognition of the key role that faith-based organizations have played in recent successful social movements, including the U.S. civil rights and labor movements, I am part of a group that has launched an effort to advance this faith community advocacy; our organization is called People of Faith for Access to Medicines (PFAM).

As was the case with the HIV/AIDS treatment campaign, recent access-to-medicines activism has featured leading roles played by affected patients. Manon Ress and Phillipa Saunders, breast cancer patients and members of the Union for Affordable Cancer Treatment, were instrumental in pushing the UK government to allow the generic manufacturing of the breast cancer drug T-DM1, actions that eventually forced the patent-holder Roche to lower its price. Cancer patients holding an IV pole that read “TPP: Don’t Cut My IV” disrupted TPP negotiations in 2015 and, as we have learned (chapter 1), were arrested protesting at PhRMA headquarters on World Cancer Day in 2016. One of those patients, Zahara Heckscher, is a U.S. resident and has been treated with patented biologic drugs that would have been subject to extended monopoly protection and unaffordable pricing under TPP. “One of my current cancer medicines could cost me over $100,000 if I were not in a clinical trial,” Heckscher told the media after her arrest. “If [the TPP] passes, thousands of women like me will die waiting.”

Some patients are taking affordable access to medicine into their own hands. Lu Yong, a Chinese leukemia patient, violated national law by purchasing and distributing generic medicines from India to his fellow patients. When Yong faced charges for his actions, hundreds of those Chinese leukemia patients petitioned the court on his behalf. Their advocacy seemed to have an impact; soon after the patients’ petition was filed, the Chinese patent office invalidated the national patent on the medicines that Yong was importing.

Greg Jefferys, a hepatitis C patient in Australia, similarly has openly broken the law by importing generic medicines for fellow patients, including patients in the United States “The patients with liver cirrhosis are sitting there and waiting,” Jefferys said. “And so I’d have to ask the (patent-holding) company—how do you sleep at night?”
In India, patient groups are currently pushing hard for access to affordable breast cancer and hepatitis C drugs. Their efforts follow in the footsteps of Indian patients who helped lead a very successful 2005–2013 campaign for access to a leukemia treatment. It is a campaign that is worth reviewing here, as it holds several promising lessons for current activists.

The leukemia treatment in question was imatinib mesylate, the most effective medicine for chronic myeloid leukemia. The pharmaceutical corporation Novartis holds patents on the medicine, which it markets as Glivec or Gleevec. When its original Indian patent on the drug was running out, Novartis applied to patent a new form of the medicine, this one in beta crystalline form, thus extending its monopoly.

In response, a generic manufacturer and the Cancer Patients Aid Association (CPAA) opposed the patent application, charging Novartis with pursuing a classic evergreening effort; that is, the company was trying to prolong its patent by introducing a new version of the drug that was not significantly different, much less better, than the original. For Indians with leukemia, the stakes were life and death. The generic version of imatinib mesylate was priced at $170 per month, while patent-protected Glivec sold in some countries for as much as $3,000 per month, far out of the reach of most Indian leukemia patients.

In January 2006, the Indian Patents Office refused the Novartis application, agreeing with the challengers that the new version of the drug was not a significant innovation on the older version. Novartis filed an appeal. Anand Grover, a distinguished Indian lawyer who was also serving as the UN special rapporteur on the right to health, signed on to represent the CPAA. As years of appeals dragged on, the CPAA showed real staying power, sticking with the case in the face of both threats and offers of cash from Novartis.

The struggle was intense, in both India and beyond. Novartis recruited U.S. government officials to exert trade pressure on India, while Indian activists and attorneys mobilized in the courts and in the streets. When the case was argued before judges, advocates conducted loud demonstrations outside the courthouse. Indian activists were joined by international organizations such as Médecins Sans Frontières/Doctors Without Borders (MSF) and Knowledge Ecology International. MSF organized a 2006 Drop the Case campaign against Novartis, circulating a petition
signed by nearly a half million people, and conducted a global day of action on the eve of a 2012 Novartis board meeting. Activists persuaded Dr. Brian Druker, whose research had helped develop imatinib mesylate, to write an open letter urging broader access to the medicine.

Finally, on April 1, 2013, the Supreme Court of India issued a final rejection of the Novartis patent claim. The court wrote a strongly worded anti-evergreening decision that underscored that Indian law does not allow monopoly extensions based on minor drug changes that do not add therapeutic value.

A dozen years after the dramatic success of the HIV/AIDS treatment campaign, access-to-medicine activists had won another huge victory. The time is right to lay the groundwork for the next one.

I have now spent many pages discussing how patients suffer without medicines, how pharmaceutical corporations make enormous monopoly profits, and how a money-corrupted system produces this injustice. By now, I hope you are asking, “What can I do to make this change?” Inspired by the dedicated access-to-medicine activists around the world, from South Africa to India to the United States, here are some answers to that question.

Join an Existing Access-to-Medicines Team

You are now well aware that there are several organizations filled with dedicated and knowledgeable activists working hard to increase access to medicines. The globally admired MSF conducts an access-to-medicines campaign that includes public education about the corrupted system and direct calls for advocacy on issues such as vaccine pricing. Sometimes MSF-led activism calls for contacting lawmakers on issues such as the TPP; sometimes it is more creative. For example, in late 2015, MSF activists dumped $17 million in fake cash at the New York City headquarters of Pfizer, representing the daily revenue that the company makes on vaccine sales. Those efforts are bearing fruit: in late 2016, MSF advocates achieved a significant victory when the two manufacturers of the vaccine against the leading cause of pneumonia agreed to reduce the price they charge to humanitarian organizations, a corporate change of heart that MSF attributed to advocates’ petitions, calls, tweets, and in-person demonstrations.
Several other advocacy groups also do great work. Knowledge Ecology International is known for its mastery of the complex details of the laws and trade terms that impact access to medicines. U.S.-based Public Citizen leverages the size and reputation of a broad-based consumer action organization to call for access to medicines. I have discussed the student-led group Universities Allied for Essential Medicines (chapter 21), which has recruited prominent members of the international scientific and academic communities to push for a global medicines research agreement to fund research and require that medicines be available at affordable prices. I have also mentioned a new organization I am involved in, People of Faith for Access to Medicines, which has the aim of building a faith community base for access-to-medicines advocacy.

All these organizations would love your help at whatever level of involvement you can take on, ranging from starting a local, congregation, or campus chapter to simply retweeting and sharing their regular calls to sign petitions, share your story, and push lawmakers. Check their websites for more about how you can pitch in.

Another action opportunity for you is to reach out to the organization or community ties you already have and urge them to make access-to-medicines activism a top item on their agenda. As we have learned, faith-based organizations, the AARP, and unions all have lent their voices to the access-to-medicines cause. But those voices will be louder and more insistent with your help. This is especially true if you are a health care provider; when organizations such as the California Nurses Association, Physicians for a National Health Program, and the American Medical Association speak out demanding reform in the medicines system, their voices carry great weight.

Access-to-medicines activists know well that they are facing a formidable challenge. But James Love, the legendary founder of Knowledge Ecology International, is one of many who express real optimism for the cause. “I don’t think [the pharmaceutical companies] are all-powerful. I think a rag-tag group of activists are stronger,” Love said. “The American people do care. They agree with us, not Big Pharma.”

Create Your Own Access-to-Medicines Team

Chances are that you or a loved one has faced the frightening experience of needing medicines to alleviate suffering or even save a life. Being sick or
being in support of someone who is can produce a feeling of helplessness. But that difficult experience also provides insights, credibility, and impact for an access-to-medicines activist. The HIV/AIDS treatment movement has demonstrated the power of patients and their loved ones pushing for medicines reform. Patients such as Hannah Lyon, whom we met in chapter 1 at the beginning of this book, are proving that model can still work today. She and fellow cancer patient Zahara Heckscher created Cancer Families for Affordable Medicines, and their new organization is already an effective force for the human right to essential medicines. So are Patients for Affordable Drugs and T1 International, which provide passionate and uncompromising patient voices.

Tell Your Elected Officials about Access to Medicines

Elected officials at every level have enormous influence on the availability and prices of medicines. As we have discussed, government decisions fuel medicines research, write the rules that create monopoly patents, and divert billions of taxpayer dollars to pharmaceutical corporations. Those corporations know well how much power elected officials have over the medicines process, which is why they employ thousands of lobbyists and direct hundreds of millions of dollars each year to lobbying and campaign contributions. Our elected officials hear plenty from Big Pharma; they need to hear from patients and taxpayers, too.

Because I am a U.S. law professor writing a book for a U.S. publisher, it is very likely that you are a reader from the United States. If so, that means you have a great opportunity. The U.S. government that represents us is far and away the most influential player in the medicines system. Our elected officials are the ones who pass the laws that protect corporate monopolies and guarantee that we have the highest prices for medicines in the world. Our elected officials are the ones using trade deals to pressure other governments to give corporations the power to push up medicine prices around the world. If the United States exercises its right to withdraw from these trade deals, as other nations have recently done in response to the required Investor-State Dispute Systems provision, or rejects a deal such as the TPP outright, as it did in January 2017, those actions have an enormous global impact. The current profits-over-people medicine system is in large part a U.S. creation, so U.S. elected officials—spurred on by your and my activism—need to play a role in dismantling it.
Tell Your Friends, Family, Classmates, and Coworkers about Access to Medicines

As we have seen, a large majority of Americans feel that drug prices are unreasonable and that drug companies are putting profits before people. That provides a good platform for our activism; studies of social movements show that frustration is a precondition for social change. But most of those angry people do not know why our medicines system is so broken or what can be done to fix it. Those same studies of social movements show that frustration leads to change only when the cause of the problem is properly labeled and a clear alternative is presented.

That is where you come in. Person by person, you can help label the problem and identify the solution. You can explain how medicines do not have to be expensive and unattainable, and you can help transform that frustration into action.

While it would be nice if you could convince your skeptical roommate or your belligerent Uncle Earl to read the preceding twenty-two chapters in this book—and to peruse the hundreds of endnotes as well—that is usually not a realistic plan. Most of the time, we are players in a Short-Attention-Span Theater. So, here are a few talking points you can use when discussing access to medicines, along with references to the chapters in this book to bolster your point. If you connect with an access-to-medicines organization, which I recommend you do, the organization will regularly provide specific messages and suggested targets for those messages. But these talking points will give you the big-picture arguments.

“Taxpayers are paying twice for medicines” (chapter 15). There are few more potent calls to action than telling taxpayers they are getting ripped off. With medicines, that charge is absolutely true. Taxpayers pay to support the most important drug research, only to have government officials hand over the fruits of that research as monopoly patents to corporations. Then, the corporations turn around and charge enormous prices to those same taxpayers, through out-of-pocket payments; insurance premiums; or costs billed to Medicare, Medicaid, or the Veterans Administration. This has to stop.

“Medicine patents stifle innovation. Open-source development would lead to lifesaving improvements” (chapters 12 and 13). This may be an especially important point to make to younger, tech-savvy individuals
who appreciate the wonderful developments made possible by the open software movement. The patent system is great for generating monopoly profits, but its secrecy and exclusivity has proven to block new inventions. Ask your listeners to imagine what amazing treatments could be developed if medicine researchers were unleashed to build on the existing medicine knowledge that the patent system is locking away.

“The medicines system is the very opposite of a free-market system; corporations rely on government-provided monopolies that block competition and allow them to charge artificially inflated prices” (chapters 12, 18, and 19). Your Uncle Earl is likely to be a fan of the free market system—most Americans are. So it is important to point out that the massive financial success of pharmaceutical corporations spits in the face of free market principles.

Not only do these corporations rely on government-granted monopolies and avoid fair competition like the plague, they lean on government to make the riskiest investments in early-stage medicines research. In the pharmaceutical industry, the risks are socialized, but the rewards are privatized. Similarly, when it comes to medicines, the so-called “free trade” agreements are not about free trade at all. Patents are nothing if not competition-blocking protectionism, and medicine monopolies are estimated to equate to a whopping 10,000 percent tariff.127

“Medicine prices are not high because of research costs; they are high because of windfall profits and wasteful advertising” (chapters 7 and 10). When it comes to the reasons for high medicine prices, do not let your friends and family buy what Big Pharma is selling. Sky-high price tags at the pharmacy are funding endless erectile dysfunction drug ads—which your Uncle Earl is no doubt tired of watching on TV because they interrupt his football games. Americans pay the highest medicine prices in the world to fund those commercials, along with high-volume lobbying and marketing to lawmakers and physicians, not to mention record-setting profit margins. The high prices do not fund medicine research. Which leads to the next talking point:

“We can change this system immediately because governments and nonprofits are already driving the important medicine research” (chapters 9, 20, and 21). We do not have to choose between affordable prices for medicine and aggressive medicine research. Because governments are already funding the most important research now, we can cut costs
immediately and substantially. We can do so by eliminating the corporate monopolies that force patients (and the governments that administer the health care programs that so many rely on) to pay for advertising, lobbying, and huge profits. This talking point embraces the critical four-word core of any argument for social change: We. Can. Do. Better.

“Access to medicines is a moral imperative and a human right” (chapters 3, 4, 18, 19, and 22). There is no need to sugar-coat this reality: every day, people are suffering and dying by the thousands simply because the medicines that would help them are priced too high. Corporate profits are taking precedence over the lives of children and young mothers. Tobeka Daki should not have died. Ahmed should not have died.

I bet your listeners will not be comfortable with that deaths-for-profits trade-off. People were not OK with it during the HIV/AIDS crisis in the 1990s and 2000s, when activism-generated outrage turned around the treatment landscape. It shocked our conscience that millions were dying from treatable HIV/AIDS. Today, it is just as appalling that millions die from treatable cancer, or because they could not afford vaccines.

This leads to my concluding point in this book: access-to-medicines advocacy can work. We know that because it already has—both in the HIV/AIDS treatment struggle and in more recent campaigns. It is not going to be easy, of course. But there is a lot of reason for optimism. This is no longer just a struggle being waged by the desperate poor and sick in the developing world and by the caregivers and activists that work with them. Now, as we have seen, these advocates have been joined in their struggle by comparatively wealthy people in richer nations because even these people and their governments cannot pay for the medicine they need. Medicines activists are now joined by frustrated physicians, elected officials, economists, and even hospitals and insurance companies, all calling for a change to this broken system.128

And, I hope, they will be joined by you, too. Together, we can cure our sick medicines system.