The Inter-Ministerial Conference of the World Trade Organization (WTO) held in DOHA in November 2001 provided the initiation of a new round of negotiations to address a range of issues leading to the now well known DOHA Round. Eight years later, the Round is still to be completed. Considering the fact that Uruguay round which culminated in December 1993 and led to the General Agreement on Tariffs and Trade (GATT) in April 1994 took 8 years to complete and the fact that issues being addressed in the DOHA Round are much more tenuous and complex, perhaps the time elapsed is not unexpectedly long. However, even now there is no clear indication that the Round will be completed by the end of 2009, since there are so many issues on which there are diverse perceptions and contradicting views among the members, so much so that no overall solutions are in sight. The mandate of the DOHA Round includes not only implementation of already agreed upon terms for the proper functioning of WTO, but also of many fresh ones. It covers issues related to agriculture (Paras 13, 14), services (Para 15), market access for non-agricultural products (Para 16), TRIPS (Paras 17-19), trade and investments (Paras 20-22), competition policy (Paras 23-25), government procurement (Para 26), trade facilitation (Para 27), anti-dumping and subsidies (Para 28), regional trade agreements (Para 29), dispute settlements (Para 30), environment (Paras 31-33), electronic commerce (Para 34), technology transfer (Para 37), technical cooperation and capacity building (Paras 38-41), least developed countries (Para 42-43), etc. An important issue under TRIPS is defining the complex relationship between TRIPS and the Convention on Biodiversity (CBD) that the majority of WTO members agreed upon at the Global Earth Summit in Rio de Janeiro in 1992 (Para 19). Even more important from the developing and least developed countries’ perspective is with regard to access to affordable healthcare, more particularly to patented drugs under the TRIPS regime. Considering that the patent system under TRIPS embodies a system of monopoly, even if for a limited period for the inventor (patent holder), developing an equitable system of protecting the innovator’s interests and balancing them with those of the poor and needy is not an easy task. That is precisely what the DOHA declaration on ‘TRIPS and Public Health’ attempts to do.

The Declaration emphasizes that TRIPS should not prevent members from acting to protect their national health problems. It affirms Governments’ rights to enforce the flexibilities afforded by TRIPS in the form of compulsory licenses, Parallel imports and through national interventions including control on prices of drugs through appropriate legislations. Furthermore, as a result of several negotiations at the TRIPS Council, special provisions for the implementation of their compulsory licenses even by members who have no technological capability to implement them by associating with other members, have now been approved by the WTO. However, in spite of protracted negotiations on this issue and consensus on approaches, the final outcome is far from satisfactory. The procedure to produce and supply drugs using compulsory licenses is much too cumbersome and bureaucratic to offer a practical and meaningful solution to the problem; so much so during the last five years only one case has been successfully handled under these provisions to make patented drugs available through manufacture and supply under compulsory licenses to some of the least developed countries.

A particularly interesting case would be the case of compulsory licenses for Anti HIV/AIDS drugs
providing the life-line to millions of patients in developing and least developed countries at affordable prices, who have no access to much needed drugs. Subsequent to the DOHA Declaration (Para 6) of 2001, maintaining that public health issues will supersede private interests protected through the patent system when it concerns life threatening diseases such as tuberculosis, malaria and HIV/AIDS, compulsory licenses could be issued under Article 31 of TRIPS. It was only on 30 August 2003, an Agreement was reached on the modalities of exercising these provisions by the TRIPS Council. However, this provision to make drugs available at affordable prices to poor patients has not been effectively implemented. The reason has been that the conditions imposed for the supply of drugs against compulsory licenses granted to the importing country which has no technical ability to produce them themselves are so cumbersome, time consuming and restrictive that in practice they are difficult to implement. For example, the exporting country should obtain a license to export the product, produce batches only for the required quantity which has to be specially labeled and colour coded for the purpose and stop production once that demand is met. The experience of Canadian and Indian companies to supply anti-HIV/AIDS drugs have been far from satisfactory, defeating the very purpose for which these provisions have been made in the first place.

Thus, even if Special Safeguard Mechanisms (SSMs) are agreed upon and a compromise formula arrived at, it is a moot point as to how effectively it can be utilized in public’s interest. A case in point is the supply of a much needed anti-AIDS drug by the Canadian company, Apotex, to Rwanda under the provisions for utilizing compulsory licenses to import products from another country.

It took three years for the company to implement the provisions under Para 6, get over the hurdles and supply the drug. It is obvious that the medical need scenario in that country would have substantially changed during that period making the whole exercise redundant. The fact that the provisions have hardly been used during the last five years was defended on the basis that much of the needs of the poorer countries today were for drugs which are off patents and therefore compulsory licenses were truly not the issue. While this may be partly true, whether in coming years when many patented drugs would be required for major diseases of the poor would be available through the compulsory licenses route remains to be seen. At the TRIPS Council meeting in 2009, India made a strong plea for a legal, procedural and practical mode of implementing the provisions under Para 6 for the sake of countries lack in technical competence to utilize effectively the compulsory licensing system. Signs of the ineffectiveness of these provisions are already apparent with the non-availability at affordable prices of many anti-viral and anti-cancer drugs which are patent-protected.

**Seventh Inter-Ministerial Conference**

After missing out on the 2007 Inter-Ministerial, the WTO plans to hold the Seventh Inter-Ministerial Conference in Geneva in 2009 (from 30th November 2009). The theme of the Conference is ‘WTO, Multilateral Trading System and Current Global Economic Environment’. It is unlikely that considering the current Global economic crisis and its impact on global trade, much time or efforts will be devoted in furthering the cause of developing and least developed countries in areas of health, food and environment. At the WIPO Conference on ‘Intellectual Property and Public Policy’ in July 2009, the Director General of WTO, Pascal Lamy said ‘the IP system cannot operate in isolation for broader public policy questions such as how to meet human needs; basic health, food and clean environment’. He said, the objective of DOHA Declaration was and remains, ‘cheaper drugs for the poor’. Only a dedicated meeting to review the current status of implementation of Para 6 of the DOHA Declaration and address the real reasons for its failure to meet the objectives, will provide meaningful answers and solutions to the global health, food and environmental issues seriously affecting three fourths of the world’s population.