

THE GRADUATE INSTITUTE | GENEVA
GLOBAL HEALTH PROGRAMME

SANTIAGO ALCÁZAR THE COPERNICAN SHIFT IN GLOBAL HEALTH

Global Health Programme Working Paper N° 3 | 2008



SANTIAGO ALCÁZAR THE COPERNICAN SHIFT IN GLOBAL HEALTH

The author argues in this paper that the current economy- and trade-centred world is shifting towards a more health-centred world. He draws parallels with the radical mind shift provoked by Nicolaus Copernicus in putting the sun at centre stage, which had unforeseen impact in areas unconnected to astronomy.

Despite the fact that economy and trade remain central to foreign policy, the social cluster has gained growing influence and importance. The 13th International AIDS Conference, held in Durban in 2000, laid the foundations for incorporating health into foreign policy. As a result, the link between human rights and access to medicines was established. This had an impact on trade negotiations. The Ministerial Declaration on the TRIPS Agreement and Public Health (the Doha Declaration) states that nothing in the TRIPS Agreement should prevent members of the World Trade Organization from taking measures to protect public health.

The author analyses this Copernican shift in the diplomatic arena from trade to health, and highlights the important role played by Brazil in these developments, which resulted in the Millennium Declaration, the Doha Declaration and the Oslo Declaration giving health precedence over trade.

Key Words

Brazil, Copernican shift, Doha Declaration, global health diplomacy, health and foreign policy, health and human rights, health and intellectual property rights, health and trade, paradigm shift, TRIPS.

GLOBAL HEALTH PROGRAMME WORKING PAPER N° 3 | 2008

THE GRADUATE INSTITUTE, GENEVA
GLOBAL HEALTH PROGRAMME
132, rue de Lausanne
P.O. Box 136
1211 Geneva 21
Switzerland

T +41 22 908 5700

E globalhealth@graduateinstitute.ch

SANTIAGO ALCÁZAR ¹ THE COPERNICAN SHIFT IN GLOBAL HEALTH

Since time immemorial, man has been forming ideas about space and time. This is prompted by an urge to find meaning for things we encounter and not to let them pass by unnoticed. It is our desire to hold them and to play with them until a notion is formed and a relationship established. It must have been a turning point when the difference between looking and seeing was fully realized in the conscience. The difference between the two is that in the case of the former, all you are aware of are the immediate sensations produced by the eyes, whereas with the latter, it is the perceptions that are produced in the mind's eye that strike you. It is fitting to recall that the etymological origin of the word 'theory' derives from this profound sense of seeing: *to theion orao* in Ancient Greek means 'I see (*orao*) the divine (*theion*)', in the sense of seeing the cosmos – all that surrounds me and transcends me.

The glorious spectacle of the night sky is full of beauty and mystery that tease the mind. Released from the burdens of the day, one is free to speculate and wonder at the heavens. The motions of the wandering celestial bodies must have struck the first night observers. We can only try and guess what figures they made in space. With the help of the human eye, the first philosophers described the seven known spheres of the sky: the sun, the moon, Mars, Mercury, Jupiter, Venus and Saturn.

¹ The paper was presented as the closing speech at the first Executive Summer Programme on Global Health Diplomacy at the Graduate Institute of International and Development Studies, held 18–22 June 2007, Geneva. At that time, the author was Special Adviser for International Affairs to the Brazilian Ministry of Health. The author has been designated as first Brazilian Ambassador to Burkina Faso in 2008.

The idea of the seven spheres in the sky is so ingrained in our culture that we even based our seven-day week on it². Even the states of mind – sunny, loony, martial, mercurial, jovial, venereal and saturnine – are derived from the same perspective.

In the second century AD, Claudius Ptolemy, a Greek astronomer in Alexandria, added an eighth sphere to hold the stars. He actually went further. In order to explain the wandering movement of the planets, he went on to devise a complicated theory of rotating spheres, and spheres on rotating spheres called epicycles. It was so successful that it came to be known as Ptolemy's system.

Ptolemy's system needed only one premise: the fixity of the earth. In his system, everything moved but the earth, which stood still. Although very complicated, the theory seemed plausible and sound, withstanding the proof of time for almost fourteen hundred years.

In the sixteenth century, a Polish astronomer, Nicolaus Copernicus, was overwhelmed by the tremendous number of calculations he had to make in order to reconcile the Ptolemaic system with observed facts. In a flash of inspiration, he thought everything would be much simpler if he made the assumption that the sun, not the earth, was fixed, and that all the planets revolved around it. Copernicus's hypothesis was revolutionary in a profound sense. At a stroke, it radically changed our view of the universe and our planet's place in it. As a result of the earth's displacement from centre stage, man himself would be banished and, to a certain extent, diminished.

Although Copernicus's hypothesis greatly facilitated astronomical calculations, it got a generally unsympathetic reception and was even considered completely absurd. The Catholic Church, which had a high stake in an earth-centred system, had his book, *Of the Rotation of Celestial Bodies*, listed in *the Index of forbidden works*, where it remained until the nineteenth century.

The significance of Copernicus's hypothesis is that of a shift in perspective. It is not just any shift, however, but a radical one which dramatically changes our view of the world in the sense that it supports an exactly opposing one: from an earth-centred world to a sun-centred world. This radical shift had a huge impact on areas unconnected to astronomical speculation. Displacing earth from centre stage had an immediate effect on man: his role in the grand picture of creation was somewhat diminished. A consequence of this distressing situation was the need to develop a new thought in philosophy and science to take into account the new vistas created by the shift in perspective. Modern philosophy and science came about as a result of this new situation.

Much later, the German philosopher Kant, in his *Critique of Pure Reason*, used the powerful image of the Copernican shift to describe his understanding that it is not reason that adapts itself to the sensations of the objects, but the sensations of the objects that adapt to the pre-established structures of reason. In this context, therefore, Copernican shift means a change in the terms of a relationship; one that highlights the diametrical opposite of what was previously thought.

Later on, the concept of Copernican shift came to be associated with change that results from a radical mind shift, not necessarily one governed by relationships that may be diametrically opposed. It may be claimed, for example, that impressionism represents a Copernican shift with regard to classicism, even though the two schools are not diametrically opposed. In this new sense, Copernican shift simply means a revolutionary change, not necessarily based on diametrical opposition.

But what is the meaning of the expression 'Copernican shift' in a new context, such as the one we are concerned with in this lecture on global health? Well, we should start by saying that the expression has no established meaning in the area of global health.

² In Old English, the days of the week were Sun day, Moon day, Tiw's day, Woden's day, Thor's day, Frigg's day and Saturn day.

In their article ‘Foreign policy, trade and health: at the cutting edge of global health diplomacy’, Nick Drager and David P. Fidler considered that:

The interdependence produced by globalization has broken down traditional ways of conceptualizing and organizing the medical, economic, political and technological means to improve health³.

It should be noted that the crux of this quotation is the realization of a breakdown that affects the way of understanding the issue of health and of the means to organize effective responses for it. It seems it is no longer possible to use the same mind frame as that used a generation ago to respond to the new challenges of our times to improve health. What then?

In March this year, in Oslo, the foreign ministers – or their representatives – of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand issued a declaration and agreed on an agenda for action – a sort of road map for future action. Among the areas identified by the foreign ministries to take the agenda for action forward are:

- the control of emerging infectious diseases
- the development of human resources – an issue that goes beyond the health sector
- addressing conflict and natural disasters
- response to the HIV pandemic
- health and the environment
- health and development
- trade and health
- governance – something clearly lacking in the international structures put in place for specific diseases, such as several initiatives for AIDS, malaria and tuberculosis

Strangely, foreign ministers seem to be adopting an agenda that one would have thought had been originated by health ministries. Another curious thing is that foreign ministers perceive a lack of governance in

the unstructured reality of global health, apparently with the hope of contributing to overcome that difficulty.

The breakdown of the medical, economic, political and technological concepts – which can no longer be used to build a new theory to make sense of the new reality – and the breakdown of the means to organize them to improve health – as they are currently insufficient – implies that the areas of concern of the health ministries now extend beyond the health sectors. This means that a new outlook is required – a new point of view, or a new perspective, that encompasses all the above areas. The expression, Copernican shift, may fit this need for a new outlook, not in the new domain of global health but in another, also new, area that may be labelled foreign policy and global health. This combination could loosely be defined as an area where the two fields merge and where the business of foreign policy is health and the business of health is foreign policy.

It is important to note that the combination of foreign policy and health is new, in the sense that what results from it is not wholly foreign policy or health as we understand them. This newness has to be highlighted as it is through it that real change occurs. Everything that is genuinely new promotes change. Think of the Copernican shift in astronomy, the computer and the internet, all of which opened up avenues that, in so many ways, changed our understanding of the world. It is perhaps legitimate to ask what kind of change we can expect from the combination foreign policy and health. The answer will no doubt come with time, but perhaps we can now try to work it out, albeit in a very crude manner.

Foreign policy has loosely been defined as a set of political goals designed to protect the national interest. We can suggest other, more complex, definitions, but few will deny that the one given here encapsulates the fundamental aspect of the workings of foreign policy. What if, on the same basis, we define health policy as a set of political goals designed to protect the general health of a nation? Would it make sense? Would it be correct? Many may object to this definition. Countries have different policies for health, ranging from public health to private health, and in all combinations. Although there may exist a general policy to protect

the people from disease, the state may not necessarily have an obligation to provide health care. This is a distinction worth noting. In the case of foreign policy, the state has an obligation to protect the national interest, which is not at all apparent when it comes to providing health care for its own citizens. There is also a second distinction, which relates to the area of action: the first one is external to the own country, the second one concerns internal or domestic action.

The two distinctions mentioned are sufficient to show that defining the meaning of health policy on the same basis as that used to define foreign policy is not a legitimate exercise, may result in verbal abuse and would not seem to work if it were used to define the combination 'foreign policy and health'. At the same time, the two distinctions are useful in understanding how the breakdown of concepts arises.

However you choose to define public health, two aspects of it are crucial: access to treatment and access to medicine. Generally speaking, public health ensures some kind of free access to treatment and medicine. This may vary from limited access to universal access for both treatment and medicine. There may, for instance, be a list of treatments and medicines covered by the state, to various degrees; or there may be complete coverage for both treatment and medicines, regardless of complexity or cost.

Where only limited coverage is provided, health policy would not be designed on the same basis as foreign policy in the sense of protecting national interests. In other words, health policy would be designed to address domestic issues. However, it would not be a matter of national interests that needed to be protected by the state, as would be the case for the national interests that would be protected by foreign policy. Whilst this may seem strange, it is exactly the picture that prevailed, and in some cases still prevails, in many countries today.

In developing countries, limited coverage had two important effects: growing social inequity, with all the ensuing consequences; and the increasing isolation of health ministers in governmental structures, ren-

dering them irrelevant in terms of political status compared with the so-called strong ministers, due to a very small budget to deal with the agreed limited agenda. This set of conditions tends to focus the attention of health ministers solely on the domestic scene, with very few resources for changing prevailing conditions.

The two distinctions between health policy and foreign policy resulting from the use of the defining template emerge. It is here that Drager and Fidler's pertinent observation fits in. The traditional concepts of health and the organization of measures designed to improve health break down in light of the new reality marked by globalization, where the HIV pandemic and the issues of trade and development, environment, conflicts and natural disasters play an important role. It is in a scenario where the traditional concept of disease attached to biological causes has to be substituted by a more complex formulation that takes into account the social, economic and cultural determinants of health. The breakdown that Drager and Fidler mention is actually a cue for the entrance of something new, which is perhaps suggested by the notion of a Copernican shift. In what sense? In the sense that globalization takes the issue of health from the relative obscurity in which it found itself, especially in developing countries, and brings it to the front page where it is featured not as health as we know it, but as global health in combination with foreign policy, which we are still struggling to define.

Foreign policy may be directed in several areas, but it may be useful for the purposes of illustration to fix these into two clusters, so as to focus attention on features that will be useful in understanding the notion of a Copernican shift: the economy and trade, on the one hand, and the so-called social themes, on the other.

The first cluster, the economy and trade cluster, contains a series of themes that may be considered as part of the national interest that has to be protected on the international stage. Energy, the national currency, banking, investments, insurance, transport and communications, for instance, may all be found in this cluster. The main char-

acteristic of this cluster is that the elements it contains may be used as indicators of a country's strength. For example, a country with a thriving economy and a solid and diversified trade profile is usually classified as strong.

As such, a strong currency, trade surplus, advanced science and technology, and financial revenues, are all perceived as matters of national interest that should be preserved and protected. It is for this reason that they have a high standing within foreign policy to the point of being central to it.

It is perhaps worth mentioning that in a developing country, the economy and trade cluster may have made an entrance in foreign policy in a well-determined period of history. In Brazil, for example, the speeches of the head of delegation to the United Nations General Assembly – which may be used to analyse the stated priorities of its foreign policy – until 1952, are marked by the logic of confrontation that resulted from that period of the cold war. In that year, however, Brazil's foreign minister, João Neves da Fontoura, expressed concern over the economic divisions of the world. His speech addressing the General Assembly is considered a landmark in Brazilian diplomacy because it is the first time that an economic theme enters the realm of foreign policy. In it, Brazil takes its first steps in economic diplomacy, which would become much more important with the industrialization process that would soon start with the Kubitschek era and would remain so.

Although the above example refers to the Brazilian experience, it may be possible to identify other cases when economic themes first appear in diplomatic speech and when they become central to the making of foreign policy. The important thing to be retained here is that once introduced into foreign policy, the economic themes tend to become dominant, overshadowing all the others. This is especially true in relation to the so-called social themes, which did not flourish during the difficult cold war period. International debate, at that time, was focused on security and the arms race. This reality inhibited

consideration of the social themes, which could be used for fingerprinting purposes and not for what they really were.

It is only at the end of the cold war that the social themes would become an integral part of foreign policy with the development of the UN social agenda through a series of conferences in the last decade of the twentieth century: the UN Conference on Environment and Development (Rio de Janeiro, 1992), the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development (Cairo, 1994), the World Summit for Social Development (Copenhagen, 1995), the Fourth World Conference on Women (Beijing, 1995), the UN Conference on Human Settlements (Istanbul, 1996), the World Food Summit (Rome, 1996). There could be no doubt that the social themes were gaining in importance in the international landscape that followed the end of the cold war. The new themes provided young diplomats with an opportunity to develop their talents in previously untouched areas of foreign policy. New structures had to be put in place in order to address a completely new set of questions. At last, the cluster of social themes was becoming to be taken seriously in diplomatic circles.

Let's go back and picture the relative situation of the two clusters during the cold war. The economy and trade cluster, having a greater mass – or greater importance with regards to all other themes, apart from the confrontational ones – takes centre stage and submits the social themes to its rule. The social cluster orbits the economy and trade cluster, as if waiting to be addressed and considered when and if general conditions allowed. The end of the cold war does not change that picture in any fundamental way. The economy and trade cluster still occupies a central position in the priorities of foreign policy, except that now, the social cluster appears more weighty and not as easy to dismiss. It is only the perception of a new reality that changes the picture.

Again, as in the case of the entry of the economy and trade cluster in a developing country's foreign policy, it may be useful to see when the perception of the weightiness of the social cluster took place in a particu-

lar case. Once again, the example comes from Brazil's experience in the area of HIV/AIDS. At the 13th International AIDS Conference, held in Durban in 2000, the Brazilian delegation took the bold step of presenting the outline of its programme for AIDS control, in which prevention and care had an equal footing. It should be remembered that the issue of care using anti-retroviral drugs was then severely criticized by some, with arguments that proved to be unsound to the point of not resisting the test of time⁴. Today, no one will defend the view that the HIV pandemic has to be acted on solely from the point of view of prevention, while ignoring the care aspect. At issue, at that time, was the use of generic versions of anti-retroviral drugs produced in Brazil's state-owned laboratories and the possibility of eventually using, if the case was presented, provisions in the TRIPS Agreement to issue a compulsory licence. The Durban conference was really the first step in incorporating a health issue into the foreign policy agenda.

The next step would be taken during the World Health Organization (WHO) Executive Board meeting in January 2001, when the Brazilian delegation introduced into the debate the issue of placing care on an equal footing with prevention. As a result of the discussions at the Executive Board meeting, the World Health Assembly (WHA) adopted Resolution WHA54.10, in which the sixth preambular paragraph states that "Prevention and care are inextricably linked, and that their effectiveness is increased when they are used together". Operative paragraph six urges Member States "...to make every effort to provide, progressively and in a sustainable manner, the highest standard of treatment for HIV/AIDS, including the prophylaxis and treatment of opportunistic infections".

The Brazilian foreign ministry would get further involved in the AIDS issue when it decided to take the matter to the United Nations Commission on Human Rights and push for the adoption of Resolution 2001/33, Access to medication in the context of pandemics such as HIV/AIDS. In it, the following preambular paragraph of seminal importance was inserted:

[The Commission] recognizes that access to medication... is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The importance of this paragraph has to be considered in light of the link that was being established in the resolution between human rights and access to medicine. This link, which some at the time considered provocative, would become central in all other negotiation processes where health issues were being discussed. The established link between human rights and access to medicine would ultimately come to be perceived as something with the potential to change the picture of the two clusters along with the relationship between them.

Again, in the case of Brazil, the link between human rights and access to medicine is enshrined in the constitution. And it is precisely here that the need for a new outlook arises at a time when the application of traditional concepts is no longer adequate to take into account the new reality, while the means to organize them prove insufficient. Traditional policies that come out of the economy and trade cluster are usually designed to ensure the strengthening of its own elements. The economy aims to thrive, trade seeks a surplus, and investment expects returns and so on. The main focus of policies deriving from this cluster is the preservation of the strength of the cluster itself. On the other hand, the accepted link between human rights and access to medicine has the unexpected consequence that the policies of the economy and trade cluster have to be geared towards the promotion of health, the protection from disease and the care of the individual. An inversion is required to get the economy and trade cluster to work, not for itself and its own strengthening, but for the other cluster, the social cluster, in which health has a structuring role in all stages of life, from conception to death.

This inversion is what the Copernican shift is all about. The situation, exemplified by the economy and trade cluster on the one hand and the social cluster on the other, was clearly dominated by the former. The economy and trade cluster occupied centre stage. The other cluster merely

⁴ US journalist Tina Rosenberg, from The New York Times, published an article on 28 January 2001 entitled 'Look at Brazil'. In it, the Brazilian AIDS programme is presented as a model to be followed and as an example that the AIDS problem in developing countries can and should be considered from the care perspective and not only from the prevention side, as was then thought.

orbited it, like a planet travelling around the sun. In this respect, it would be appropriate to use the term 'Ptolemaic' in so far as this adjective would suggest that the economy and trade cluster would be regarded as being at the centre of the universe, whereas the social cluster would circle it, thereby reiterating an incorrect perception. Why incorrect? Because in this situation, the former cluster works for itself and not for the latter, in which mankind is found. The Copernican shift, in this context, would restore mankind's status – in an ironical twist to the true, astronomical, shift that took place in the sixteenth century – and have the economy and trade cluster working for it. This would thereby invert the relationship between the two clusters, bringing to mind the full significance of an earlier and grander inversion, according to which "the Sabbath was made for man, not man for the Sabbath".

It is perhaps fitting to recall the words, full of dramatic expression, of an article published in the prestigious UK medical journal, *The Lancet*, in 2004, in which the author states that :

The sacrifice of human life for an economic model that largely favours foreign investors and multinational companies, and undermines the welfare of indigenous populations, is flawed and immoral. Such a policy will probably backfire through revolts, and lead to political and social instability. It should be abandoned. The decline of welfare from a reckless and heartless economic strategy must teach countries to observe an absolute obligation : at the very least, no country should sacrifice existing welfare or postpone achievement of a reasonable welfare target to implement an economic strategy. Any such policy should allow the most rapid attainment of the highest possible welfare for a given level of economy⁵.

It is not without reason that the Ptolemaic situation of the two clusters is often described as egoistical or, worse still, as 'egoistically hedonistic' as a reference to its self-centred characteristic of seeking its own advantage and strength. The problem with egoism is that it usually blinds. It dazzles the vision, blurs the view and impedes one from becoming aware that ours is a world where 4.8 billion people live in developing

countries, or 80 per cent of the world population; that of these 4.8 billion, 2.7 billion live on less than 2 US dollars a day; that communicable diseases account for 50 per cent of the burden of disease in developing countries; that non-communicable diseases have an increasing impact on the burden of disease in developing countries; and that poverty directly affects the ability to acquire much-needed health products, particularly in developing countries.

It is no surprise, therefore, that a moment would come when heads of state would gather in an attempt to overcome the devastating difficulties faced by the larger part of the world's population. In New York, at the dawn of a new era, as many would describe it, they would issue the United Nations Millennium Declaration in which they emphasized the need for broad and sustained efforts to create a shared future, based upon humanity in all its diversity, recognizing that, in addition to their concerns for their own individual societies, that they had a collective responsibility to uphold the principles of human dignity, equality and equity at a global level.

The Millennium Declaration pushed for the elaboration of a set of objectives that would have to be pursued in order to uphold the lofty principles of human dignity, equality and equity. The Millennium Development Goals, which were annexed to the declaration, propose, between 1990 and 2015, the reduction by two-thirds of the under-five mortality rate and by three-quarters the maternal mortality ratio; halting and beginning to reverse the spread of HIV/AIDS, as well as the scourge of malaria and other major diseases.

It would be the height of folly to expect that these goals could be achieved without the availability and affordability of medicine, vaccines and diagnostic kits, in sufficient quantities, of good and efficient quality, and in culturally acceptable forms. Several initiatives were therefore created to take up the challenge of the Millennium Development Goals. Worthy of mention are the Global Alliance for Vaccines and Immunization (GAVI), which was established in 2000; the Stop TB Partnership, established in 2000; the Global Drug Facility, created in 2001; the Global

⁵ Okunzi, S.A. 'Dying for economic growth? Evidence of a flawed economic policy in Uganda' in *The Lancet*, Volume 364, Number 9445, 30 October 2004, pp.1,632–1,637

Fund to Fight AIDS, Tuberculosis and Malaria, established in 2002; the United States President's Emergency Plan for AIDS Relief (PEPFAR), operational since 2003; UNITAID, and the International Finance Facility for Immunisation Company (IFFI), both established in 2006.

Each of these initiatives addresses a specific aspect of the Millennium Development Goals and, in this respect, they highlight the importance of health and the need to do something about it. The abovementioned initiatives are supportive of a new attitude that derives from the increasingly important role of health, not just in the lives of individuals, but also in ensuring the security of nations. This does not mean security as it was understood during the cold war, but in a new sense, where the idea of human development is essential in order to avoid instability that may shatter the idea of civilization. At the same time, we should recognize that the initiatives are not a response from the health sector alone. Foreign ministries, finance ministries, private foundations, non-governmental organizations (NGOs), multilateral institutions, international financial entities and, of course, health sectors are all involved in one way or another. Critics have claimed that it is precisely this amalgam of actors that results in a kaleidoscope of changing patterns, not necessarily related to one another. They also claim there is a lack of governance, but this is only a detail in the big picture of the Ptolemaic versus the Copernican system of the two clusters and need not concern us here.

What has to be retained here is that the relationship between the economy and trade cluster, and the social cluster has to be shifted from the Ptolemaic to the Copernican perspective in order to meet the challenge of finding new concepts and the means to organize them to achieve the goal of better health on a global scale. The example of Brazil's diplomacy taking on board a health issue and placing it among its priorities was used to clarify the meaning of a Copernican shift, where the weightiness of the social cluster becomes – for specific reasons – more evident and urgent in the making of national policies. At the same time, this example reflects a growing and unprecedented convergence of the interests of two ministries: the foreign ministry

and the health ministry. It is important to realize, however, that this reflects a global trend, not a mere accidental circumstance. The growing importance of the social cluster may be witnessed, and the weightiness of health issues measured by the scale of the media coverage they have been receiving recently. The convergence of interests of the two ministries is not exclusive to Brazil; it is also occurring in other countries, as demonstrated by the Franco-Norwegian initiative of bringing together foreign ministers and health ministers to consider a road map for mutual collaboration in agreed areas.

The clear perception of the growing importance of health and the convergence of interests of the two ministries suggests that the time is ripe for a Copernican shift in the relationship between the clusters. There are examples that indicate that this is already happening in some areas. To examine this further, we will focus on the WHO Framework Convention on Tobacco Control (FCTC), the Doha Declaration on Trade and Public Health, and the road from Resolution WHA56.27 through which the Dreifuss Commission⁶ was established, and which sparked an ongoing debate on the question of public health and intellectual property. But let's start with tobacco.

An interesting feature of the FCTC is its unique design aimed at reducing demand, unlike the UN drug reduction agreements that were designed to reduce supply. Demand reduction, as opposed to supply reduction, requires a change of mind, similar in many ways to the change in outlook that we have just labelled 'Copernican shift'.

Tobacco is a huge industry. It has been interwoven into national economies and has been an important import and export for a relatively long period. It provided employment for many and guaranteed an excellent return on investment. A business with such credentials can hardly be the object of measures to reduce supply. Unless, of course, the best scientific evidence shows that tobacco kills⁷. In this case, even though many jobs could be lost and investments dwindle, there is no question that a time would come when governmental structures would take the view that tobacco is a public health enemy that must be controlled,

⁶ The Dreifuss Commission, named after its chairperson, Madame Ruth Dreifuss, is the Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH).

restrained and, if possible, beaten. It soon became an instance of the health versus trade battle or, to describe it in more colourful terms, of Copernicus versus Ptolemy.

The first paragraph from the preamble of the FCTC states that the parties are determined to give priority to their right to protect public health. It has to be remembered that when the statement was made, it was not at all obvious and was hard to reach a consensus, although it was merely based on previously agreed language. The tobacco industry still had a strong voice and was able to argue against many of the proposals that were thought to jeopardize its position in the eyes of investors. Even so, it is fair to say that the agreed text of the FCTC is tough enough and puts the industry in a straitjacket from which it will never escape to do as it wishes.

Today, everyone agrees that tobacco is the enemy of public health and this alone could be used to explain the enormous success of the FCTC, which entered into force in record time. The point, however, is more profound and has to be considered in light of the mind shift that made possible the idea of a public health convention that points the finger at an important part of the economy and trade cluster; that allowed for the intense, and often dramatic, process of negotiation; and that enabled the respective domestic approval procedures in a very short time. It is this mind shift in relation to tobacco, and in particular to the tobacco industry, that will come to characterize the Copernican shift.

The previously agreed language from which the first paragraph of the FCTC was extracted comes from the Ministerial Declaration on the TRIPS Agreement and Public Health, better known in health circles as the Doha Declaration. The language adopted in that declaration states that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. The significance of this simple language is that it comes – sweet as it may sound – from a tradecentred institution such as the World Trade Organization (WTO). A paradigm shift

seemed to be in operation; one capable of propelling the solid governmental structures from a trade-centred world to a health-centred world.

In March 2001, the Council of TRIPS was finalizing the preparatory work for the 4th World Trade Organization Ministerial Meeting, which was scheduled to take place in Doha, Qatar. The African Group, under the leadership of the Permanent Representative of Zimbabwe to the United Nations in Geneva, Ambassador Boniface Chidyausiku, took the initiative of preparing a draft declaration on the TRIPS Agreement and Public Health, in light of the HIV pandemic that was ravaging the continent. In general terms, the aim of the African Group was to advance the interpretation of TRIPS, according to which the agreement had to be sufficiently flexible so as to allow for the protection of public health policies.

The road to Doha was an opportunity for developing countries to unite in defence of the principles of public health. The idea of the African Group soon became encapsulated in a well-rounded formula that would be repeated to the point of exhaustion: “Nothing in the TRIPS Agreement shall prevent Members [of the WTO] from taking measures to protect public health.” Ambassador Celso Amorim, currently Brazil’s foreign minister and, at the time, Permanent Representative to the United Nations in Geneva, would repeat incessantly that the question of stressing the point of the flexibility of TRIPS to allow for the protection of public health boiled down to the question of guaranteeing access to much-needed medicines. More than technical or rhetorical, the question is really about life or death. Putting the question in these terms can seem dramatic. But this is exactly the point: health is about saving lives, no matter the cost. It was appropriate at the time to stress the life-saving importance of health and to propose political slogans that would convey the idea that the economy and trade cluster had to be geared up for the protection of the social cluster – and not the other way round. Without actually saying it, people were acting as if a paradigm shift was taking place.

Two documents went to the 4th Ministerial Meeting in Doha: Document IP/C/W/312, supported by developing countries and containing the mantra that nothing in the TRIPS Agreement shall prevent mem-

⁷ During the negotiations that were to lead to the FCTC, NGOs spread the word that tobacco is the only product that, if used in accordance with the producer’s instructions, kills one in every two consumers.

bers from taking measures to protect public health, was of a Copernican nature; while Document IP/C/W/313, supported by industrialized countries, was clearly of a Ptolemaic nature. Political pressure for the withdrawal of the former document was mounting, as is usually the case when the interests of the economy and trade cluster are used to justify its own interests rather than those of the social cluster. The rest of the story is well known. The declaration was adopted by consensus and recalled in various documents and resolutions, particularly the part that encapsulates the mantra, although with varying degrees of difficulty. It is as if acceptance of the paradigm shift which it embodies was, and still is, the object of debate in the hard-line, hard-to-die mind of the Ptolemaic world believers. It is perhaps a consolation that Copernicus's *Of the Rotation of Celestial Bodies* remained in the *Index of forbidden works* until the second half of the nineteenth century.

What was extraordinary about the Doha Declaration is that it did not receive strong support at WHO, where it should have been accepted without hesitation in the first place, at least at Secretariat level. It is, of course, in the nature of things that this would not be the case given the considerable influence of industrialized countries in the WHO decision-making process. There may be different views as to why a certain decision followed a certain path and not another. Nevertheless, in January 2003, the Brazilian delegation at the Executive Board meeting decided to present a draft resolution that would force the involvement of the Secretariat in the heart of the Doha Declaration: the question of the impact of intellectual property rights on public health.

The issue of patents for health products is a relatively recent one. Industrialized countries recognized patents for medicines only after they had reached a certain level of development. At the end of the Uruguay Round, an agreement was reached that put medicines and other industrial products on a par. Naturally, one may ask what the consequences are of putting a medicine like an anti-retroviral drug and a software program on an equal footing, as provided for by the TRIPS Agreement. There wouldn't be any if both the anti-retroviral drug and the software program obeyed the same market laws. They don't,

however. An anti-retroviral drug is only dispensed and consumed out of necessity. There is no other reason for taking anti-retrovirals. Necessity is the reason for taking medicine and not just any medicine, but one that is appropriate.

A software program, on the other hand, may be purchased for several reasons that may have nothing to do with necessity. For example, one may buy the program because its features are important, because it's good value, or because someone has recommended it. If medicines and software programs are so radically different in nature, then why are they lumped together? This is because Article 27 of the TRIPS Agreement says that any invention, of a product or of a process, in any technological field may be patented. It would seem that, under TRIPS, all products and processes are created equal, in a sort of parody of the opening words of the American Declaration of Independence, according to which "all men are created equal". How can medicines and software be considered the same under TRIPS if, for anyone with an ounce of common sense, apples and bananas are so different? In any case, what TRIPS does is to erase any distinction between products and processes that are required for life-saving purposes and those that are consumed for lesser reasons.

In TRIPS, patented products and processes, in any technological field, are subject to the same rules that are applied for the protection of international trade. Is this familiar? Doesn't it look like the situation that prevailed in the Ptolemaic relationship in which the economy and trade cluster worked for itself, for its own strengthening, and not for the social cluster, which merely orbited it? There is no doubt that the Ptolemaic vision of the world is strong and persistent, even at WHO.

This is why the draft resolution proposed by the Brazilian delegation at the Executive Board meeting in January 2003 was important in reiterating the terms of the agreed language that was still the object of resistance at WHO. But, of course, it was not only agreed language that moved the draft resolution. There were originally three objectives:

1. to examine the impact of intellectual property rights on public health
2. to propose measures to generally increase access to medicine
3. to propose a new mechanism to spearhead research and development for the production of new medicines for diseases that predominantly affect developing countries

It is fair to say that at the end of what were considered very tough negotiations, these clear-cut objectives were looking rather murky. In order to implement the resolution, it was proposed that a commission of experts be established, the integration of which was left to the then Director-General of WHO, Doctor Lee Jong-wook.

The devil is in the detail, as the saying goes. The notion of a tree is not necessarily the same for everyone. Some may recall a particular tree, at a particular time of their lives. Others may associate it with a song, or an apple tree from which an apple pie comes to mind. It is the same with commissions. Some consider that the best way of achieving the objectives is by getting directly to the point, while others believe the best tactic is to go in ever decreasing circles. It came as no surprise, therefore, that when the commission was established and work had to begin, problems soon arose. At the end of the day, what had been expected from the agreed text was further lost and what came out of the commission's work was a set of 60 important recommendations divided into four main groups, but which bore little or no relation to the high expectations some delegations had with respect to the original ideas:

- the process of discovery
- the process of development
- the process of delivery
- the process of fostering innovation in developing countries

There is no question of the importance and relevance of the four headings of the commission's recommendations. But it has to be agreed that between these and the original objectives there is an insurmountable

gap. And the reason for the gap is that the three objectives of the original draft resolution (adopted as Resolution WHA56.24) derived from and were inspired by the field of public health, where access to medicine is always the main concern. The recommendations of the commission's report, on the other hand, were adapted to fit the innovation equation, where research and development play a central role. Access and innovation belong to different spheres or to different clusters. Access is crucial in the social cluster where health has a central role. (Remember the Oslo Declaration of making the 'impact on health' a point of departure and a defining lens to be used to examine the elements of foreign policy and development strategies.) When medicines were put into the basket of patentable products, it was then necessary to include in the agreement flexibility that would guarantee access for public health purposes. The flexibility is about access, and this was the main concern of Resolution WHA56.27, initially proposed by the Brazilian delegation. This resulted in the establishment of the Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH). (The order of the terms, which is the same as the title of the resolution, reflects a Ptolemaic preference and is to be considered an indicator of the toughness of the negotiations.) The report of the commission changed that order in its adopted title to Public health, innovation and intellectual property rights, a small concession in light of its 60 recommendations geared mainly towards the question of innovation, without a clear reference to the question of access.

Backers of Ptolemy and supporters of Copernicus met at the 59th World Health Assembly, which merely took note of the commission's report without endorsing it. There were two issues. On the one hand, supporters of Ptolemy would propose a face-saving solution for the work done by the commission, which meant redeeming some of the recommendations that could be described as 'low-hanging fruit'. On the other, supporters of Copernicus would propose the reinstatement of the lost objectives of the initial draft of Resolution WHA56.27. What supporters of Copernicus had in mind when proposing what was to become Resolution WHA59.27 was the establishment of an intergovernmental working group (IGWG) with a mandate to propose a global strategy and plan of action. This would provide a framework to secure an enhanced and sustainable basis

for needs-driven health research and development for relevant diseases that disproportionately affect developing countries. In essence, that was what had been proposed in Resolution WHA56.27. When Resolution WHA59.24 was adopted, after a hot and strenuous debate, resolved by what was to become known as the spirit of Geneva, the Ptolemaists were not amused. This is why they did all they could to undermine the Copernicans at the next World Health Assembly.

Sometimes, a single issue makes a difference, a single turn produces a shift and a singularly new idea gives rise to a paradigm shift. In the present case, a series of apparently unrelated events would come to suggest a new perspective, different from the one that dominated the relationship between the clusters of foreign policy priorities. This new perspective is what has been referred to in this paper as the Copernican shift in the new combination of foreign policy and global health.

The Millennium Declaration, the Doha Declaration, the Oslo Declaration and the adopted resolutions in the UN family are all signs of a change of perspective that legitimize the use of the expression ‘Copernican shift’ in the very specific context explained in this paper. Political authority for the use of the expression rests assured after Brazilian president Luiz Inácio Lula da Silva, after signing the presidential decree that issued a compulsory licence for the anti-retroviral drug Efavirenz, said that health takes precedence over trade. He added that if the case ever arose for further issuances to assure the health and dignity of his fellow citizens, or of that of any human being, then he would do it again without question. The change of perspective was becoming clear for many observers of the Brazilian scene.

Ambassador Celso Amorim, Brazil’s foreign minister, made it even clearer when he addressed the 60th World Health Assembly (WHA). He had been invited by his colleague, Brazil’s health minister, José Gomes Temporão, to deliver Brazil’s speech at the plenary session of the World Health Assembly. Symbols are always important. The presence of the Minister of External Relations at the 60th WHA was a strong symbol of the confluence of Brazil’s foreign policy and health policy. In his speech, the

ambassador recalled his government’s decision to issue the compulsory licence for Efavirenz. In the context of our two clusters – the economy and trade cluster, and the social cluster – he said that many, in Brazil as well as abroad, had expressed concern over the possible negative impact on the flow of international investment into Brazil. Following the direction of Brazil’s foreign policy, Ambassador Amorim assured everyone that not a single economic or trade consideration can be used to hinder measures in favour of public health. This is exactly the situation pictured, on the one hand, by the old Ptolemaic view that the economy and trade cluster has to be strengthened for its own purpose, and on the other, by the new Copernican view, championed by the ambassador, in which the social cluster occupies centre stage and is served by the economy and trade cluster.

It is in this same vein, perhaps inspired by the spirit of Geneva, that WHO Director-General Doctor Margaret Chan decided to immerse herself in the question of intellectual property and public health, and to bring the debate to the organization where it has profound implications. At the closing session of the 60th WHA, Doctor Chan would say engagingly and with enthusiasm:

“I am fully committed to this process [the IGWG] and have noted your desire to move forward faster. We must make a tremendous effort... We know our incentive: the prevention of large numbers of needless deaths and suffering.”

This also is a sign of change in the organization; and it is one reminiscent of a Copernican shift.

