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How Change Happens: Access to Medications in Thailand

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Abstract: Many actors in the development world are paying increasing attention to the so-called 'theories of change'. Whether in programming or advocacy, this approach seeks to analyze various power relations and possibilities surrounding any given change process, as well as the assumptions employed by this analysis. This paper applies Oxfam's thinking on change to a particular influence-wielding exercise – the long-running campaign to improve access to medications in Thailand.

Keywords: medications, Oxfam, power analysis, poverty, Thailand

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'We have to do this because we have so many patients to treat with so little budget. We cannot watch our people die and their patents have been here for so long.'

Public Health Minister Mongkol Na Songkhla

Power Analysis

In Oxfam, the discussion of a given change process is often termed a 'power analysis'. Here, 'power' is understood as a subtle and pervasive force field connecting individuals, communities, and nations, which takes place in a constant process of negotiation, contestation, and change. It takes different forms: visible, invisible (norms and values), and hidden (behind the scenes). It operates in different spaces − decisions made by different fractions of the elite, decisions in which masses are invited to participate by those in power, or decisions in which, by contrast, masses demand and create their own space.[1]

Power lies at the heart of change or its denial. Oxfam's work is based on the understanding that unequal power relations are one of the main underlying drivers of inequality, poverty, and suffering. One of Oxfam's aims is to transform power relations in order to allow poor men and women have greater influence over policies, structures, and social norms that affect their lives.

However, unequal power relations manifest themselves in many different ways: from unfair trade regulations that disproportionately benefit rich countries to the social norms that cause young girls to suffer malnutrition because they are only allowed to eat after their brothers have had their fill. One way to disentangle this complex web is through power analysis.

A power analysis identifies and explores multiple power dimensions and actors that affect a given situation in order to better understand different factors that interact to alleviate (or reinforce) poverty. Having a more complete understanding of the power relations at

[1] http://www.powercube.net/

play helps us identify appropriate strategies and entry points for our programmes.

The complexity of power means that there is no 'one size fits all' solution to transforming power relations. Often would-be 'change agents' need to act at more than one level and address more than one dimension of power simultaneously to bring about lasting change. For example, civil society actors may successfully influence governmental policies, but this influence will not automatically translate into improvements in the lives of poor men and women if steps aren't taken to ensure an appropriate implementation of the new legislation, which may include addressing the ideas and beliefs that sustain the practice in the first place.

In conducting a power analysis, there are some key questions to ask:

WHO? Actors, Organisations, Institutions

Who are the main actors involved (poor communities, decision-makers, private sector companies)? Beyond these leading players, what other individuals or institutions (media, religious institutions, intellectuals, traditional leaders) are relevant and influential, as potential allies of change, blockers, or 'shifters' − potentially important players who can be convinced to support the change?

WHERE? Levels, Spaces

In what kinds of "spaces" are those who seek or block change operating? Is it formal/closed, invited, created/claimed from below? Do the relevant changes and decisions take place at household, community, local government, national government, regional, or global levels?

WHAT? Sectors, Issues, Power

Which aspects of poverty and marginalisation are being addressed? What change is Oxfam and its partners trying to affect? Which kinds of power relations are relevant (e.g. visible, hidden, invisible/

internalised)? What are the gender dimensions of these power relations?

HOW? Strategies, Methods, Models

Alliances: What combination of likely and unlikely allies will maximise the chances of a successful outcome? A traditional partnership with a local CSO or NGO? Building broad NGO coalitions? Forging relationships with sympathetic individuals or ministries within the national government? A joint approach with private sector companies?

Approach: What is most likely to influence the target individuals and institutions whose support is necessary to bring about change: is the barrier to change created by laws and policies or social norms, attitudes, and beliefs? Does the issue offer rigorous empirical evidence for the benefits of the change we seek? Would a successful example (e.g. a pilot project or evidence from a neighbouring country) be persuasive? Or is this more likely to be about contestation than cooperation - political mobilisation, numbers of people in the streets, etc.?

Events: Is change most likely to occur around a specific event, whether foreseeable (e.g. an election campaign) or unforeseeable (e.g. a military coup - as in this case study – the death of a leader, a natural disaster, economic crisis or conflict)? How do we prepare for and respond rapidly to the opportunities to promote change created by such 'shocks'?

Complexity: Is the change we seek relatively simple (the government abolishes user fees) or complex and messy (how to help people feel less disempowered and excluded from decision-making)? The former type lends itself to traditional approaches such as demonstration pilots and public campaigning. The latter type is less predictable and requires more improvisation and experimentation, e.g. supporting a range of experiments to identify successful models, competitions, and prizes for good ideas.

Access to Medicines in Thailand: A Case Study in How Change Happens

The Change

In late 2006 and early 2007, the Thai government decided to enforce a public health safeguard policy, known as Compulsory Licensing (CL), to address public health concerns about the cost of patented life-saving medications that included two antiretroviral (ARV) drugs (*Efavirenz and Lopinavir/Ritonavir*), a medication used for the treatment and prevention of cardiovascular diseases (*Clopidogrel*), and four anti-cancer drugs (*Docetaxel, Letrozole, Erlotinib, and Imatinib*). According to the Ministry of Public Health (MoPH), this action, aiming to ensure access to affordable medications in the public sector, complied with the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS)[2] and the Doha Declaration on the TRIPS Agreement and Public Health.[3]

Following this decision, a concerted counter-lobby by the United States, the European Union, and large pharmaceutical companies was fended off by the Thai government, supported by an extensive coalition of allies in civil society, academia and the international arena. The US cleared the way for sanctions by putting Thailand on its 'Priority Watch List' in 2007. Although it officially denied that this step was related to the CL decision, US officials privately admitted that it was one of the concerns that led to the blacklisting measure.

The decision had knock-on effects at both global and national levels. Transnational pharmaceutical companies significantly reduced their ARV drugs' prices in developing countries; the Brazilian government decided to follow Thailand's lead by issuing a compulsory license for the same ARV drug *Efavirenz*; Ecuador in 2010 issued a

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[2] http://www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm.

[3] http://www.who.int/medicines/areas/policy/doha_declaration/en/index.html.

compulsory license for the AIDS drug *Ritonavir*.[4]

In addition, Thailand took the unprecedented step of using compulsory licenses to reduce prices of medications used to treat non-communicable diseases like cardiovascular diseases and cancers, which are severe global health treats. This helps correct the myth that compulsory licensing is merely intended for infectious illnesses like AIDS and the avian influenza.

International organizations (e.g. WHO, World Bank, and UNAIDS) also changed their stance and issued statements to support the right of developing countries to fully make use of TRIPS flexibility in order to address the lack of affordable medications due to barriers created by IP rules.

Impact

Following the decision, the numbers of Thais with access to free ARV drugs rose from 10,000 in 2002 to 200,000 in 2009, (see chart 1).

Moreover, the price of key ARV and heart drugs such as Efavirsenz, Lopinavir-Riponavir, Clopidogrel, Docetaxel and Letrozole fell initially – i.e. between 2005 and 2007 by between 67% and 98%.[5]

According to a recent study by the Thai Health Ministry[6] "The public health benefits of the government use licenses were generally positive". More specifically, the policy helped increase access to

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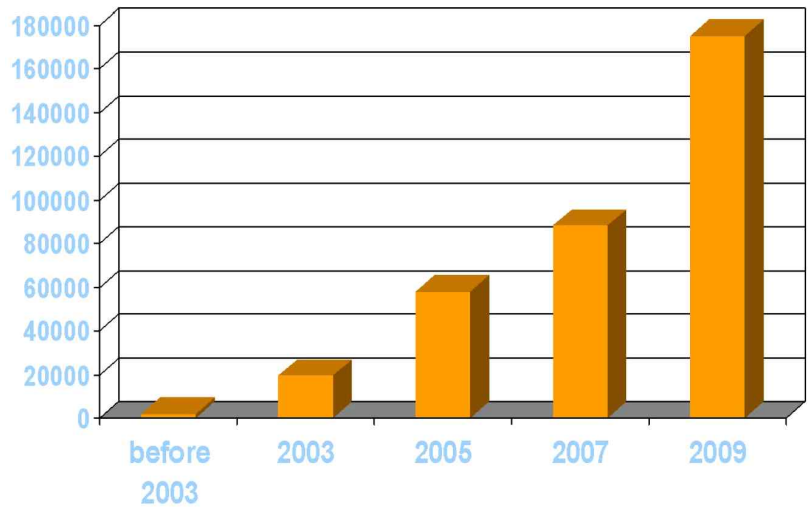
4 http://www.ip-watch.org/weblog/2010/04/22/ecuador-grants-first-compulsory-licence-for-hivaids-drug/.

5 Figures are from Suwit Wibulpolpresert, Thai MOH, quoted in Martin Khor, 2007, "Patents, Compulsory Licences and Access to Medicines: Some recent experiences", Third World Network. a

6 Inthira Yamabhai, Adun Mohara, Sripen Tantivess, Kakanang Chaisiri1, Yot Teerawattananon, 2011, 'Government use licenses in Thailand: an assessment of the health and economic impacts', Health Intervention and Technology Assessment Program [HITAP], Bureau of Health Policy, Thai Health Ministry and Strategy, Ministry of Public Health, Thailand, published in Globalisation and Health, 2011, 7:28.

Chart 1. Numbers of People in Thailand with Access to ARV drugs, 2003-2009[7]



patented drugs, while the impact on trade and investment was "not significant".

The same study also suggested that, as a result of the granting of the government use licenses, "an additional 84,158 patients were estimated to have received access to the seven drugs over five years". The study also found that health-related economic benefits to society arising from the government use licenses, as expressed in terms of the difference between national productivity and health expenditure, was "approximately US$132.4 million, over the five-year period".

Another consequence of the decision is that the state pharmaceutical enterprises have increased their production capacity.

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7 Chalermsak Kittitrakul, Thailand's Experience in Increasing Access to Medicines, October 2010 (powerpoint presentation).

Background and Context

Thailand has a long history of health activism, with active civil society actors using both insider strategies (participating in committees) and outsider strategies (litigation and protests) to influence government policies. This activism has experienced both defeats (US pressure, backed up by the threat of trade sanctions, which led to the introduction of highly restrictive legislation in 1992[8]) and victories (the MoPH agreed to make 1st line ARV drugs free to all by late 2005).

The Constitution of 1997 guaranteed the rights of the Thai people to essential public services, and the health reform has been central to several administrations since then, including the instigation of the Universal Health Coverage (UC) scheme, one of the most popular policies of the Thai Rak Thai government.

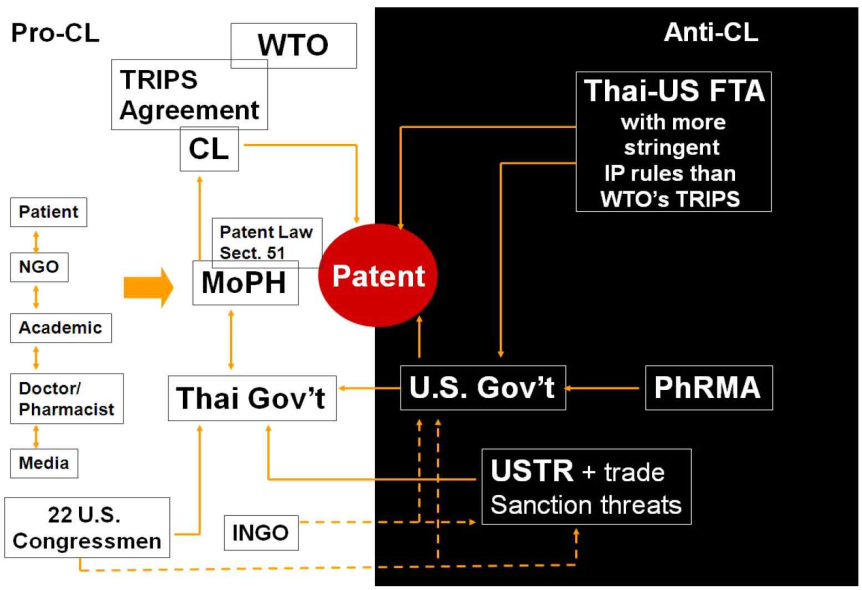
Thailand also has a high incidence of HIV/AIDS, with an estimate of 700,000 people living with the disease as of 2003 (out of a total population of approximately 62 million). However, by the middle of the 2000s, an effective intervention by the government health service had greatly reduced both infection and death rates. Compulsory licensing has been in the Thai Patent Act (Article 51) since 1979, but it had never been used prior to this case.

Power Analysis

Table 1 and Chart 2 provide two graphic representations of the power analysis of the compulsory licensing process.

8 Patent Act number 2, September 1992.

For Compulsory Licensing	*Against* Compulsory Licensing
Ministry of Public Health	US government
Minister of Public Health, Health Minister, Na Songkhla	European Commission (Peter Mandelson an insistent opponent of CL)
Progressive health academics in the 'Drug Study Group' were involved in both supporting the campaign and drafting the first Patent Act and Drug Act	Big Pharma
Thai CSOs and NGOs	
International NGOs, including Oxfam	
The Thai Network of People Living with HIV/AIDS (TNP+), with over 20,000 members	
Allies in US Congress	
The Thai Pharmaceutical Manufacturers Association (TPMA) were not directly or actively involved, but constituted an important domestic group that stood to benefit from CL.	



The Key Periods and Moments in the Change Process

Pre-Compulsory license issuance (1992 – late 2006)

The Thai Patent Act was amended in 1992 under pressure from the US government through the Special 301 Report. As a result, Thailand amended its patent law before the launch of the TRIPS Agreement in 1995, even though the WTO's developing country members were only required to introduce product patenting within six years of the TRIPS Agreement that came into effect in 1995. Thailand's action contrasts with the approach chosen by India, which used every possibility for manoeuvring under the TRIPS agreement in order to build up a world-class generic-drug production capacity. Today, Indian generic manufacturers produce over 67% of the world's generic drugs and 80% of anti-retroviral drugs needed to treat HIV and AIDS.[9]

The Thai civil society's move for the use of compulsory licensing started in December 1999. The network of people living with HIV requested the government to issue a compulsory license on the AIDS drug *Didanosine* (or *ddI*). The government refused the request, but allowed the Government Pharmaceutical Organization (GPO) to step up the production of ARV drugs, including the non-patented powder form of *ddI*. In 2002, the GPO successfully developed a generic cocktail ARV from three off-patent drugs, costing about US$ 30 per month per patient, less than a tenth of the cost of the original drug combination.

After this success, the civil society coalition went on to call on the government to include ARV treatment in the Universal Coverage Scheme. The government initially refused to do so due to the long-term high cost of the treatment, but after protests and lobbying, it announced the inclusion of ARV treatment in the Universal Coverage Scheme at the XV International AIDS Conference in Bangkok in July 2004. The promise was implemented in October 2005.

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[9] personal communication, Chalermsak Kittitrakul

At that time, however, the US government was speeding up negotiations on bilateral trade agreements (Free Trade Agreement or FTA) with developing countries, including the introduction of the 'TRIPS plus' intellectual property protection stricter than the WTO's standard. The FTA negotiations between Thailand and the United States began in June 2004. Civil society groups from various sectors (e.g. people living with HIV, small farmers, organized labor, the Assembly of the Poor) joined forces to run the campaign against the trade negotiations. This campaign became a nation-wide media story when a massive protest happened at the sixth round of negotiations in Chiangmai in January 2006. The protests were claimed to have contributed to the fall of the government through a military coup in September 2006. The FTA negotiations have been suspended ever since the coup.

Compulsory license issuance (late 2006 – early 2007)

Even though the GPO had the capacity to develop and produce a number of basic ARV drugs, and they were included in the health benefit package under the Universal Coverage Scheme (UCS), a great number of people living with HIV needed more-advanced HIV drugs, which were patented, very expensive, and not available under the UCS.

Civil society, including activists and NGOs working on HIV/AIDS issues, kept pushing the government to consider making use of the public health safeguards to reduce the drugs' prices. At the same time, a group of academics had been working on the same issue - access to affordable medications and patents. Both groups had a chance to share experiences and concerns and then join forces to advocate for policies promoting access to medications.

Within the Ministry of Public Health, a number of officials had recognized the need for essential medications at affordable prices and worked behind the scenes to find ways to address this problem.

After the military coup in September 2006, a window of opportunity opened. The new military government stepped in and was

keen to gain support from society before the adoption of a new constitution and the country's transition to democracy. A new Minister of Public Health, Mongkol Na Songkhla, was appointed, who showed considerable determination in addressing the country's health threats.

Government officials sympathetic to the promotion of access to medications backed the Minister, providing academic and legal information that allowed him to enforce the compulsory licensing policy and paving the way to this policy by taking steps to minimize pressures from the pharmaceutical industry and foreign governments and to show sincerity in addressing the lack of affordable medications. To do so, the MoPH had several price negotiation meetings with several large drug companies. Since these companies refused to reduce their prices, the government could argue that it had no choice but to invoke the use of compulsory licensing.

In late 2006 and early 2007, the government issued three non-commercial government-use licenses (or compulsory licenses) on AIDS, heart-disease, and cancer drugs, and, since then, the government has provided those drugs to Thai patients under the national health insurance systems at no cost.

Post-compulsory license issuance (2007 – now)

The issuance of compulsory licenses was followed by the pharmaceutical industry's retaliation and considerable diplomatic pressure from its home governments. Examples of this retaliation included the withdrawal of registration for new drugs in Thailand and letters sent to generic-drug suppliers in India threatening them with legal action if they supplied the medications under the compulsory licensing policy to Thailand. The EU and US governments wrote to the Thai authorities urging them to reconsider and stop the compulsory licensing policy and mentioning that such policies might affect their bilateral economic relationships. Furthermore, Thailand has been on the U.S. Priority Watch List of the IPR violation report (Special 301 Report) since 2007.

After the December 2007 elections returned Thailand to civilian rule, the new government announced a review of the compulsory licensing policy initiated by the previous administration. NGOs, civil society groups, and INGOs joined forces to call on the new Minister of Public Health not to suspend or revoke the policy. He was removed from the position months later (for reasons unrelated to this campaign), and the CL policy remained unchanged.

The EU government followed the U.S. government's model by opening and speeding up the Free Trade Agreement negotiations with the countries in Southeast Asia, including Thailand. Similarly to the U.S. FTA, the EU's version tries to introduce stricter IPR provisions that undermine access to medications at affordable prices.

In another positive change since the CL issuance, the government agreed to the civil society's request to extend the period of the CL issuance on the AIDS drugs until the patents lapse.

The CL movement was bolstered by the heavy-handed response from Abbott, the US pharmaceutical giant, which cancelled applications to market seven of its drugs in Thailand in response to the CL announcement. These drugs included a crucial heat-stable version of the LPV/r HIV/AIDS drug that required no refrigeration. In addition, Abbott threatened not to register any of its new drugs in Thailand in the future. This harsh measure prompted a worldwide condemnation, forcing Abbott to subsequently back down.

After the CL announcement, campaigners worked to win over wavering actors and strengthen the coalition in favor of access to medications. WHO's Director-General Margaret Chan was initially critical of Thailand's use of the CL order, and she urged the Thai government to continue negotiating with the pharmaceutical companies, a position also being pushed by the US. She reversed this position after heavy criticism from developing countries, AIDS groups, and NGOs, and in February 2007 she wrote to the Public Health Minister expressing WHO's unequivocal support.

The MoPH initially met hostility from the Ministry of Commerce

(itself under heavy pressure from the US and Swiss governments) and others fearful of the overall impact on Thailand, but a sustained lobbying effort won them over.

The battle is far from over, however. Pressure from the US and EU continues - via Thailand's continued presence on the US priority watch list, the EU's demands for TRIPS-plus clauses in an EU-Thailand FTA, and the prospect for a global Anti-Counterfeiting Trade Agreement (ACTA) that could broaden the definition of counterfeit drugs to include IP infringements and generics. Leading figures in the campaign see the CL victory as just the latest in a long series of battles, aimed at securing the right to health for all Thais.

Oxfam's Role

Oxfam began to work on the issue in 2003, initially supporting partners to run campaigns. After 2006, it became more active in working with partners, international networking, and direct government advocacy. Throughout, Oxfam's Chalermsak Kittitrakul, (Project Coordinator for HIV &AIDS and Access to Medications), widely known as 'Jockey', played a central role as advocate, networker, strategist, and provider of technical support.

In a complex, multi-actor process such as this, attempting to attribute specific changes to particular players is probably impossible, but a tentative internal evaluation highlights the range of contributions from Oxfam, as well as some weaknesses:

Funding: Oxfam's flexible funding policy was highly appreciated by partners having to respond to a rapidly changing landscape of opportunities

Technical support: Oxfam's expertise, on access to medications, trade negotiations and advocacy and lobbying techniques, was highly valued, for example in connection with the Chiangmai protests.

Global links: Oxfam played an important brokering role, connecting Thai groups to the international media, lobbying in key

capitals, and communicating with companies

Brand: Oxfam's brand (along with that of MSF and other key international allies) had a powerful legitimising impact, 'helping us explain to the world that what we were doing was not illegal, it was humanitarian' in the words of one interviewee.

However, Oxfam's cumbersome internal decision-making processes sometimes prevented it from supporting the A2M movement in fast-moving national debates. Its support for 'reformist' measures such as patent pooling also caused tensions with local civil society organizations that took a more radical anti-patent position.

What kinds of change strategies were involved?

The A2M work in Thailand combined a number of the standard change strategies used by NGOs and others.

Change Strategy	Relevance to the Thai A2M experience
Active Citizenship: People in the streets	Popular mobilization by Thai civil society was at the heart of the change
Active Citizenship: Grassroots leadership	Besides Oxfam's Chalermsak Kittitrakul, a number of dynamic CSO leaders were instrumental
Elites: enlightened leaders	The Minister of Public Health was a crucial driver of change
Elites: evidence-based policy	Sympathetic officials played a vital role
Cross-Class: Democracy works	While A2M did not feature directly in the 2007 election campaign, NGOs and other actors raised the issue of transparency in FTA negotiations, and won concessions
Cross-Class: Coalitions of dissimilar players (e.g. civil society, private sector, sympathetic state officials)	The CL victory was possible thanks to an alliance of Thai CSOs, INGOs, academics, sympathetic state officials and (to a limited extent) domestic drug companies.
Dynamics: steady incremental progress	A decade of civil society campaigning helped change the public and official understanding of the rights of patients, and the quality of generic drugs.
Dynamics: shocks, tipping points and breakthroughs	The military coup created a window of opportunity for the CL decision.
Dynamics: the power of example	The international campaign on access to medicines, and previous work by the Government Procurement Office, showed what CL could achieve, but in many respects, the Thai CL decision was a brave and ground-breaking step

Conclusions and Final Thoughts

The Thai Access to Medications campaign demonstrates a number of features common to many influence-wielding exercises. Firstly, change often occurs through a combination of long-term, incremental change and sudden and unpredictable shocks. In the case of Thailand, the decades of campaigning by the civil society and its allies (academics, journalists, etc.) created the conditions in which a political shock such as the military coup of 2006 could act as the trigger for change.

Secondly, change is not just about mass movements, economic transformation and other 'tides in the affairs of men.' It is also about individuals such as the new health minister or, for that matter, experienced and skilled civil society campaigners such as Jockey.

Finally, change is usually a process, not an event. A subsequent defence of a breakthrough is just as important as winning the initial change – the battle for access to medications in Thailand is far from over.

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