Universal Periodic Review: Austria

Joint Civil Society Submission

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Médecins sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters, and exclusion from healthcare. Our actions are guided by medical ethics and the principles of neutrality and impartiality. Today, MSF works in over 60 countries. MSF speaks out publicly in an effort to bring forgotten crises to public attention and to advocate on behalf of our patients. Through it's Access Campaign, MSF campaigns for access to and the development of life-saving and life-prolonging medicines, diagnostic tests and vaccines for patients in MSF programmes and beyond. The Austrian section of MSF was founded in 1994. In 2014, MSF Austria sent more than 150 medical and non-medical staff to its projects worldwide.

Universities Allied for Essential Medicines (UAEM) is a non-profit organisation founded in 2001 by students at Yale University. Committed to social justice and health equity, we find it unacceptable that millions of people do not have access to essential medicines. UAEM is particularly concerned about people in developing countries who are disproportionately affected by the access to medicines crisis. As a global movement of university students, UAEM campaigns for improved access to medicines in low- and middle-income countries through changed patenting and licencing norms, and ensuring university research meets the needs of people worldwide.

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1. Introduction

Achieving the human right to health is a global challenge. Indeed, as the Alma-Ata Declaration states, "the attainment of health by all people in one country directly concerns and benefits every other country".[2] By calling for "international assistance and cooperation, especially economic and technical", the Convention on Economic, Social and Cultural Rights, and subsequent conventions and resolutions, demand an international response to secure the global right to health.[3]

Today, access to medicines, and thus the right to health, remains a distant goal, particularly in low- and middle-income countries. Prohibitively high prices, amongst other factors, limit the number of people able to afford treatments, and the number of patients that can be treated by non-profits such as MSF. Meanwhile, health care workers are faced with a vast number of diseases for which no adequate treatment options exist due to a chronic lack of medical research and development for poverty related and neglected diseases.

As profoundly global challenges that infringe upon the global right to health, MSF and UAEM believe the international community must respond in line with its global human rights commitments. As non-profits actively engaged in global public health, MSF-Austria and UAEM believe that Austria has not been adequately fulfilling its obligation to "take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization" of the right to health and the inherent dignity of the human person.[4]

2. The Global Right to Health

The Convention on Economic, Social and Cultural Rights (henceforth referred to as "the Convention") offers the most comprehensive, and for ratifying states legally binding, enshrinement of the global right to health. [5] General Comment Number 14, Article 33 to the Convention clarifies the specific obligations of signatory states regarding implementation.[6] Firstly, states have an obligation to respect the human right to health, meaning, "to refrain from interfering directly or indirectly with the enjoyment of the right to health". Secondly, states have an obligation to protect the right to health, meaning, "to take measures that prevent third parties from interfering with article 12 guarantees". Finally, states have an obligation to fulfil, meaning, "to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health".[7]

The imperative conditions for securing the right to health are further clarified in General Comment 14, comprising the physical and economic access, availability, acceptability and quality of medicines.[8] Reports by the Special Rapporteur on the right to the highest attainable standard of physical and mental health have reiterated this imperative on multiple occasions, as have, Human Rights Council Resolution 12/27, the Commission on Human Rights Resolution 24/14 and multiple further resolutions, particularly those pertaining to the HIV/AIDS pandemic.

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[2] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978, Article IX.
[3] Convention on Economic, Social and Cultural Rights, January 1976, Article 1.
[4] *Ibid.*, Article 2.1.
[5] *Ibid.*, Article 12.
[6] General Comment No. 14, The right tot he highest attainable standard of health, May 2000, Article 33.
[7] *Ibid.*
[8] *Ibid.,* Article 12..a-d.

International cooperation and mobilisation are meanwhile enshrined in Article 56 of the United Nations Charter. In relation to the global right to health, the Convention emphasizes the need for international cooperation in Articles 2, 15 and 23, as well as in General Comments 2 and 3. Various United Nations initiatives, to which Austria has assented, such as the Millennium Development Goals, have further codified this international commitment to attaining the global right to health.

3. Access to Affordable Medicines: Accessibility

Globally, more than 2 billion people do not have access to the medicines they need in order to lead healthy, dignified and productive lives.[9] With pricing and infrastructure being major limiting factors, patients in low- and middle-income countries are particularly at risk of not being able to access the medical treatment taken for granted in wealthier countries.

Low and middle-income countries pledged to increase their health financing to 15% of their budgets in the Abuja Declaration. [10] Austria, as signatory of the Convention on Economic, Social and Cultural Rights, has meanwhile committed itself to promote the global right to health, through technical assistance, judicial and policy measures. As funding shortfalls persist, sustainable and substantial overseas aid programmes are essential to overcoming still prevalent barriers to access to medical care posed by deficient medical infrastructures. MSF witnesses, on a daily basis, what the absence of such structures means for patients in the settings in which we work.

The high price of medical care, and medicines in particular, pushes 100 million people into poverty each year, and prevent hundreds of millions more from affording the medical care they need. [11] The cost of medicines is significantly impacted by the availability of generic medicines, which in turn relies on favourable patenting and trade policies. Austria's commitment to protect the right to health thus also requires the defence of access to affordable medicines on global trade platforms, as set out by the Doha Declaration. [12]

3.1. Austria's Engagement

Austria's international promotion of the right to health through technical and financial assistance remains limited. Despite being a signatory of the Monterrey Consensus, Austria's overall overseas development aid (ODA) contributions remain far below the agreed 0.7% of gross domestic product (GDP), at approximately 0.28% in 2013.[13] Health related spending in Austria's ODA has been low for a number of years and appears to be reducing further.

Bilateral funding for health projects is at an all time low. Austria's total global public health financing collapsed in 2013 to only 49.5 million US Dollars after reaching an all time high of 99 million US Dollars in 2012.[14] Austria's bilateral financing of HIV programmes is illustrative of this funding shortfall, amounting to just 92,937 US Dollars over four projects in 2013.[15] Importantly, Austria's overseas development aid agenda, published by the Austrian

[9] Access to Medicines Index, 2014
[10] WHO, Abuja+10 Evaluation Report, 2011.
[11] WHO, The Right to Health, Factsheet No. 323, 2013.
[12] WTO, Doha Declaration on the TRIPS Agreement and Public Health, November 2001.
[13] OECD/DAC Statistics QWIDS Database
[14] OECD/DAC Statistics, QWIDS Database
[15] OECD/DAC Statistics, QWIDS Database

Development Agency for the period 2013-2015, places no emphasis on global public health.[16] Health related concerns are only referenced in relation to HIV programming in Armenia, which in 2013 was financed with just 39,830 US Dollars.[17]

Austria provides little to no financial contribution to multilateral bodies working to secure the global right to health. Most notably, the Austrian government has made no contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria since it's founding contribution of 1 million US Dollars in 2001.[18] In 2013, Austria contributed just €1,000 to the Joint United Nations Programme on HIV/AIDS (UNAIDS) through it's ODA budget.[19] Other than Austria's membership contribution to the WHO (€3.45 million), no financial contributions were made to any other specifically health related development or humanitarian multilaterals.[20]

Austria's protection of the right to health has also remained limited in the face of threats posed through trade platforms. Free Trade Agreements (FTAs), negotiated bi- and multilaterally, have a major influence on the global access to medicines. Clauses pertaining to patent protections beyond the TRIPS Agreement (trade-related aspects of intellectual property rights, WTO) and the Doha Declaration, and those pertaining to trade regulations, are of particular concern. Austria is signatory of a number of FTAs, both bilaterally and multilaterally. A number of further FTA negotiations are underway; of particular note are TTIP, CETA and the EU-India trade agreement. Aspects of all these treaties threaten to interfere with the enjoyment of the right to health by placing major restrictions on generic drug manufacturing and trade.

Austria's record of protecting the global right to health has been mixed during FTA negotiations. Austria tends to engage broadly in line with the European Commission's position, which in turn has been frequently criticized for threatening the global right to health and access to affordable medicines. Importantly, Austria has also abstained repeatedly from votes of the Human Rights Council relating to the protection of the access to medicines and the full use of Doha Declaration TRIPS flexibilities (e.g. Human Rights Council Resolution 23/14, 24th June 2013).

3.2. Global Impact Testimony

The access to medicines crisis is vast, and impacts patients suffering from and at risk of a wide variety of life threatening and life limiting diseases, including neglected diseases such as Chagas, Dengue, Trypanosomiasis and a number of poverty related diseases such as HIV, Malaria and Tuberculosis. The prevalence of these human rights challenges is well documented, and too vast to cover in its entirety in this submission. As an illustrative example, the following discussion of HIV/AIDS gives an insight into the importance of sustainable international financing, technical support and trade policies.

Global Crisis

According to the WHO, 35 million people are living with HIV.[21] Antiretroviral (ARV) therapy offers the best treatment to HIV positive people, suppressing the virus and thus the progression of the disease. Of the 28 million eligible for antiretroviral treatment under the

[16] Austrian Development Agency, Three-Year Programme 2013-2015, December 2012.
[17] OECD/DAC Statistics, QWIDS Database, (Bilateral HIV Funding- CRS Micro data).
[18] The Global Fund to Fight AIDS, Tuberculosis and Malaria, Government Donor Pledges 2002-2016.
[19] Austrian Ministry of Finance, 2013 EZA Budget
[20] Austrian Ministry of Finance, 2013 BMG Budget.
[21] World Health Organisation, HIV/AIDS Factsheet, Factsheet No. 360, November 2014.

WHOs consolidated treatment guidelines, only 11.7 million have access to it.[22] This puts global antiretroviral coverage at only 38% amongst adults.[23] Among children, coverage is even lower, at approximately 24%.[24] Médecins sans Frontières provides 331,005 people with ARVs (first and second line treatment) in a total of 20 countries.

Financing Infrastructure Rollouts

Over 70% of HIV positive people live in sub-Saharan Africa, many in resource poor settings.[25] The current lack of secure infrastructures, advanced diagnostic equipment and community-based models of care is drastically limiting the number of patients able to maintain a long term, effective ARV treatment. In Gutu district in Zimbabwe, a sparsely populated rural area where 7 in 10 people are HIV positive, most live 10 to 20km from the nearest clinic with some as far as 46km away. MSF has been on the frontline of introducing decentralised and innovative care programmes, and has witnessed dramatic improvements in long-term care retention of these patients. The rollout of such life saving initiatives beyond MSF programmes have however been hampered by funding shortfalls. This is despite the fact that a recent investigation conducted by MSF demonstrates that innovative decentralized models of care are more cost-effective in the long run. [26]

Financing Advanced Treatments

Current ARV-coverage rates are made possible through access to cheaper generic therapies, whose introduction secured a significant price drop. Today, the price of recommended regimens is approximately 140 US Dollars per patient per year, while in 2000 a first line ARV therapy cost approximately 10,000 US Dollars.[27] However, pricing has once again become an issue in low -and middle-income countries. A recent report published by MSFs Access Campaign revealed that today, second and third line regimens can cost up to 15 times more than first line regimens.[28] The Democratic Republic of Congo (DRC) has experienced funding shortfalls for a number of years. In MSF's HIV clinic in Kinshasa, 80% of patients arrive after the disease has already progressed to clinical stages 3 or 4.[29] Second and third line treatments are frequently still under patent protection, increasing costs, and thus reducing access significantly. There is an evident demand for not only increased financing to cover rising costs, but also sustainable patent policies.

International Pressure: Free Trade Agreements

Today, approximately 80% of the antiretrovirals used in sub-Saharan Africa are generics produced in India. Yet, developing countries continue to be challenged by policies that threaten to overwhelm their ability to purchase these affordable generics. Particularly middle-income countries, in which three quarters of the world's poor live, are increasingly put under pressure through FTAs to limit their use of patent flexibilities that allow the manufacturing and trade of generics between countries. MSF and UAEM are particularly concerned about FTA provisions which increase patent length and thus defer the earliest possible date at which affordable generic medicines can be made accessible to poor people. Furthermore, MSF has had direct experiences with strict in-transit policies that make the essential trade and transport of life-saving medicines between producers and patients increasingly difficult. The EU, of which Austria is a member, is actively involved in efforts to

[22] *Ibid.*
[23] UNAIDS, Fast-Track: Ending the AIDS Epidemic by 2030, 2014, p.7
[24] *Ibid.*
[25] World Health Organisation, HIV/AIDS Factsheet, Factsheet No. 360, November 2014.
[26] MSF Internal Investigation, Ärzte ohne Grenzen Pressemitteilung: „Welt-Aids-Tag: Behandlungsansatz muss radikal umgestaltet werden", 20. November 2014.
[27] MSF, Untangling the Web of Antiretroviral Price Reductions, 17th Edition, July 2014.
[28] *Ibid.*
[29] MSF, Issue Brief: Pushing the Envelope, July 2014

introduce such measures, for example through the EU-India Free Trade Agreement currently under negotiation. Should this agreement limit India's ability to utilize TRIPS flexibilities, it's standing as "pharmacy of the world", and as such the global access to affordable medicines, would be further undermined.

3.3. Evaluation

Austria's annual ODA places it in 11th place amongst EU member states, both in terms of the annual sum and in terms of percentage of GDP.[30] At 0.28% of GDP, Austria's current annual ODA budget is still significantly below the 0.7% target originally signed onto in 1970.[31]. Despite Austria's commitment to achieving the 0.7% threshold by 2015 during it's last Universal Periodic Review, Austria will not attain this goal by the end of 2015 given its current levels and ODA strategy.[32]

Health remains a dangerously small element in Austria's ODA-Strategy, making up a total of less than 4% of its already low aid budget.[33] According to the OECD's statistics, Austria provided only 92,937 US Dollars in bilateral funding for the fight against HIV/AIDS. This amounts to 0.027% of the bilateral HIV funding provided by EU-DAC members, and 0.0018% of bilateral HIV funding provided by all DAC members combined.[34] To offer a comparison: Austria's GDP amounts to 2,39% of the former cohort's GDP, and 0,94% of the latter's.[35]

Austria's failure to contribute to multilateral organs such as the Global Fund stands opposed to countries of much smaller GDPs making significant contributions for a number of years, such as Ireland and Rwanda.[36] Norway, a DAC member of similar economic power as Austria, has provided 847,719,656 US Dollars since the Global Funds founding.[37] All these examples illustrate that Austria is investing significantly less than it's international counterparts in global health. Austria is thus failing to promote the human right to health in line with its human rights obligations to do so commensurate with its available resources.

During FTA negotiations, Austria has meanwhile failed to demonstrate active protection of access to medicines and the global right to health. By aligning itself with the European Union, specifically the Commission, on matters pertaining to access to medicines in FTAs, Austria has made a *de jure* commitment to protecting the right to health. Despite this, various Commission directives and suggested FTA texts have repeatedly illustrated that access provisions are deprioritized in the face of perceived economic gain. Extended patent periods, expanded patent and trademark enforcement as well as investment clauses have all been tabled by the European Union in negotiations of the EU-India FTA. In this respect, Austria has arguably also contributed to a failure to respect the right to health at an EU level.

Where Austria has openly taken positions alternate to those advocated by the Commission, such as the Foreign Ministry's recent communications regarding investor state dispute settlement provisions in the TTIP agreement, these positions are not justified in light of any human rights or global health perspectives. This reconfirms the wider perception that the

[30] AidWatch 2014
[31] United Nations General Assembly, Resolution 25/2626, October 1970.
[32] Report of the Working Group on the Universal Periodic Review: Austria (A/HRC/17/8/Add.1), Art. 93.33. Austrian Development Agency, Three-Year Programme 2013-2015, December 2012.
[33] OECD/DAC Statistics, QWIDS Database
[34] OECD/DAC Statistics, QWIDS Database. Own Calculations.
[35] World Bank
[36] Global Fund to Fight AIDS, Tuberculosis and Malaria, Donor Spreadsheet, 2014.
[37] *Ibid.*

Austrian government suffers from a significant deficiency in political will with regard to the promotion and protection of the global right to health.

3.4. Recommendation

In light of Austria's limited engagement in the field of global public health and access to medicines, MSF and UAEM make the following concrete recommendations:

Austria should intensify its national and international engagement to improve global access to essential medicines.

Austria should significantly increase its annual ODA to reach the 0.7% threshold. This financing should be sustainable and predictable.

Austria should also commit to increasing specific ODA spending on the promotion of the global right to health, through bilateral and/or multilateral mechanisms.

In order to secure broader access to HIV treatment, Austria should include HIV/ADS care in it's budget for humanitarian aid. Furthermore, the humanitarian aid budget should be secured within a clear legal framework and dissociated from ad-hoc legislative practices.

Austria should make financial contributions commensurate with its economic power to major multilateral mechanisms engaged in the fight to secure a global right to health, such as the Global Fund.

Austria should proactively protect access to medicines during bilateral and multilateral FTA negotiations, by promoting the use of TRIPS flexibilities and politically supporting those countries that utilise them (e.g. through compulsory licencing).

4. Access to Affordable Medicines: Availability

More than a billion people worldwide, including 500 million children, are affected by the diseases on the WHO's list of neglected diseases alone, not including HIV, malaria or tuberculosis.[38] These diseases are characterized by a profound lack of treatment and diagnostic options combined with limited scientific knowledge. For patients, this often means difficult, painful and ineffective treatments or even no available treatment at all. For health care workers, it drastically limits the arsenal of possible medicines that could be used to restore a patient's health.

The common denominator amongst these varied infections and illnesses, from leishmaniasis to sleeping sickness and tuberculosis, is their status as poverty-related. The vast majority of individuals suffering from these life-limiting and life-threatening diseases live in resource-poor settings and would often be too poor to pay for expensive treatment options.

Today, profit is the main incentive for conducting pharmaceutical research and development (R&D). In the eyes of most pharmaceutical companies, patients without established medical insurance or adequate financial security do not represent enough purchasing power to warrant the initial investment required to develop new pharmaceutical tools. This has led to a situation in which, between 2000 and 2011, only 4 out of 336 new chemical entities approved

[38] Drugs for Neglected Diseases Initiative

were for the treatment of neglected diseases.[39] Only around 1% of clinical trials target neglected diseases. It is estimated that neglected diseases meanwhile make up around 12% of the global disease burden. [40]

In instances of market failure, the onus is on governments to incentivise the R&D essential for the attainment of the right to health. Today, however, scientific research conducted in public institutes, non-profit product development partnerships (PDPs) and through other innovative funding mechanisms, is chronically underfunded. This global challenge must be addressed globally, through existing and new R&D infrastructures.

4.1. Austria's Engagement

The Austrian government finances research at public research institutes and universities through funding institutions, the most sizeable of which is the FWF. The FWF's budget for the financial period 2016-2018 is a sizeable €550 million for all subject areas of scientific research. [41] In 2013, the FWF provided €80.2 million in financing for the broadly categorized life sciences. This included a total of €2.7 million for clinical studies, €1.5 million for pharmacology and toxicology, as well as €7.3 million for hygiene and medical microbiology.[42]

Importantly however, a minimal amount of this funding flows into research of relevance to neglected diseases. Currently, the FWF is financing fourteen research projects of varying relevance to neglected diseases, HIV, malaria, or tuberculosis.[43] When calculating the annual financing at current levels according to the active research projects (value and research period), the FWF is providing just €69,373.90 each year to neglected disease research at Austrian institutions.[44]

Central to this underfunding is that no research calls have ever been issued with specific reference to neglected diseases or global public health, and no ring-fenced funding exists for research in this field in Austria. This means biomedical researchers seeking to finance research projects in the field of neglected diseases are forced to apply to more general funding where chances of selection are much slimmer. Here, funding bodies tend to prioritize research in areas that receive the most public attention. In the absence of funds specifically dedicated to research in poverty related diseases, competition against projects related to diseases highly prevalent in high-income countries, such as cardiovascular disease, dementia or cancer, can be overwhelming.

Increasingly, scientists and researchers are turning to international funding opportunities in order to finance neglected disease research at Austrian institutions, predominantly through the European Union and partner universities. But even as a member of the European Union, Austria's engagement remains limited. Despite its membership of the European & Developing Countries Clinical Trials Partnership's (EDCTP) governing structure, Austria provided just €1,572,000 (or 0.2%) of the partnerships funding between 2003-2013**.** [45]

[39] Pedrique et al. "The Drug and Vaccine Landscape for Neglected Diseases (2000-11): a Systematic Assessment", The Lancet Journal of Global Health, pg. e371-79, (2013).
[40] *Ibid.*
[41] FWF
[42] FWF Annual Report 2013
[43] Research projects tagged with any neglected disease, HIV, TB or Malaria in the FWFs Database.
[44] Total Sum of Ongoing Projects / Total Project Length
[45] EDCTP Annual Report 2013.

The Austrian government provides no funding through its international development aid or its research ministry to non-profit product development partnerships, such as DNDi, who specialise in research and development of neglected disease diagnostics and treatment.

4.2. Global Impact Testimony

Kala Azar, a neglected disease also known as visceral leishmaniasis, is transmitted by sand flies. Of the 200,000-400,000 yearly cases, 90% occur in Ethiopia, Bangladesh, Brazil, India, South Sudan and Sudan.[46] Left untreated, Kala Azar leads to high fevers, dramatic weight loss, swelling of the liver and spleen, and anaemia, usually resulting in death. In Africa, diagnosing Kala Azar requires microscopic analysis of spleen or bone marrow tissue, while treatment requires painful injections and infusions. Without skilled staff and an established infrastructure, the treatment of Kala Azar outbreaks is very difficult. In South Sudan, MSF has been witnessing regular outbreaks of the disease, reaching their peak during the rainy season. In contexts such as this, treatment is especially difficult for both doctors as well as patients, who have to travel long and dangerous distances to reach health posts. Without research and development of new diagnostics and adapted treatment options, the situation for these patients will remain dire.

Drug resistant tuberculosis (DR-TB) is another public health crisis threatening to escalate further if no new treatment options (antibiotics) are developed. Antibiotic research and development peaked between the 1950s and 1970s following substantial public funding. This was followed by decades of inactivity and R&D stagnation. Although two new medications have recently come onto the market, they remain difficult to implement in clinical settings particularly due to the still lacking trials about their use as part of complete treatment regimens. Yet resistances to standard treatments have been spreading at an alarming rate, particularly in Africa, Asia and Eastern Europe. MSF runs two projects in Uzbekistan, in Tashkent in the Southeast und Nukus in Karakalpakstan. Here, MSF diagnoses multiple-drug-resistant tuberculosis (MDR-TB) in up to 40% of patients who have never been treated for TB before. [47]

Current treatments for DR-TB are arduous and ineffective requiring six months of painful injections and more than 14,000 tablets, all while enduring serious side effects ranging from psychosis to permanent hearing loss. Cure rates remain dismally low, with only a 50% success rate for MDR-TB, only 13% for extensively resistant TB (XDR-TB). For children, these statistics are even more worrying. No adequate diagnostic tests exist for paediatric TB, and very few TB-drugs are available in paediatric dosages.

These realities are only illustrative of the difficulties faced by patients and doctors confronted with the diseases neglected by pharmaceutical R&D. Concentrated efforts in countries with existing biomedical research infrastructures and through collaboration with global partners is essential to finding solutions to this pressing human rights issue. However, the innovative financing and incentivisation mechanisms that could stimulate this progression, such as milestone prizes and ring-fenced-funding, remain underfunded and unimplemented in the Austrian context.

4.3. Evaluation

Restricted public funding opportunities have hugely limited Austria's engagement in neglected disease research. While the expertise and eagerness to conduct research on topics

[46] World Health Organisation, Leishmaniasis Factsheet Factsheet No. 375, 2014.
[47] MSF, Out of Step: Deadly Implementation Gaps in the TB response, October 2014

such as Malaria and HIV are very much present at Austrian research institutions, they have, in UAEM's experience, struggled to attract adequate financing within Austria.

An increased number of European countries, such as Sweden and the Netherlands, have instituted financing mechanisms specifically to subsidize research in the field of neglected diseases. It is in areas where the traditional R&D system has failed that the creation of such funds is central to securing medical innovation to promote the global right to health. On a European level, Austria's minimal financing in the field of neglected disease R&D stands opposed to the financial commitments made by it's European counterparts. Austria's annual financing (at 2013 levels) of less than €70,000 stands opposed to countries such as Sweden (7.55 million US Dollars), the Netherlands (25.9 million US Dollars), and the United Kingdom (120 million US Dollars).[48]

Meanwhile, Austria is failing to provide significant funding to the product development partnerships heavily involved in finding solutions to these challenges outside of traditional R&D structures. Austria's contribution to EDCTP was the lowest of any of it's contributing members, representing just €1.574 million of the €842.104 million budget between 2003-2013 (0.2%). In real terms, this means Austria contributed less than Luxembourg, Portugal, Ireland, Greece, and Denmark despite having a considerably higher GDP. To illustrate this further: Ireland's contribution is 12 times that of Austria, despite Austria's GDP being 1.85 times larger than Ireland's in 2013.[49]

The World Health Organisation's Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) has recommended that all countries should commit to spend at least 0.01% of GDP on government-funded R&D devoted to meeting the health needs of developing countries.[50] In light of Austria's GDP, this would amount to an annual investment of approximately €42.8 million (at 2013 GDP levels).[51] When combining Austria's national neglected disease financing and its equivalent annual contribution to EDCTP between 2003-2013, Austria is only providing 0.5% of this sum.[52]

As an organisation made up on young scientists, medical, pharmaceutical and law students, UAEM also wishes to emphasise the consequences the current situation has on fostering younger generations of medical and pharmaceutical researchers. With funding shortfalls and drastic cuts, perspectives in the field of neglected disease research are incredibly limited, forcing many young students to focus on alternate specialisations or consider leaving Austria. The longer the current situation persists, the lower the chances that Austria will be able to make a significant contribution to securing the global right to health within its own research infrastructure in the future.

4.4. Recommendation

In light of Austria's limited engagement in the field of global public health and access to medicines, MSF and UAEM make the following concrete recommendations:

Austria should intensify its national and international engagement to support R&D on neglected diseases.

[48] G-Finder, Policy Cures, Financial Year 2013 Dataset.
[49] Own Calculations based on EDCTP Annual Report 2013 and World Bank Statistics. (Austria: $428tril GDP/ €1.57m. Ireland: $232tril GDP/€19.9m EDCTP)
[50] WHO, CEWG, Report by the Secretariat (A/CEWG/3), 2012.
[51] Own Calculations based on World Bank Statistics (Austria's GDP 2013: €428,321,897,648)
[52] Own Calculations based on World Bank Statistics

Austria's overall financial contribution to R&D to address poor countries' health needs should be raised incrementally in line with the WHO-CEWG recommendation of 0.01% of GDP. In Austria, this would amount to approximately €42.8 million annually, to be invested nationally and internationally.

Austria should ring-Fence public funds for research and development in the field of poverty related diseases, either through the creation of a special fund, or through specific calls for research proposals through the FWF.

Austria should significantly increase its contribution to the EDCTP's next financing phase, to a level commensurate with its economic power. A sum of no less than €10 million should be invested between 2014-2020, with the aim of securing the EU's matched funding commitment of €1 billion.

Austria should engage in capacity building efforts in Austrian and partner universities' research infrastructures for neglected diseases. Importantly, this should include the financing and implementation of CEWG Demonstration Projects of alternative incentivisation mechanisms.[53]

Austria should finance product development partnerships such as DNDi. Non-profit product development partnerships offer one of the best chances to attain specific R&D goals in the field of neglected diseases.

Austria should ensure all medical research financed through public funds is developed with equitable access to medicines provisions. Ensuring publicly financed research outcomes remain publicly accessible regardless of patient wealth is central to providing sustainable solutions for patients around the world.

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Annex

List of Abbreviations

ARV – Antiretroviral
CETA – Comprehensive Economic Trade Agreement (EU & Canada)
CEWG – Consultative Expert Working Group of Research and Development
DAC- Development Assistance Committee
DNDi – Drugs for Neglected Diseases initiative
DR-TB – Drug-Resistant Tuberculosis
EDCTP – European and Developing Countries Clinical Trials Partnership
EU – European Union
FTA – Free Trade Agreement
FWF – Fonds zur Förderung wissenschaftlicher Forschung (Austrian Science Fund)
GDP – Gross Domestic Product
GFATM – The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV/AIDS – Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
MDGs – Millennium Development Goals
MDR-TB – Multiple Drug Resistant Tuberculosis
MSF – Médecins sans Frontières (Doctors without Borders)
NTDs – Neglected Tropical Diseases
ODA – Official Development Assistance
OECD – Organisation for Economic Co-Operation and Development
PDPs – Product Development Partnerships
R&D – Research and Development
TB - Tuberculosis
TRIPS – Agreement on Trade-Related Aspects of Intellectual Property Rights (WTO)
TTIP – Transatlantic Trade and Investment Partnership
UAEM – Universities Allied for Essential Medicines
UNAIDS – Joint United Nations Programme on HIV/AIDS
WHO – World Health Organisation
WTO – World Trade Organisation
XDR-TB – Extensively Drug Resistant Tuberculosis

Further Reading

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