Prescription for the People
Quigley, Fran

Published by Cornell University Press


For additional information about this book
https://muse.jhu.edu/book/56377
Tobeka Daki lived with her two sons in the Mdanstane Township in the Eastern Cape province of South Africa. Her youngest son, Khanya, is eleven years old. She was a breast cancer patient, struggling with a particularly aggressive strain of the disease known as HER2.\(^1\)

Trastuzumab is a medicine that is effective in treating HER2-positive breast cancer.\(^2\) Marketed under the brand name Herceptin by the pharmaceutical company Roche, the medicine is so successful at improving survival rates for HER2 patients such as Tobeka that the World Health Organization has placed it on its “Essential Medicines List,” an exclusive category of drugs that are considered necessary to meet the minimum medicine needs for a basic health care system.\(^3\) The development of trastuzumab was so impactful that the story was turned into a Lifetime TV movie, *Living Proof*, starring Harry Connick Jr. as the physician whose research helped show that the medicine would benefit cancer patients. Herceptin has become one of the best-selling prescription drugs in the world.\(^4\)
The cost to manufacture a year’s worth of trastuzumab, the recommended length of treatment for a patient such as Tobeka, is about $176. Yet that same amount of medicine is sold by Roche in South Africa at a price of about $34,000. The company holds the South African patent for the medicine until 2033; this means that there are no competitors to push Roche to lower the price. Roche sells over $6 billion of the medicine each year.

The $34,000 price tag for trastuzumab was far more than Tobeka could pay. The same goes for the vast majority of other HER2-positive breast cancer patients in South Africa, where the per capita income is $6,800. Few private insurers cover the drug. The public-sector health care system so rarely provides trastuzumab that physicians in that system usually do not even tell their HER2 patients about the existence of the drug.

When I spoke with Tobeka in March 2016, she explained that her cancer had recently spread to her spine, so she had officially reached the Stage 4 level. Her sons were distraught. One of her fellow patients, with whom she had grown close, had died five days before. “Thousands of people in South Africa die because they cannot access this medicine,” she said. Tobeka Daki died in November, 2016. She never received trastuzumab.

The story of Tobeka, Roche, and trastuzumab is just one version of a story that can be repeated for millions of patients and hundreds of lifesaving medicines across the world. The fact that this particular story is set in South Africa is sadly ironic. South Africa was the center of the historic struggle to dramatically increase access to HIV/AIDS drugs, a struggle described in the conclusion of this book. By challenging patent medicine monopolies, South African activists won a victory that ensures that millions of Tobeka’s countrymen and countrywomen receive affordable antiretroviral therapy for HIV/AIDS.

But trastuzumab and many other medicines remain protected by patents and priced out of reach. Some say that means that medicine activists won the HIV/AIDS treatment battle but have lost the broader access-to-medicine war. But others say the victory won for HIV/AIDS medicines is possible for other kinds of drugs, too. Lillian Dube, also a South African woman with breast cancer, was struck by the sight of her fellow patients, such as Tobeka, going without the medicine they need. “I am with young women (at our doctor). These are women who are 40, 30, and they have small children,” Dube says. “And they have to lose their lives because they cannot afford Herceptin. It should not be like that.”
As I show in this book, there are dozens of reasons why Lillian Dube is right: it should not be like that. And there are many activists such as Lillian Dube who are working to change the system. “Until I die, I’ll be fighting this,” she says.\textsuperscript{15}

Ahmed is a little boy, and he is dying. He could be in India or Nigeria or Haiti. And he could be dying from pneumonia or diarrhea or measles.

Unlike Tobeka Daki, Ahmed is not one particular person. He cannot tell his story to an interviewer. He lays anonymous, engulfed in fever, in a hut in a remote village or in a shack in a teeming urban slum. Neither his family nor his government could afford to give him the immunizations that would have prevented his illness. And they cannot afford the antibiotic medicines that would help him survive now.

One out of every five children living in poor countries never receives even the most basic package of vaccinations.\textsuperscript{14} Millions do not have access to antibiotic drugs.\textsuperscript{15} Ahmed is one of 6 million children in low- and middle-income countries who will die from an infectious disease this year.\textsuperscript{16} Chances are that his disease is pneumonia because that is the leading cause of childhood death, in large part because three out of four of the world’s children have not been vaccinated against it.\textsuperscript{17}

There are massive global efforts to expand the vaccination of children, such as Ahmed. Gavi, the Vaccine Alliance, leverages funding from the Bill and Melinda Gates Foundation and from other public and private sources, to immunize millions of children in low-income countries.\textsuperscript{18} MSF delivers nearly 7 million doses of vaccines each year.\textsuperscript{19} But even these efforts were not enough to reach Ahmed, and they will not reach millions of other children.

The biggest reason is the cost of the medicines. Dr. Greg Elder, deputy director of operations for Médecins Sans Frontières, says, “The rising price of the basic vaccines package means that we can’t afford to protect kids living in crisis.”\textsuperscript{20} That price for a full package of vaccines in 2014 was sixty-eight times what it was in 2001.\textsuperscript{21} The most expensive vaccine in that package is the pneumococcal vaccine, which generates almost $7 billion in sales each year for the pharmaceutical corporations GSK and Pfizer, which control the market for the drug.\textsuperscript{22} In late 2016, a determined multiyear advocacy campaign led by MSF finally succeeded in convincing the two chief producers of the pneumococcal vaccine to lower the prices.
they charged humanitarian organizations. But advocates cautioned that, even after the price drop, the vaccine was still unaffordable in many poor countries.23

Tobeka and Ahmed are not isolated examples. The UN World Health Organization says that one-third of the world’s population do not have access to essential medicines.24 Other UN health officials estimate that 10 million people die each year because they do not receive the medicines that would have saved them.25 That adds up to one person dying every three seconds—more people each year than the entire population of New York City.

The World Health Organization and others can categorize that number by the diseases that are left unchecked. Over a million die each year from tuberculosis, and a million-plus more from AIDS, malaria, and hepatitis.26 Those dying from infectious diseases such as these tend to be younger, like Ahmed. But millions more, like Tobeka, die prematurely from untreated noncommunicable diseases such as cancer, cardiovascular disease, and diabetes.27

The 2015 annual report of the World Health Organization sounds like a broken record repeating the same tragic notes:

- Access to medicines for noncommunicable diseases “is still very poor in many low- and lower-middle income countries.”28
- A majority of newborns who need hepatitis B immunizations do not get them, and most cancer patients who need chemotherapy do not get that either.29
- New cancer and hepatitis medicines are enormously effective, but as we have learned (chapters 1 and 2), they are “largely unaffordable while under patent, even for many high-income countries.”30
- For diabetes patients in low-income countries, “essential medicines are frequently unavailable or unaffordable.”31 Same goes for patients in need of mental health medicines.32

Even when the lack of medicines is not immediately fatal, it often makes survival a miserable experience: billions of people lack access to opioid analgesics that can ease the excruciating pain of diseases such as cancer.33 Those lucky enough to be able to buy essential medicines often make enormous sacrifices to do so. As much as 90 percent of people in low- and
middle-income countries pay out of pocket for their medicines, making it the second-largest family expenditure after food. In these countries, medicine costs account for nearly half of all health care spending, drawing resources away from hiring doctors and nurses, building clinics, and buying other supplies.

This crisis has not gone unnoticed. Thomas Pogge, a Yale University philosopher, calls this poverty-induced suffering and death “the morally pre-eminent problem of our age.” The global community has recently agreed on a set of Sustainable Development Goals that includes achieving universal access to essential medicines. In 2015, the UN secretary-general convened a High-Level Panel on Access to Medicines, emphasizing the urgency of the situation, and the panel issued a report underscoring that millions are dying of treatable diseases because they cannot access needed medicines.

But the suffering of Tobeka, Ahmed, and millions of others continues. There is no more stark example of our broken medicines system than the Ebola epidemic of 2014.

On October 13, 2014, Dr. Margaret Chan, the director-general of the World Health Organization, provided the keynote address for the sixty-fifth session of the WHO Regional Committee for the Western Pacific. Most conferences like this are highly bureaucratic; the speeches delivered are typically long on platitudes and short on drama. But Dr. Chan’s remarks were delivered in the midst of the Ebola outbreak in western Africa, an outbreak she told the attendees had generated more fear than any event in her public health career.

So Dr. Chan took the occasion, and the global media attention to the outbreak, as an opportunity to be remarkably frank. Over 11,000 people will die from Ebola, she said. “The outbreak spotlights the dangers of the world’s growing social and economic inequalities,” she told the attendees. “The rich get the best care. The poor are left to die.”

Dr. Chan was correct. Ebola was a dramatic example of the inequities in the global health care system, inequities that are particularly stark in the field of medicines. The reason Ebola was so frightening and so deadly was that no medicines were available to prevent it or to treat it. It turns out that promising vaccines to prevent Ebola, and drugs to treat it, had been uncovered years before the outbreak. Yet they were allowed to languish without further development. “There is a lesson here,” said
Professor Adrian Hill from Oxford University, who led the Ebola response for Britain. “If we had invested in an Ebola vaccine, had it sitting there as the outbreak comes, you could have nipped it in the bud, been able to vaccinate the region when it started.”

So why was the Ebola vaccine not developed? Because pharmaceutical corporations saw no prospect of significant profit to be made on the drug. The expected need was limited, and those who would benefit were likely to be too poor to pay high prices. As far back as 2003, Thomas Geisbert, an Ebola researcher, recognized the problem, writing with regret that there was “little commercial interest for developing an Ebola virus vaccine.”

After the 2014 outbreak began claiming lives by the thousands, Professor Hill labeled the problem in stark terms. “Who makes vaccines? Today, commercial vaccine supply is monopolized by four or five mega-companies—GSK, Sanofi, Merck, Pfizer—some of the biggest companies in the world,” Hill said. “The problem with that it, even if you’ve got a way of making the vaccine, unless there’s a big market, it’s not worth the while of a mega-company. . . . There was no business case to make an Ebola vaccine for the people who needed it the most.”

The 11,000 people who died from Ebola are just the latest and most visible examples of a core flaw of the for-profit medicine system. Medicines that address the diseases that kill millions of the global poor do not present a compelling business case. The U.S. satirical publication The Onion put a sadly accurate spin on the tragic situation, publishing a spoof article entitled “Experts: Ebola Vaccine at Least 50 White People Away,”

So medicines that would save the lives of the global poor go undeveloped. All the while, for-profit corporations rush to market hair-loss cures and erectile dysfunction drugs. Such medicines often duplicate others on the market and are often frivolous compared to other needed medicines. But they still present a good business case, as long as they address the real or perceived needs of consumers who can pay high prices.

As she concluded her October 2014 speech, Dr. Chan did not shy away from identifying the obvious cause for the 11,000 deaths. “Ebola emerged 40 years ago. Why are clinicians still empty-handed, with no vaccines and no cure? Because Ebola has been, historically, geographically confined to poor African nations.

“The R&D [research and development] incentive is virtually nonexistent. A profit-driven industry does not invest in products for markets that cannot pay.”