Prescription for the People
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Part IV

Trading Away Our Health
Most of us define the term *public good* broadly. We use the term to refer to goods such as law enforcement, street lights, and mass transit, which are collectively provided and deliver shared benefits to all.\(^1\) When economists describe public goods, they refer to these goods as being nonrivalrous and usually nonexcludable in their consumption.\(^2\) We do not use those terms in everyday discussion, but their meaning is not that complicated. *Nonrivalrous* means that any one person can benefit from a good without reducing others’ opportunity to benefit as well. My eating an apple means you cannot consume it, so that is a rivalrous good. But I can watch the same TV show as you without lessening your opportunity to enjoy it as well—that is nonrivalrous. *Nonexcludable* means what it sounds like: a person cannot be prevented from consuming the good in question. Clean air is a good that can be enjoyed by all without denying access to those who do not register or pay a fee. In contrast, access to a private swimming pool is an excludable good.
The classic example of a nonrivalrous, nonexcludable public good is a lighthouse: that one ship benefits from its warning does not subtract from the chances of any other ships enjoying a similar benefit, and there is no practical way of limiting the warnings from a lighthouse to a select few.

In terms of medicines, an individual pill is rivalrous—not everyone can consume that one pill—but the details of the formula for creating that pill are not. That formula is knowledge, and knowledge is a classic public good because it can be shared widely without penalty to the original owner. As Thomas Jefferson said, “He who receives an idea from me, receives instruction himself without lessening me; as he who lights his taper at mine, receives light without darkening me.”

But pharmaceutical corporations, with a big assist from the U.S. government, have responded to the nonrivalrous character of medicinal knowledge by cutting the wick off Jefferson’s neighbor’s candle. As we see in chapter 17, those corporations successfully pushed for international trade agreements that created the patent system. By prohibiting the use of patented medicine formulas by anyone except the patent-holder, that system artificially imposes exclusivity where none existed before. Economists call this process the transformation of a public good into a “club good.” The analogy is taking a public park and turning it into a gated, dues-required golf course.

Yet those legal maneuvers cannot obscure the fundamental nature of essential medicines: they are a public good. For example, access to medicines has public health implications, which create positive externalities, an economics term that means that one person’s consumption of an essential medicine provides benefits beyond the direct consumer. Vaccines provide the most obvious example of positive externalities because they prevent the recipient both from getting ill and also from spreading the disease to others. If a society vaccinates widely enough, the chain of disease transmission is broken, leading to a significant public good: widespread immunity. What could be more valuable to the public than the global distribution of the smallpox vaccine, which has led to the eradication of a disease that once infected 50 million people a year?

Even medicines that are of less obvious population-wide benefit allow their recipients to better contribute to the social fabric and economic productivity of their communities. These medicines save costs for the broader society, too. When a diabetic takes insulin or a person with a risk for heart
disease takes cholesterol-reducing medicine, he or she is more likely to make a positive contribution to the economy. Such people also lower their prospects of needing more extensive—and expensive—medical treatment, which is a cost often shared across multiple consumers and taxpayers. The public good nature of medicines is further demonstrated by the potential negative externalities when people in need of medicines are deprived of them. The lack of access to medicine causes enormous social problems in terms of contagion and economy-depressing illnesses and premature deaths.\(^7\)

Medicines are clearly a global good as well. The bubonic plague, cholera, influenza, HIV, and many other diseases have proven that the positive and negative externalities of access to medicine do not stop at national borders. Modern versions of medicines are most often developed in wealthy countries that are home to research-investing governments and corporations.\(^9\) But those products are sometimes derived from plants and remedies that originated in low-income countries, which also provide the sites for many clinical drug trials.\(^10\)

Among the public, medicines continue to be treated as a good quite distinct from consumer items such as cell phones and flat-screen TVs. That is because the unaffordability of a patent-protected consumer item does not invoke the moral challenge that comes with the impossibly high price tag placed on a lifesaving drug.\(^11\) Millions of AIDS patients died in the 1990s and early 2000s because they could not pay for patented antiretroviral drugs, just as we have seen that millions die now due to lack of access to patented cancer medicines (chapter 4).

Tragedies such as these arouse the conscience of the global community. As a result, the human right to access essential medicines has found its way into international treaties and national constitutions.\(^12\) Economists and philosophers have agreed that intellectual property rights should never trump the imperative to save the lives of human beings.\(^13\) Faith-based organizations and civil society actors have advanced a moral claim for universal access to essential medicines.\(^14\)

Researchers are well aware of the public-good nature of the products they are discovering. The creator of the first synthetic malaria vaccine donated the patent to the World Health Organization.\(^15\) The inventors of insulin sold the patent to the University of Toronto for $1 each.\(^16\) Jonas Salk declined to pursue a patent for the polio vaccine, saying the patent
belonged to the people.\textsuperscript{17} As Salk asked in 1952, “Could you patent the sun?”\textsuperscript{18}

As Salk’s comment suggests, medicines have proven to be a poor fit in the free market model. That model assumes the existence of well-informed consumers who exercise deliberate choices among competing products. But even thoroughly capitalistic societies have long recognized that the free market approach is not appropriate when the consumer is a sick person in urgent need of a remedy.\textsuperscript{19} So, it is little wonder that, for nearly all of human history, societies and nations have treated medicines as a commonly held benefit. As we see later (chapter 17), until well past the middle of the twentieth century, few countries allowed individuals or companies to hold exclusive rights to produce medicines.\textsuperscript{20}

Governments still take an extremely active, hands-on role in the medicines industry, creating the very opposite of a laissez faire market. Most industrialized governments tightly regulate the production and distribution of medicines, as well as actively promote vaccinations and encourage the safe use of other drugs.\textsuperscript{21} Most of those countries, with the United States being a notable exception, also exert significant government control over the price of medicines.\textsuperscript{22} Governments are both the leading funders of medicine research and the top purchasers of the end products of that research.\textsuperscript{23}

Why do governments assume an activist role in the field of medicines? Because their citizens have demanded it. As we see in the conclusion to this book, grassroots-yet-global activism in the 1990s and 2000s gave voice to passionate outrage over the devastating human cost of limited access to patent-priced HIV/AIDS medicines. Demonstrators in the United States threw the ashes of AIDS victims on the lawn of the White House; global activists conducted mock trials charging pharmaceutical companies with genocide.\textsuperscript{24}

These protests led to the dismantling of patent price barriers and, then, to massive government-funded programs. The same medicine that the patent-holding corporations once deemed too expensive for the global poor is now distributed to millions by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria.\textsuperscript{25}

But the HIV/AIDS treatment experience is not the norm. The U.S. government and pharmaceutical corporations have largely succeeded in their
concerted effort to turn the public good of medicines into a for-profit commodity. In walling off access to medicine, corporations are following a disturbing historical precedent. Between the fifteenth and nineteenth centuries, the rich and the powerful in England managed to fence off commonly held land and transform it into private property.\textsuperscript{26} The countryside was changed from a source of subsistence to a source of profit, and small farmers were relegated to wage laborers. The process is widely referred to as the enclosure movement, but in \textit{Das Kapital}, Karl Marx described it by coining a new term: land-grabbing.\textsuperscript{27} To Edward P. Thompson, a British historian, it was “a plain enough case of class robbery.”\textsuperscript{28}

Now, a similar enclosure movement is taking place.\textsuperscript{29} This time, the fenced-off commodity is essential lifesaving medicines. Playing the role of modern-day lords of the manor are the pharmaceutical corporations, which have taken a good that was once considered off limits for private profiteering and turned it into an exclusive, expensive commodity. Instead of displacing small landholders, this particular enclosure movement causes suffering and death.