THE HIV/AIDS PANDEMIC & POGGE'S INCENTIVES BASED PHARMACEUTICAL DISTRIBUTION

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This article serves as a philosophical review of Thomas Pogge's model, the Full Plan for the Provision of Pharmaceuticals (FP1) for the global distribution of patented treatments and medicines to the neediest individuals in underserved populations – people who rarely have means for essential treatments. Founded upon the notion of a necessary global right to healthcare, Pogge presents a method that would run in parallel to the capitalist method of drug distribution, in which corporations are rewarded based on how far their respective treatment reaches in the dilapidated world – the Patent-2. The paper rests on the notion that solving the problem of communicable disease will be a concerted, global effort, and that nations involved in such a program will be willing to contribute a miniscule fraction of their GDP to solving the crisis of such preventable illnesses.

The United States government annually appropriates an average of $36,000 per person for healthcare (inflation adjusted to current Consumer Price Index).[1] In destitute regions of the third world, healthcare expenditure, barring that the government does not misappropriate the funds, ranges between $75-$200 per person, per year. To put this into perspective, even taking into consideration GlaxoSmithKline's 47% price cut on the drug Combovir in developing nations from $1.70 to $.90, an HIV/AIDS victim in the Sub-Saharan African country of Burkina Faso with an income of ($75/yr)[2] could only afford the medication from January 1 until roughly March 23.[3] This, of course, is an optimistic figure, as it does not consider the cost of a paying a physician to properly administer the medication or buying other medications for opportunistic infections. Of the forty million HIV positive individuals worldwide, twenty-eight million live in poverty-stricken regions of Africa.[1] Compared to 750,000 HIV positive people that live in the United States.[4] In addition, estimates state that 90% of AIDS deaths are in developing countries.[5]

In this paper, I strongly support positions advanced by Thomas Pogge in Incentives for Pharmaceutical Research: Must they Exclude the Poor from Advanced Medicine, in which he argues that increased pressure from the World Trade Organization (WTO) to protect intellectual property has led to a massive shortage of drugs for diseases prevalent in the third world. While Pogge generalizes the claim to include opportunistic and tropical diseases (including HIV/AIDS), I will focus on HIV/AIDS, as it is concentrated in poorer regions. Further, I submit that Pogge's patent reform plan, the Full Pull Plan for the Provision of Pharmaceuticals – (FP^1) – is a genuinely feasible, pragmatic, and ethical distribution proposal for pharmaceuticals to these regions. I posit that the FP^1 has the greatest potential as an effective "pull program," meaning it is most likely to succeed in widely distributing necessary treatment to poor countries. In order to achieve this, it should also promote the importance of treating highly communicable diseases first. Lastly, I propose some possible drawbacks of the FP plan and respond to them with alternative solutions and/or moral justifications. Overall, I contend that a global incentives-based distribution plan of HIV/AIDS medication will be beneficial to pharmaceutical companies and to the populations in developing countries alike as it maximizes utility. The care for human rights is a necessary duty, and the reform plan posited shows that the benefits of undertaking Pogge's reform plan far outweigh the sacrifices made on an individual basis in the Western world; overwhelmingly in favor of the FP^1. As in Pogge's work, this paper addresses the problems of the suppressed and the unheard.

The law permits U.S. market factors to determine the prices of pharmaceuticals and forbids the production of generic versions of patented drugs. Such policies have proven detrimental to the global effort to reduce HIV/AIDS deaths. Actions were taken against India and Thailand in the creation of the WTO's International Property Rights Act (IPRA) in 2005. The IPRA condemned the unregulated proliferation of intellectual property, including "generic drugs".[1] These were identical to those produced by pharmaceutical powerhouses in the Western world, but manufactured at a considerably lower cost and distributed at lower prices to those who could not afford the Western product.

Thus, while other intellectual property fraud may have harmed the U.S. private sector, "generic drugs" did

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not threaten revenues because they were providing for those who otherwise would not have gotten any medication. Pogge claims that while the annual appropriation of health care in these countries ranged between one and two hundred US dollars, corrupt governments and political juntas reduced spending to a range between ten and fifty dollars annually. The argument posited by the companies was that they approve the free distribution of "charity" products, rather than allowing local manufacturing. The UN admits, however, that the "free distribution [of pharmaceuticals] are often not taken in the full annual course and cannot, in most cases, be depended upon as a sustainable fight against HIV/AIDS."[6] The global population in poverty is increasing. As the socioeconomic gap widens, these companies are not providing charity, rather they are perpetuating a system in which a majority of the world's poor have limited access to the treatment that generic drugs could provide.

Countries like India and Thailand, who were committed to producing and providing generic drugs to the poor within their countries and in Africa, also have an economic dependence on the US markets. If they had not agreed to the IPRA in 2005, they would have faced sanctions from the United States, an economic cost that neither country could afford. This pressure compelled those countries to abandon their generic pharmaceutical production companies.[1] But who suffered most from this? As usual, those in most need of the medicines and those without a voice in the debate.

The conflict, commonplace with global health issues, is money. This is not to say that corporations are evil; this view is far too naïve and overlooks the fact that distributing innovations in medical research in an open market has proven to be an effective system. Rather, the public's belief that corporations have a duty to promote good will conflicts with corporations' foremost concern: the happiness of shareholders and a profitable return on preferred issued stock. In the competitive global market, corporations rely on both the high prices of drugs and protection, by any legal means, of patented drugs that they have spent billions of dollars to develop. Therefore, worldwide distribution is not the primary concern of a powerhouse pharmaceutical corporation, but maximizing distribution to those who can afford its products is. This is the fundamental problem of the global pharmaceutical market, as Pogge sees it.

The FP[1] is both novel and feasible. It does not subvert corporations' intentions to maximize gains; neither does it involve an idealistic and flawed notion that we might be able to create such interventions and pharmaceuticals without them. Rather, it relies on offering two distinct, parallel systems of declaring patents on intellectual property that are intended for goodwill. The first type of patent is the standard patent, which offers "treatments to 'Western' illnesses" a lucrative financial option for drug companies in the current market system. For example, if Firm A invented a revolutionary prescription-strength anti-aging skin cream, and placed it in a market where there was no competition (as other firms were lagging in their research), Firm A would stand to make a considerable gain by stating a high price that consumers would undoubtedly pay.

However, the concentration of highly communicable and tropical diseases in the lower economic global population renders the standard patent system insufficient. Investing billions in research, and possibly losing a huge margin based on costs incurred, corporations prefer the safe route in investing in interventions for Western illnesses. Strikingly, from 2000-2005, 163 new drugs were introduced of which 5 (3.2%) were for infectious diseases in developing countries. No new interventions were introduced for tuberculosis, which, when combined with other infectious diseases, amounted to 12% of annual global mortality.[1] Clearly, although the ailments are relevant, they are not within the corporate spectrum of "feasible distribution."

For such cases, Pogge offers a different patent route, exclusive to FP[1]. He explains that "if [the pharmaceutical company] chooses the latter, the patented knowledge is treated as a public good, making the new medicine available for generic production worldwide." This makes it exempt from complying with international property rights (IPRs). He calls this route "Patent-2." Patent-2 provides interventions and drugs as global property for the pharmaceutical company instead of taking the traditional route.

Patent-2 does not cloud the essence of free-market production, but it does, however, provide a non-classical incentive in the market. Its basic strategy is to ratify a global bill, both in the Western and underdeveloped world, for a global pharmaceutical push to address under-treated ailments. First, governments would sign a treaty in which each would commit an annual percentage of GDP to an incentives pool. This pool is used to lure pharmaceutical companies to conduct research on the diseases that are now often overlooked. Companies that provide effective medications and/or interventions to reducing diseases that ravage the underdeveloped world are then appropriated an amount from the incentives pool; what makes the FP truly interesting, however, is that the further the new drug or intervention is "pulled," or distributed worldwide, the more

lucrative it becomes. Therefore, companies that conduct intensive research for multiple years on drugs to treat communicable diseases such as tuberculosis or malaria will stand to gain the most if and when their treatment goes global.[1] Pogge astutely proposes a plan that accommodates the need to slow the global spread of ailments "lost in the shuffle" and also appeals to corporations' financial sensibilities.

A key incentive of the FP[1] plan for pharmaceutical companies that Pogge did not elaborate on is that by gaining global distribution, the competition of the generic drug market is virtually dissolved. This incentive will prove effective in starting an entirely new economic machine to fight HIV/AIDS. Once major companies develop Patent-2 pharmaceuticals, GDP incentives will kick in, allowing companies to set up local manufacturing companies in the affected areas, and by doing so, outsourcing the production of the pharmaceuticals at a lower wage.

This is a multi-faceted incentive to the major pharmaceutical company, as it saves money on transporting the drugs and, as aforementioned, on wages in production. Furthermore, once the drug is produced and proven effective, the company does not waste US based human capital, which can be used to produce and distribute other pharmaceuticals – either Patent-1 or -2. Thus, companies will invest time trying to simultaneously research for cures to multiple ailments. This may also provide more jobs in the developing nations and in improving poor countries' health care systems, which may be appealing to pharmaceutical companies' because it displays their goodwill to the perceptive global public. While the incentives of the FP[1] plan seem appealing to corporations both financially and for an image of goodwill, some important questions have yet to be raised.

Two possible non-financial drawbacks in FP[1] are a) the lack of hierarchy for which illnesses to treat and b) the public feeling "thrust into new taxes."

As with all progressive movements, a gradual change would prove more effective and feasible than a sudden change. This holds true, then, for the revolutionary ideas of FP[1]. In the proposal, the collection of GDP would be a gradual one, and the percentage would increase slowly at an annual rate. For example, it may start at .01% of the GDP, but increase to an overall of .25% over several years.[7] This allows time for the incentives pool to grow annually, leave reserves, and compound into a largess sufficient enough for pharmaceutical companies to expect reasonably large returns for distributing interventions and/or drugs.

Further, with this notion, the pool does not overfill, that is, get too large and remain stagnant while companies are conducting research for the first several years. After all, these are federal funds from national GDP that could be used for other social goods in the countries that committed them. A gradual approach to FP[1] thus would allow adequate time for pharmaceutical companies to conduct research in providing efficacious treatments without significant immediate expenditures from the GDP.

Further, because complete, relevant research is highly rewarded by the incentives of the FP[1] program, illnesses are toppled based on their numbers; the most prevalent will be treated first and researched with the most Patent-2 resources in private laboratories. Therefore, highly communicable diseases such as tuberculosis, and HIV/AIDS, would be among those with the most potential incentives, while several other infectious diseases would be further down on the list. This is not to say, however, that they will be excluded. Rather, pharmaceutical companies who hope to capitalize upon less prevalent diseases could conduct precise effective research and dominate that sector of the Patent-2 market. By conducting quick and efficient research, such 'capitalizing firms' will get an instant increase in their perceived goodwill, which could be reflected by higher stock prices in the market. Good will is an intangible financial asset, which in turn raises a company's perceived Earnings per Share Ratio. Such intangibles, in turn, are what often cause brokers on Wall Street to value a company higher than its actual monetary earnings.[8] One would hope the good will of solving global health crises will not be overlooked in valuing these pharmaceutical companies' stocks.

For sick people in poor nations and for pharmaceutical companies alike, this is a win-win situation. Using a gradual approach and natural hierarchy, there seem to be few moral dilemmas in FP.[1]

A Cost-Benefit Analysis (CBA) seems unnecessary when weighing the costs of global HIV/AIDS research and distribution versus the possible incentives of treating and preventing the pandemic. Pogge writes that an average US family making $50,000 a year (the details of GDP contribution are not fully laid out at this point, but Pogge believes this to be a fair estimate of the average middle-class household) will contribute, indirectly in taxes, approximately $100 a year to the Patent-2 incentives program. This seems an infinitesimally small cost for the return, however, as he continues, "the household in question would contribute one cent for every 900 afflicted persons getting necessary treatment, or one cent for every 450 premature deaths averted."[1] With such compelling statistics, it is difficult to argue that

a CBA overwhelmingly favors what the global population can gain if such a plan were instituted. The care for human rights and the "sanctity of human life" are one and the same. Although there are financial drawbacks, the good will in treating these patients compensates for whatever losses companies may incur.

Whether we choose to accept it or not, health and health care have become economic commodities and providing appropriate means for those confined in the bottom of the economic strata should be a moral concern for all parties. I believe this is so because a global concerted effort will a) prove the most effective (each country contributing a smaller percentage of GDP), and b) has the potential for the most overall utility. Ethically, we have a social duty as well as a moral duty towards promoting global health. The latter comes from the intrinsic value our society places on "life," especially in the medical field. Sanctity of life is an absolute in the modern world, and overlooking this view in some cases while relying on it for other medical justification is not humane. We cannot pick and choose when to value life, or what life to value, rather it is in the interest of medicine to maximize beneficial care.

The treatment and prevention of highly communicable diseases would lead to social utility in developing countries, and the promotion of sustained economic development. In some developing nations, significant percentages of the population suffer from HIV/AIDS (greater than 10% in Kenya and South Africa).[5] Sick, untreated AIDS patients cannot contribute to the economic landscape in their respective countries. Imagine if AIDS medications were "pulled" through these countries, where 75% of afflicted patients are on no retroviral medication whatsoever.10 The pharmaceutical company responsible for the distribution would stand to gain considerable revenue from the Patent-2, and treated patients and their healthy offspring would be valuable assets to the economic and social landscape as they would provide more output per person and have a lifespan that includes time for developing skills. Rather than being mortality statistics, the FP[1] offers the Western world and developing countries a chance to increase the overall productivity of future generations in poor countries.

The United Nations' Universal Declaration of Human Rights states:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services... or other lack of livelihood in circumstances beyond his/her control."
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> – Article 25, Section 1

The right to health must be considered a higher priority than the other rights, however, because it substantiates the potential for all other rights. Without access to adequate medical care, HIV/AIDS patients lack the necessary strength and mental capabilities to obtain food, clothing, and/or housing. Output in local AIDS infected communities could be increased. Our social duty, if we can agree there is one, should therefore be to this primary right. Thus, it is justified to create a revolutionary distribution method as it addresses the most pressing issue of global health.

Pogge cites avian bird flu and SARS as two "pandemic fears" that recently swept through the Western world. New, feared illnesses such as these are more likely to communicate to the Western world than pandemics that affect the developing world. Thus, prevention in these areas leads to prevention at home.

Affordable prevention of pandemics should not be left on the back burner of the "pharmaceutical regimes' agendas," rather it should be of prominent concern. According to Pogge, "the beauty of the FP is that it works with pharmaceutical companies," so as not to view them as domineering regimes, but the developing countries' most crucial partners in global health. This partnership could create more equitable distribution reform in affected areas of the developing world.

References

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5. United Nations. Executive Summary: 2004 Report on the Global AIDS Epidemic. UNAIDS: United Nations Programme on HIV/AIDS. Geneva, Switzerland. 2004.
6. Executive Summary. UNAIDS.
7. Not actual figures. Used to illustrate the "gradual FP1" proposal with actual figures. Important to note, however, is that the GDP percentage required would be inversely related to the amount of countries that ratify the FP1. Therefore, the more that ratify FP1, the less each contributes per fiscal year.
8. FASB (Financial Accounting Standards Board) Statement 142. Goodwill and Other Intangible Assets. Issued June, 2001.