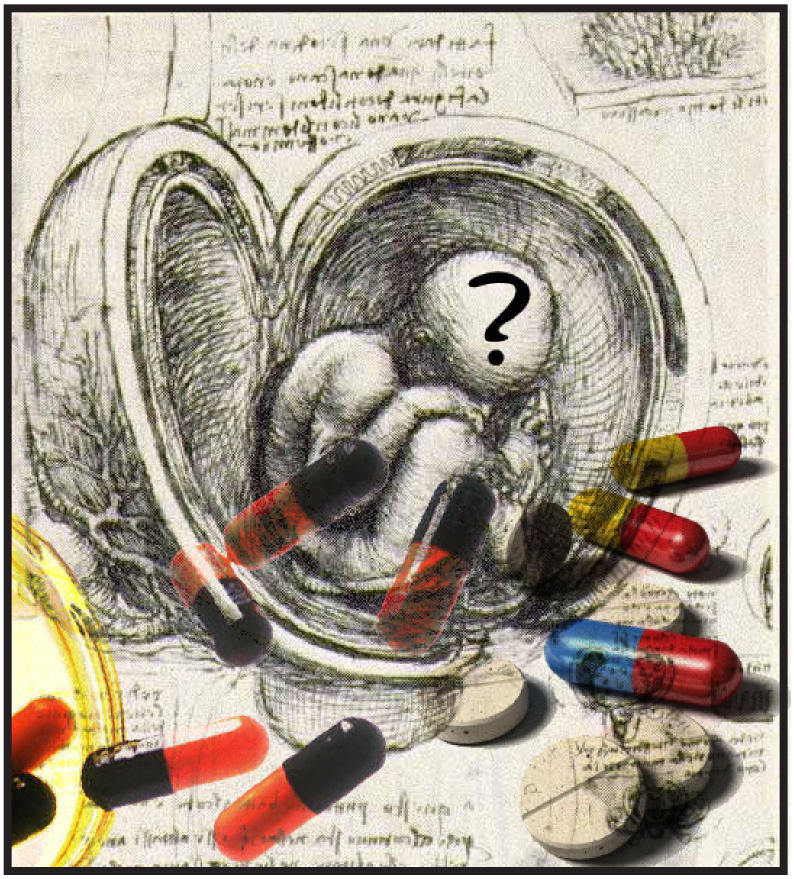
TUFTSCOPE

THE INTERDISCIPLINARY JOURNAL OF HEALTH, ETHICS, AND POLICY

Spring 2008 Volume 7, Issue II



Featured Articles

Anthropological Work with Vulnerable Populations: Significance of the International Sex Trade and Industry
Benjamin James Sacks

Surrogacy: Human Incubators and a Defense of Contractual and Financial Agreements
David Y. Harari

A Publication of TuftScope,
a Student Organization of Tufts University

TUFTSCOPE

THE INTERDISCIPLINARY JOURNAL OF
HEALTH, ETHICS, AND POLICY

INSIDE THIS ISSUE

FEATURED ARTICLES

Anthropological Work with Vulnerable Populations: Significance of the International Sex Trade and Industry *Benjamin James Sacks* 2

Mr. Sacks explores the social and economic status of sex workers in society. The associated health risks, social consequences of the trade, and assistance projects are discussed.

Surrogacy: Human Incubators and a Defense of Contractual and Financial Agreements *David Y. Harari* 5

Mr. Harari explores the role of surrogate women as "human incubators" for couples who cannot conceive. His paper details the ethical and scientific background behind surrogacy and evaluates its role in today's society as a contractual service.

COMMENTARIES

Diseases in Developing Countries: The Gaps to Accessing Essential Medicines 10
Ashley Allison, John Chiosi, Anisha Gandhi, Erica Popovsky, Swati Shah

The Tufts Chapter of Physicians for Human Rights describes the gaps in the development and allocation of essential medications to individuals living in developing countries. The authors suggest that universities can take action by endorsing petitions like the Philadelphia Consensus Statement.

Remittances: The Health and Well- Being of Senders and Receivers 13
Corey Kestenberg

Ms. Kestenberg explores the role that remittances play in the health of individuals and their importance as a source of additional monetary support for families looking to pay for healthcare.

ORIGINAL ARTICLES

The HIV/AIDS Pandemic & Pogge's Incentives Based Pharmaceutical Distribution 15
Shamit S. Desai

Mr. Desai presents the case for fundamental change in the system associated with the distribution of medication to low income nations. Using HIV/AIDS as its leading example, this paper examines Thomas Pogge's approach to changing the way pharmaceutical companies do business on the global scale.

Public Policy and Assisted Reproductive Technologies 19
Stephanie Feldstein, Yael Nobel, Rachel Sachs

Ms. Feldstein, Ms. Nobel, and Ms. Sachs discuss the ethics of Assisted Reproductive Technologies (ART) and the public policy implications of "maximizing the autonomy of the individual with regard to his or her reproduction." The concepts of gamete ownership, implanted and unimplanted embryos, and reproductive rights are discussed in detail.

©2008 TuftScope is published biannually in conjunction with Tufts University, Medford MA.
Founded in 2001, TuftScope receives funding from the Tufts Community Union Senate.
For more information, please visit http://ase.tufts.edu/tuftscope

FROM THE EDITOR

Dear Readers,

Welcome to the Spring 2008 (Volume 7: Issue II) issue of *TuftScope: The Interdisciplinary Journal of Health, Ethics, and Policy*. Over the past seven years *TuftScope* has sought to provide the undergraduate community with a journal dedicated to academic scholarship and research. The Editorial Staff has always tried to present articles that not only inform readers about the pressing biosocial, ethical, and healthcare debates facing our modern society, but also inspire students to explore new and exciting fields that they may not have known about. Often in the rush of courses and activities students may be unable to keep up with issues and topics that are not immediately relevant to their majors or passions. And yet, the rapid development of medical technology and its associated social and economic consequences, the growth of global health crises, the maladies facing our healthcare system, and new bioethical challenges simply cannot be ignored. By framing discussion around these and many other issues through the lenses of health, ethics, and policy, *TuftScope* hopes to continue to provide a platform for inspiring active change and discussion in the community. In this issue topics ranging from doctors performing “embryo theft” to the “access gap” causing the high price of drugs in developing countries allow the reader an interdisciplinary overview of some of the major concerns facing both the modern and developing world.

This issue not only marks some of the finest articles that the Editorial Board has received over the years, but also the inauguration of *TuftScope’s* expansion into the greater undergraduate community. The 2007 - 2008 publication cycle has seen the implementation of major changes to the journals policy, layout, and focus. This issue sees the introduction of papers and commentaries from students from universities outside of Tufts. We believe that this expansion will allow the undergraduate communities of Tufts and other universities the chance to review the arguments and ideas developed around critical issues in new and exciting ways. In the coming academic year *TuftScope* plans to continue its development plan by publishing both relevant and insightful articles for its readers, bringing speakers and programs to the Tufts campus, and expanding into new venues.

As always, the publication of *TuftScope* depends on many individuals. We have the utmost thanks for those authors from both Tufts and other universities who continue to write for our journal and submit papers and commentaries. We continue to encourage authors to write about issues that they feel the journal has not explored, and we invitie our readers to send us their comments about how *TuftScope* can improve. Also, we wish to provide the sincerest thanks to Dr. Bernheim and Dr. Feldberg of the Tufts Biology Department, who have guided the editing process for the journal and continue to make TuftScope better with each new issue. We hope you enjoy this issue!

Sincerely,

The TuftScope Editorial Board

Cole Archambault, David Kudlowitz, Margaret O’Connor, Michael Shusterman, Alice Tin, and Ron Zipkin

ANTHROPOLOGICAL WORK WITH VULNERABLE POPULATIONS: SIGNIFICANCE OF THE INTERNATIONAL SEX TRADE AND INDUSTRY

Benjamin James Sacks

Amongst vulnerable populations, sex workers have become defined by much of formal society as one of the most destitute and ignored socio-economic groups. Their careers, by default, convey notions of criminality and disease. The widespread dissemination of AIDS, variants of Multiple Drug-Resistant Tuberculosis (MDRTB) and venereal disorders serve to propel such preconceived, damaging beliefs and hinder the human rights and civil liberties of a population that is caught in a vicious, frequently lethal cycle of penury and abuse. In a vulnerable group that is derided by nearly all formal and many informal institutions, the extraordinary level of interconnectivity that pervades the lives and world of sex workers is often ignored. Subsequently, assistance can encompass a variety of situations and projects. Research work and aid is certainly achievable in such a field that has been deemed unmentionable in many societies. Within this context however, most anthropological research and societal support related to sex workers come from private organizations; non-governmental organizations (NGOs) and community-based organizations (CBOs) have taken primary responsibility for many aspects of sex work assistance.

Amartya Sen, the 1998 Nobel Prize Winner in Economic Science, argues that the ability of one to scale the socio-economic hierarchy and to improve their wellbeing is dependent upon the "centrality of individual freedom and the force of social influences on the extent and reach of individual freedom." Sen highlights the importance of informal and formal stakeholders in removing "various types of unfreedoms" and their high level of interconnectivity.[1] Indeed, sex workers are forced to rely on their sole remaining asset – their bodies. Although they can use their bodies in the sex trade to earn profit throughout their lifetimes, their use of the body represents systematic failure of both socio-economic influences (i.e. caste and class, financial distribution, opportunities for women) and drives a pervasive feeling of hopelessness that will inevitably lead many to use their bodies for income generation.

The geography of such a vulnerable population is expansive, and its origins are diverse. In Eastern Europe, countless women (as well as men and children) can be found plying the sex trade, the result of a systematic collapse of formal authority and socio-economic ideology. These sex workers are forced through coercive or economic means to migrate into other European and Asian countries as a means to earn more profit, "preserve personal honor," or as sex slaves of criminal racketeering organizations.[2] In Southeast Asia (particularly Thailand), the sex trade has rapidly driven up HIV infection rates across the region; "An…equally explosive epidemic occurred…among brothel workers in North Thailand whose primary risk of HIV was attributed to sexual intercourse with multiple partners."[3] As early as the end of 1991, 25.2% of the sex worker population in Thailand was HIV-positive.[3] In Haiti, the poorest nation in the Western Hemisphere, a severe paucity of career opportunities force many women and girls into house servitude and sexual slavery. The medical anthropologist Paul Farmer describes the case of Acéphie, a young woman who is unwittingly forced into sexual work for several soldiers of Haiti's disorderly army and subsequently perishes of AIDS in her mid-twenties.[4]

Although the remarkable anthology Voices of the Poor, published by the World Bank on the eve of the twenty-first century, provides an exhaustive outlet for non-Western case studies,[26] the sex trade continues to flourish in the world's most advanced countries. In San Francisco, individual researchers and interns can assist with St. James Infirmary, a medical clinic dedicated to providing "free, confidential, nonjudgmental medical and social services for female, transgendered, and male sex workers."[5] Beyond HIV/AIDS advice, treatment, and screening, St. James Infirmary provides resource guides and initiates city-wide support for the sex worker community in San Francisco.

The growing use of Participatory Poverty Assessments (PPAs) in field anthropology as an effective means of collecting ethnographic data has yielded exceptionally positive results in sex work research. PPAs refer to:

Iterative, participatory research process that seeks to understand poverty from the perspective of a range of stakeholders, and to involve them directly in planning follow-up

Author Contact Information:
Undergraduate student of Tufts University, Class of 2010. Correspondence should be addressed to Benjamin J. Sacks at Benjamin.Sacks@tufts.edu

action.[6]

PPAs allow researchers to live with a localized vulnerable population, often for a considerable duration. This is accomplished in order to learn and observe as much as possible about the respective constituency through their language, culture, and societal behaviors. In the internationally-recognized documentary Born into Brothels, a teacher of photography not only extends her photographic knowledge to children of Calcutta but delves into their entire world, from familial concerns to the failure of the Indian bureaucracy to assist in the development of these impoverished children.[7] In accomplishing this, Zana Briski emphasized the integrated, multifaceted nature of such an environment. Diverse stakeholders play considerable roles in the welfare and survival of the children, as well as contribute towards the continuation of cyclic abuse, prostitution, and destitution.

The children's mothers, sisters, and grandmothers are forced into the sex trade from an early age; caste and class are often inhibiting and confirming factors. Their fathers, if they have not fled from the household, have become drug addicts and alcoholics. The husbands of sex workers "feel displaced when their wives earn more than they do," and become the principle breadwinner of the household.[8] This phenomenon has become global in scope. The leading social development specialist for the World Bank, Deepa Narayan[9] described similar situations in Mali, where "there are relatively few alternative strategies to pursue…" and in Latvia, where many "men had collapsed under the current stresses…"[10] Considerable physical abuse and a high vulnerability for infection lead many sex workers into a self-debilitating cycle of hunger, illness, loss of income, doctors expenses, bribes and extralegal charges, humiliation, and pain.[11] As a result of preconceived fears of dealing with sex workers, a global environment where women earn less money, respect, and rights than their male counterparts, and formal institutional failure, many sex workers are deliberately ignored or exploited.[12] Sen maintains that, "The richer countries too often have deeply disadvantaged people, who lack basic opportunities of health care, or functional education, or gainful employment, or economic and social activity."[13]

These multifaceted, interconnected issues severely inhibit the availability of process aspects (the allowance of actions) and opportunity aspects (opportunities to advance) for the sex worker population.[14] A nonfunctional education prevents a vulnerable person from gaining leverage in the job market, or pursing higher education and networking. This inability to gain employment restricts the individual from earning an income utilizing aspects other than their body. The chain of despair is reciprocal. Lack of gainful employment and education significantly increases the difficulties in sending their children to school, thus enhancing the possibility that the children will follow their parents into a life of sex work. Lack of economic and social activity at that particular step of the hierarchal ladder further restricts the possibility of any of these factors changing the wellbeing of the individual. In Calcutta (focus of Born into Brothels) and across India, the "Permit Raj" bureaucracy utilized thousands of forms, stamps, and signatures to reduce opportunities for sex workers and their dependents to gain access to food rations, medicine, or even formal identification.[15,16] Indeed, Jeffrey Sachs, the Director of the Earth Institute of Columbia University, contends that such bureaucratic licensing, and "traditional social structure, with its meticulous stratifications by caste," serves to solidify the outcast status of sex workers, both in India and through cultural variations abroad.[17]

As such, it is imperative that one pursue ethnographic and internship research of sex workers with an understanding of the multidisciplinary character of the respective vulnerable population. Operating within a more traditional scope, the Sex Worker Education and Advocacy Taskforce (SWEAT) in Cape Town, South Africa deals primarily as a civil society organization, acting as a lobbyist and mediator between sex workers and the South African Government.[18] SWEAT prioritizes health, HIV/AIDS protection, and civil liberties training for sex workers, and attempts to raise awareness of their plight. Researchers or interns have an opportunity to assist the Training and Services Support Programme, The Advocacy and Lobbying Programme, and The Research Programme, encompassing a variety of interests and backgrounds that influence varied stakeholders.[18]

The sex trade bears a preconceived notion of "profession often considered shameful" by both formal and informal society.[19] However, as is correctly stated by Sampada Grameen Mahila Sanstha (SANGRAM), women (and men) who are involved in the sex trade are human beings and powerful, albeit often untapped, sources of change.[20] SANGRAM's mission focuses on local-level awareness and distribution of condoms. Work with the Coalition against Trafficking in Women allows research on a tangent of the sex trade that, although it is a global phenomenon, has remarkable importance in Eastern European and CIS26 human geography. Sex trafficking can occur through two methods: mobility as a consequence of a desire to protect personal honor, and forced trafficking through exploitation and extensive criminal networks. Narayan draws attention to the case of a 45-year old single mother in the Former Yugoslav Republic of Macedonia: "I do it in neighboring cities to avoid unpleasant situations in the city I live in."[21] The Coalition against

Trafficking of Women serves to combat and prevent trafficking, act as a negotiator between informal society and government, and also lobbies for programs that will restrain male (and, in some instance female) needs to utilize prostitution.[22] Researchers with the Coalition delve into child trafficking, loss of formal authority, ethnic humiliation (i.e. Eastern European women in Western Europe and North America) and systematic abuse.[22]

In spite of the concentrations of respective sex trade assistance organizations, they share several common attributes. Such establishments clearly support the argument of Sen: women, regardless of their profession, must be "vindicated."[23] Not only are individual aspects of women's lives addressed; rather, the entire well-being of women is becoming a focal point for assistance and societal growth.[23] The stakeholders who work with, influence and direct women's lives become integral members in the success (or failure) of lives marked by "material deprivation; physical ill-being; bad social relations; vulnerability, worry and fear, low self-confidence; and powerlessness."[24]

Indeed, Sex workers, as was justified by SANGRAM are classic examples of the "agency aspect" of women that Sen stresses is inherent with well-being.[25] As such, successful organizations will be those who will be able to broker a voice for sex workers across a spectrum of stakeholders, rather than to castigate the entire industry. Traditional methodology sought the criminalization of prostitution which resulted in increased destitution and subsequent abuse as many sex workers have little skilled training or cannot work in other careers due to stigmatization and caste-style distinctions. By increasing the level of agency women, especially those who are sex workers, health levels amongst this vulnerable population can rise and political and societal dreams can be realized. Whether research work is conducted in HIV/AIDS assistance, civil society lobbying, or 'safe sex' protection, Amartya Sen's goal of female vindication and agency can be achieved.

References

1. Sen, Amartya. Development as Freedom. New York City: Anchor Books (Random House), 1999.
2. Narayan, Deepa, Raj Patel, Kai Schafft, Anne Rademacher, and Sarah Koch-Schulte. Voices of the Poor: Can Anyone Hear Us? 3rd ed. Vol. 1. New York City: Oxford University Press for the World Bank, 2002.
3. Havanon, Napaporn, Anthony Bennett, and John Knodel. "Sexual Networking in Provincial Thailand." Studies in Family Planning 1st ser. 24 (January/February 1993): 1-17. JSTOR. Tisch Library, Tufts University, Medford, Massachusetts. 25 June 2007.
4. Farmer, Paul. Pathologies of Power: Health, Human Rights, and the New War on the Poor. Berkeley, California: University of California Press, 2005. 33-35.
5. "Home." St. James Infirmary. 2007. St. James Infirmary. 26 June 200 <http://www.stjamesinfirmary.org/>.
6. Narayan, Patel, Schafft, Rademacher, Koch-Shulte, 15.
7. "About Us: Zana Briski." Born Into Brothels. 25 June 2007. Kids with Cameras. 26 June 2007 <http://www.kids-with-cameras.org/home/>.
8. Narayan, Patel, Schafft, Rademacher, Koch-Shulte, 182.
9. "Deepa Narayan." News and Broadcast. 2007. The World Bank. 26 June 2007 <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:2002867~menuPK:34490~pagePK:36880~piPK:36882,00.html>.
10. Narayan, Patel, Schafft, Rademacher, Koch-Shulte, 182.
11. Narayan, Deepa, Robert Chambers, Meera K. Shah, and Patti Petesch. Voices of the Poor: Crying Out for Change. New York City: Oxford University Press for the World Bank, 2000.
12. Narayan, Patel, Schafft, Rademacher, Koch-Shulte, 184.
13. Sen, 15.
14. Ibid, 17.
15. Cutler, Howard, and William Cran. "Chapter 4: India's Permit Raj." Commanding Heights: the Battle for the World Economy. 2002. PBS. 26 June 2007 <http://www.pbs.org/wgbh/commandingheights/hi/story/tr_menu_02.html>.
16. Sachs, Jeffrey D. The End of Poverty: Economic Possibilities for Our Time. 1st ed. New York City: The Penguin Press, 2005.
17. Sachs, 171.
18. "About SWEAT." SWEAT. 2006. Sex Worker Education and Advocacy Workforce. 26 June 2007 <http://www.sweat.org.za/index.php?option=com_content&task=view&id=5&I mid=2>
19. Narayan, Patel, Schafft, Rademacher, Koch-Shulte, 193
20. Sridhar, Lalitha. "Programme Experiences: SANGRAM India." The Communications Initiative. 01 Sept. 2004. Sampada Grameen Mahila Sanstha. 26 June 2007 <http://www.comminit.com/experiences/pds92004/experiences-2059.html>.
21. Narayan, Patel, Schafft, Rademacher, Koch-Shulte, 193.
22. "CATW Campaigns, Programs and Projects." Coalition Against Trafficking in Women. 2007. 26 June 2007 <http://www.catwinternational.org/campaigns.php>.
23. Sen, 189.
24. Narayan, Chambers, Shah, Petesch, 22.
25. Sen, 189-190.
26. In this context, "Western" refers to Western Europe, the British Isles, Australia and New Zealand, Japan, South Korea, the United States and Canada.
26. Refers to the Commonwealth of Independent States, an organization comprising the Russian Federation and many of the fomer SSRs – Soviet Socialist Republics.

Acknowledgements

This analysis is part of series of reports conducted in July, 2007 concerning data garnered from research and subsequent creation of a University-wide digital database that will provide Tufts students, faculty, and alumni with access to Anthropological internships, research opportunities, and venues of a similar caliber in both the United States and abroad. The Author greatly appreciates and wishes to thank Professor Jennifer Burtner-Rangel of the Department of Anthropology at Tufts University for her considerable expertise and support throughout the research course, as well as Andrea Daley for her assistance in the intricacies of Microsoft Access 2003. **Editors Note**: Information concerning the Database research conducted in this paper can be found at www.ase.tufts.edu/tuftscope in the archives, alongside a digital copy of this journal.

The Interdisciplinary Journal of Health, Ethics, and Policy

SURROGACY: HUMAN INCUBATORS AND A DEFENSE OF CONTRACTUAL AND FINANCIAL AGREEMENTS

David Y. Harari

This paper addresses the rising trend of surrogacy and the use of women as human incubators (both as full and gestational surrogates), employed by couples that experience infertility. Surrogacy is one of the common approaches now adopted by infertile parties as a method of producing a child. As of yet, the United States federal government has remained silent on the matter of surrogate contracts, leaving the decision in the hands of each state government. One issue to be examined is the commercialization and commodification of women as surrogates are entering into contracts and receiving payments. Some even liken this commodification of human life to a return to slavery. Other critics point to the exploitation and degradation of women assuming the role of surrogates, calling them "breeder-woman." There is a worry that women's bodies are being exploited for their reproductive capacities. Opponents claim that surrogacy seekers are inappropriately targeting women from minority races and lower-income demographics. Supporters of surrogacy contracts argue that providing a financial incentive simply encourages women to become surrogates and ultimately gives the gift of life to desperate parents and should therefore trump any other concern. While this approach is not entirely satisfactory, the author suggests, with the aid of human testimonies and via analogies, that surrogacy be viewed through the lens of providing a service, a laudatory one indeed. Invoking our right to procreate and our right to contract, the author demonstrates how surrogacy contracts seem to escape all of the commonly attributed moral and ethical concerns. Along the lines of treating surrogacy as a pure contractual service, the author further argues for the surrogate woman's right woman to demand a different price depending on whether gestational or full surrogacy is chosen.

In 1985, twenty-six-year-old Mary Beth Whitehead agreed to carry the child of William and Elizabeth Stern, the intending parents (Spar, p. 69). The price: $10,000. In April 2005, twenty-five-year old Teresa Anderson agreed to carry the child of Enrique and Luisa Gonzalez. The price: $15,000 (Spar, p. 229). These women, referred to as surrogate mothers, or quite simply as surrogates, are but two participants in the growing practice of contractual and commercial surrogacy. The rising trend of employing a woman to gestate a child not entirely her own calls into question critical ethical issues. Are women being used, taken advantage of, exploited, and treated like commercial items? Or, perhaps there should be nothing troubling about women voluntarily offering their wombs as human incubators and receiving compensation.

For centuries, infertile couples have been searching for remedies and solutions to solve their problems of infertility. The advent of in vitro fertilization (IVF), first performed successfully in 1978, allowed couples experiencing difficulty in conceiving through conventional means to enter into a process in which sperm and egg were collected and fertilized outside of the human body, in a test tube or Petri dish in a fertility lab. The fertilized egg and resulting embryo was then placed in the womb of the mother-to-be. The popularity of the innovative and promising technology of IVF spurred an increase in gestational surrogacy cases worldwide.[1] A woman physically incapable of carrying and giving birth to her genetic child (perhaps due to a hysterectomy or old age) could now have one of her eggs removed, fertilized with the sperm of her husband or donor, and inserted in a surrogate mother willing to carry and give birth to "their" own genetic child. Occasionally, a biological, single-parent father may choose to form a contract with a surrogate much like a single unmarried woman may use the sperm of a third-party donor. Janet L. Dolgin, a professor of law at Hofstra School of Law and author of Defining the Family, clarifies that "although now surrogacy arrangements can take many forms, they all involve the participation of a woman who agrees to gestate and give birth to the child whom she further agrees to surrender to other parents. These parents are variously called 'contracting.' 'intending,' or 'social' parents" (Dolgin, p. 64).

The commercial and contractual aspect of the relationship between the intending parents and the surrogate mother has aroused great interest and curiosity. Deborah L. Spar, a professor at Harvard Business School and author of The Baby Business, comments on this unique relationship: "Instead of giving birth to her child, the intended mother borrows—employs, rents, purchases—the womb of another. The pregnant woman is not the mother in a surrogacy arrangement; the paying woman is (p. 71)."

Although some women are altruistic enough to

Author Contact Information:
Undergraduate student of Yeshiva University, Class of 2008. Correspondence should be addressed to David Y. Harari at dyharari@gmail.com

lend their bodies to relatives and friends at no cost, the vast majority of surrogacy arrangements presently involve some form of payment or compensation. What is being paid for exactly, the child or the physical labors and inconveniences that the surrogate undergoes, might be a matter of dispute. What is clear, however, is that contracts are being formed and money is being exchanged.[2] In the United States, the federal government has been silent and has yet to legislate any law prohibiting surrogacy contracts.[3] The matter is mostly left up to the state courts and legislative bodies, allowing for a wide array of opinions. Some legislatures outlaw contractual surrogacy on all grounds and make it a criminal offense to participate in such a contract. In Michigan, for example, "arranging or mediating such a contract is a felony, punishable by a fine of up to $50,000 and/or a prison term of up to five years. In New York, surrogacy agreements are void and unenforceable; participants are subject to civil penalties and brokers and other mediators receiving payment are subject to a civil penalty for a first offense and to criminal penalties for subsequent offenses" (Dolgin, p. 77). Some states like Alabama, Nevada, and West Virginia, exclude contractual surrogacy from the laws prohibiting payment for adoption, but do not actively regulate surrogacy arrangements. States like New Hampshire, on the other hand, permit surrogacy contracts and efficiently regulate them (Dolgin, p. 77).

Many critics of surrogacy point to the commercialization and commodification of women and children. In 1987, Gena Corea, an author who writes profusely on women in contemporary society, stated: "The rise of the surrogate industry does not take place in isolation. It is part of the industrialization of reproduction. It is part of the opening up of the 'reproductive supermarket'" (Spar, 77). The making of babies is turning into an industry; people are beginning to 'shop' for babies. Opponents of commercial surrogacy maintain that the very notion of putting price tags on humans is deemed inappropriate and considered unacceptable. Of course, society at large subscribes to the view that babies themselves should not be bought or sold. Spar expresses this majority feeling in the preface to her book: "As people—as parents—we don't like to think of children as economic objects. They are products, we insist, of love, not money, of an intimate creation that exists far beyond the reach of any market impulse" (Spar, p. xi). Renting space in surrogates' wombs, critics claim, does not circumvent the uneasiness surrounding the buying and selling of babies. The implication is one and the same; human life is being treated as a commodity. In 2004, the President's Council on Bioethics raised some ethical concerns regarding the commercialization of reproduction:

> Some argue that the commercialization of reproductive tissues might diminish respect for the human body and human procreation…If the essential materials of human procreation are regularly bought, sold, and esteemed in accordance with market valuations, the human meaning of bringing forward the next generation may be obscured or undermined. (p. 149-150).

Those who maintain that the "essential materials of human procreation" should not be treated as commodities do not always make their reasons explicit. There is a general sense of uneasiness that hovers over any talk of babies as property or exchangeable items. When asked to pinpoint the problem, it is not unusual for someone to respond by saying 'it's just wrong' or 'it doesn't sit right with me.' As Spar simply commented, "we don't like to think of children as economic objects" (emphasis mine, p. xi). Certain individuals, such as Ron Gray from the Christian Heritage Party of Canada, however, argue that the commodification of people is morally objectionable in that is a "return to slavery." "Slaves," explains Peter King of the University of Toronto, "are unambiguously treated as mere things—as property…this treatment is reflected in the authority claimed by the masters, who, in failing to treat the slaves as complete moral agents, dehumanize them, and thereby regulate them to inferior status" (King, p. 11). King continues to elaborate that dehumanization is a form of injustice that unduly limits the moral status of an individual. Thus, the treatment of babies, and people in general, as commodities may be the moral equivalent of slavery. If slavery was outlawed, then the reaction to baby selling should be no different. In short, whether an explicit argument is presented or not, critics opine that something is bothersome, troubling, and making us anxious about mingling economics with procreation.

Dolgin notes that by entering into surrogacy contracts, the resulting babies are no longer thought of as "gifts of nature." The children born from such business dealings are mere commodities that may be exchanged for money in the marketplace. Babies "are valuable," insists Dolgin, "but are not to have a monetary value put on them" (Dolgin, p. 72). A gift is bestowed upon a person with no strings attached; yet, a contract becomes necessary when the item being transferred is a commodity. A gift is also something that is usually exchanged between people in a close relationship, such as friends or relatives. The gift giving experience is characterized by love, care, and emotion. The acquiring of a commodity, on the other hand, is a rather cold, market-oriented, and purely business-like transaction.

In addition, the treatment of babies as commodities and property tends to lead to difficult relationships between surrogates and intending parents once the baby is surrendered. As Dolgin paraphrases the Kenyon College professor, Lewis Hyde: "While gifts transform relationships, contracts leave them untouched, and while gifts bespeak attachment, contracts bespeak freedom" (Dolgin, p. 74). When anthropologist Helena Ragoné asked one of the contractual surrogates she studied to reflect on her experience, the woman reported: "I felt they [the intending parents] had been my friends, but after they got what they wanted, they weren't" (Dolgin, p. 74-75). In other words, once the business deal in a surrogacy contract is completed, ties are often cut and further communication is not always desired, leaving surrogates vulnerable and frustrated.

Others object to the exploitation and degradation aspect of the surrogate women. Corea goes so far as to refer to these surrogates as "breeder-women" (Spar, p. 77). Similarly, Spar quotes a critic who claims that surrogacy contracts "create a national traffic in women exploited for their reproductive faculties and functions…They are reproductive purchase orders where women are procured as instruments in a system of breeding" (Spar, p. 83). Susan Martha Kahn, a Brandeis University anthropologist who studied fertility cases in Israel, worries that "the reproductive capacities of women both Jewish and non-Jewish, married and unmarried may be exploited in both the local and international marketplace" (Kahn, p. 157). Women should not be treated as tools to be used and exploited, even for the production of something as cherished as a child. The New Jersey Supreme Court mirrored this view when it ruled that financial payment to a surrogate is "illegal, perhaps criminal, and potentially degrading to women" (Dolgin, p. 86).

Since every pregnancy is accompanied by physical labors, stress, personal sacrifices, and inconveniences, most women today who nevertheless opt to be surrogates are naturally from the poorer sections of society. Mary Gordon, professor of English at Barnard College, is thus concerned by the danger posed by surrogacy in that it could lead to "large-scale baby farms where poor women are turned into breeders for the rich who cannot or choose not to bear their own children" (Dolgin, p. 74). Surrogacy arrangements may also lead to increased racial gaps as intending parents are likely to select a gestational surrogate from a different racial background to demonstrate that they, not the surrogate, are the real genetic parents. Spar writes: "By 2000, thirty percent of gestational surrogacy arrangements at the largest U.S. program involved surrogates from different racial backgrounds" (Spar, p. 82). Surrogacy opponents see a phenomenon of inappropriate race exploitation taking place; often, the well-off Caucasian woman is seen as essentially handpicking the poorer black or Hispanic woman and 'using' her facilities.

Supporters of surrogacy contracts argue that providing a financial incentive helps a couple produce a child, and should therefore be endorsed. They call upon the "parental desperation" (Spar, p.77) and the pain experienced by parents who cannot conceive a baby on their own. In its discussion of buying and selling gametes, the President's Council on Bioethics similarly justified the sale of gametes: "…the ability to buy and sell gametes helps otherwise infertile couples to participate in the activities of human procreation and child-rearing…if there are no payments for gametes, some couples might remain childless because of an inadequate supply of eggs and sperm" (p. 150-151). Although the issue of gamete transactions might be different from surrogacy contracts in some regards, they are certainly related. Reproductive essentials (eggs, sperm, womb, ect.) are being exchanged and the practice is validated due to its benefits. Couples willing to pay the right price could secure a child for life. If monetary compensation was not allowed, there would likely be a decrease in the numbers of donors and surrogates offering their resources. Payment, some claim, is the only method to maintain a constant supply for the increasing demand of infertile couples.

The above approach, however, does not entirely escape the previously mentioned objections to surrogacy. It does not really dispel the moral dilemma of buying and selling babies nor does it completely avoid the notion of women being exploited or discriminated. Instead, it acknowledges these problems and nevertheless confirms that the primary concern must be providing the means to have a child. Champions of this view must hold that the troubling moral issues surely do not outweigh or amount to anything as great as the possibility to procure a child.

The unsettling moral problems of commercial surrogacy, I believe, stem solely from the fact that people choose to view surrogacy contracts as actual baby selling. We would do much better by looking at surrogacy as a pure service, albeit a procreative service. Individuals and groups provide services and construct contracts regularly in everyday society with ease. The dry cleaner, waiter, and exercise instructor all offer services that we pay for willingly and gladly, even without the slightest bit of ethical and moral inner conflict. Surrogacy contracts should be no different. As free citizens, we have the right and freedom to contract, and as Spar points out "if individuals were allowed to procreate and to contract, then surely they should be able to procreate under contract" (Spar, p. 77). Indeed, the surrogate woman is providing a vital and noble service—a means to an end—and it is only right that she be allowed to be compensated duly for the stress, discomfort, restricted lifestyle, and overall labors that come along with being pregnant. Contractual surrogacy is far from baby selling; payment is solely for the service, not for the child.

Surrogates themselves often mention the 'service' aspect of surrogacy in their decisions to carry a child in their wombs. A surrogate woman from Herzliya, Israel, explained what it means for her to be a surrogate: " To me, it's like someone who rents their car, I rent my womb, and then cut the connection" (Kahn, p. 149). Another woman said, "…the egg and sperm will not be mine, and I will just give my womb to rent. It's exactly like giving my child to a babysitter to take care of: she feeds him and takes care of him" (Kahn, p. 153). One husband seeking a surrogate insisted that "we just want to use the services of a womb that we don't have…We just don't have a human incubator for our embryo" (Kahn, p. 154). These testimonies demonstrate that individuals treat surrogacy as a service. Whether it is likened to a rental car, a babysitter, or a human incubator, the message is clear. Commercial surrogacy is viewed as yet another service; like any other service in which a monetary agreement is reached, compensation is not only appropriate, but also obligatory.

Once contractual surrogacy is regarded as a service, the issue of treating babies and women as commodities is no longer applicable. Babies and women's bodies are not being bought or sold. The payment is the fee for the pregnancy service. The baby produced is still a "gift of nature," for no price tag was ever put on the priceless baby itself. There need not be worries of discrimination, degradation, or exploitation. We are not dealing with surrogate women who are coerced into carrying the child of another couple. Surrogate women, as conscious and free citizens, willingly decide whether they are interested in performing this procreative service. The fact that the majority of women performing the surrogacy service may be poor or from a particular minority race should not be regarded as discrimination. It just happens to be that a particular class of women is attracted to this service. If an individual opens a sushi restaurant and seeks workers and all the applicants turn out to be Japanese, is it discriminatory to hire only Japanese individuals? I would tend to think not. It should be no different then if the vast pool of surrogacy candidates is poor or belongs to a minority race. There is no intentional singling out or handpicking, but rather the coming together of two free parties to forge a legal and binding contract.

I do, however, believe that there should be a difference in price between traditional and gestational surrogacy along the lines of treating surrogacy as a pure service. In traditional surrogacy, the surrogate gives her genetic material in addition to her womb. This should mean that the traditional surrogate at least be allowed to demand higher fees than the gestational surrogate, who only rents her womb. The higher price should not be taken to mean that more money is necessary to pay for the actual genetic material. The service in which both the womb and the genetic material of the surrogate are utilized is defined as a more expensive service. The surrogate is giving more of herself and has a right, therefore, to demand more money for the overall service if so desired. When forming a contract, the two parties may stipulate whatever conditions they agree upon. If the couple is looking for a particular genetic makeup that only a certain surrogate possesses, then the surrogate may stipulate that providing such a service may cost more money. This is not to say that the contracting parents must pay more for traditional surrogacy. I am only arguing that the traditional surrogate has the right to demand greater compensation if she considers traditional surrogacy a more elevated service.

Some might object and say that contractual surrogacy is baby selling after all. They may point out that a surrogate who goes through with the whole pregnancy only to give birth to a stillborn often receives less payment then if the child was born alive and healthy. If one is not paying for the actual baby, then why should there be a difference if the baby is born alive or dead, or for that matter, with seven fingers or a missing arm? Clearly, the critics contend, we are indeed paying for the result. But this is incorrect reasoning in light of the fact that the two parties have a right to stipulate whatever conditions they desire when forming the binding contract. A couple may decide to pay x amount of dollars for a service that produces a live child and y amount of dollars for a service that results in a stillborn. It is not the live or dead newborn, however, that is being paid for. The result is only an indicator of what type of service has been provided. Although the pregnant woman who gives birth to a stillborn goes through the same exact process of the woman who bears a live child, the quality of the service, not the child, is the determining factor. Granted that the quality of the child affects the quality of the service in return, but this by no means implies that the child is the item being paid for here.

An analogy may be helpful. Consider the service provided by a driver of a car service. A businessman hires a driver to take him to the airport and agrees to pay him $50 on condition that they arrive at the airport 3:00 PM. In addition, the businessman stipulates the following condition: even if they arrive to the airport at 3:00 PM, he will only pay the driver the full price if he makes his flight in time. If he misses the flight, there will be a $15 deduction. The driver willingly agrees with all the conditions and the two parties sign a contract and shake hands. They arrive at the airport by 3:00 PM, and yet the businessman misses his flight. The businessman rightfully pays the driver only $35. Now, one may ask why this is so. The driver performed the same activities as he would if the businessman had indeed made his flight. He filled up the car with gas, he was cautious on the road, he loaded and unloaded all the suitcases, picked him up and dropped him off on time, etc. Yet, there was a crucial, stipulated condition that was missing. The driver had not performed the exact service requested of him. The service entailed the businessman making his flight. In other words, the outcome or result—the making or missing of the flight—was a reflection of the type of service provided. The surrogacy case is quite similar. The surrogate woman refrains from alcohol and drugs, she nourishes her body, she shows up for all the necessary doctors appointments, and ultimately delivers the baby. Yet, the status of this baby is a reflection of the quality of service provided by the woman. The surrogacy service that brings forth a stillborn baby is a different type of service than surrogacy that involves a live baby, even though the same protocol was adhered to prior to delivery. If this difference in services is stipulated in the contract, then different levels of payment may apply.

The issue of commercial surrogacy is complex and laden with subtleties. We live in a society where individuals enter into contracts freely and are no strangers to the idea of paying money for services we wish to benefit from. Surrogacy should be treated no differently. It is an integral and vital service that is worthy of payment. Thus, when it comes to our particular case of the use of human beings in science—surrogate mothers—let us regard the practice as upholding the highest ethical and legal standards in our society.

References and Notes

Editors Note: Due to the nature of this paper the citations have been left as parenthetical

1. There are, in fact, two forms of surrogacy: partial (traditional) surrogacy and full (gestational) surrogacy. In partial surrogacy, the sperm of the commissioning father and the egg of the surrogate mother are used to conceive the child, thus resulting in a child genetically related only to the intending father. In full surrogacy, however, both the egg and sperm come from the commissioning and intending parents, producing a child that is genetically related to both of the parents (Golomback, p. 38-39). Although traditional surrogacy was an option even before IVF, the technology added a new twist in that it allowed for the separation between the egg utilized and the womb into which it would be placed; another woman other than the gestational surrogate could now provide the egg.

2. Dolgin estimates that commercial surrogacy "involves payments of between $10,000 and $15,000 to the surrogate" (Dolgin, p. 65). More money is dispensed to brokers and middlemen, such as entrepreneurs Noel Keane and Bill Handel, who charged approximately $15,000 per surrogacy arrangement (Spar, p. 80). As early as 1979, Dr. Richard Levin of Kentucky opened a practice in commercial surrogacy. Levin charged around $15,000 for just sealing the deal between surrogates and intending parents (Spar, p.76-77). Dolgin records that couples were paying fees between $28,000 and $45,000 for the entire surrogacy process in 1994 (Dolgin, p. 65). Spar's findings are quite similar, as she notes that couples "were paying roughly $25,000 to $45,000: a $10,000 fee for the surrogate, $15,000 for the brokers, and all expenses" (Spar, p. 80). As the price for surrogacy settled at around $20,000, 1,210 gestational surrogacy attempts had been recorded in the year 2000 alone (Spar, p. 82). Currently on the Family Formation website, the surrogate agency promises that "if you are selected to be a gestational carrier, the compensation is $23,000 plus additional amounts for gestating multiples, delivery via c-section, certain expense reimbursements, etc. (http://www.gestationalcarriers.com).

3. Some countries have been quick to bring surrogacy contracts to a halt. Egypt, Germany, France and Denmark prohibit surrogacy. In the United Kingdom, surrogacy is permitted only if the couple is married and is then regulated by the Human Fertilization and Embryology Authority (HFEA). In Israel, the couple must be married, the surrogate must be single, and the process is regulated by the Ministry of Health (Spar, P. 71, 215). Surrogates in Israel are barred from accepting more money than the sum approved by the government-appointed committee. Violators, including both the surrogate and the contracting parents, are liable to a one-year prison sentence (Kahn, p. 151).

4. Dolgin, Janet L. Defining the Family. New York: New York University Press, 1997.

5. Gray, Ron. Christian Heritage Party. "The Commodification of People is a Return to Slavery." 29 May 2002. <http://www.chp.ca/arcCHPSpeaksOut/embryoResearchIsImmoral.htm>.

6. Family Formation. 10 December 2006. <http://www.gestationalcarriers.com>.

7. Golombok, Susan. Parenting: What Really Counts? London: Routledge Taylor & Francis Group, 2000.

8. Kahn, Susan Martha. Reproducing Jews. Durham: Duke University Press, 2000.

9. King, Peter. "Slavery and Commodification: The Case against Market Socialism."<http://individual.utoronto.ca/pking/unpublished/Slavery_and_Commodification.pdf>

10. "Reproduction and Responsibility: The Regulation of New Biotechnologies." The President's Council on Bioethics. March 2004. <http://bioethics.gov/reports/reproductionandresponsibility/chapter6.html>.

11. Spar, Deborah L. The Baby Business. Boston: Harvard Business School Press, 2006.

Commentary

DISEASES IN DEVELOPING COUNTRIES: THE GAPS TO ACCESSING ESSENTIAL MEDICINES

Ashley Allison, John Chiosi, Anisha Gandhi, Erica Popovsky, Swati Shah

There is no clean water in Aqua Negra, but there are power lines. There are few latrines, but there is plenty of garbage littered across the shore where the river slowly engulfs the make-shift aluminum houses. These houses will have to be rebuilt after the river's annual flooding.

The members of the Tufts Timmy Foundation recently set foot in this barrio on the outskirts of Puerto Plata during a medical relief trip to the Dominican Republic. For many, this was their first time experiencing the grim realities of extreme poverty. This was their first time putting a face to the living-on-less-than-$1-a-day statistics. Over the course of five days, they traveled to many villages similar to Aqua Negra and witnessed the hope and desperation associated with medical care. Hope, because the group brought doctors, Children's Tylenol, and toothpaste to those in need. Who knows when the next group would come? Trips such as this one, while charitable, do not provide effective solutions in sustainable healthcare to the global impoverished.

Sustainable healthcare can only be achieved when patients have access to essential medicines. According to the World Health Organization (WHO), essential medicines address the priority health needs of a population.[1] These medicines should be available in health systems at all times, be of assured quality, and be available at a price that the individual and the community can afford. The United Nation's Universal Declaration of Human Rights declares that everyone has a right to the adequate provision of health.[2] However, ten million people die annually around the globe because of the lack of access to essential medicines for curable diseases.[3] This is because many barriers arise between the initial research into a health problem and the actual provision of medicine to a population affected by a particular disease. In order to truly ensure health as a human right, providing access to essential medicines is vital.

The Research Gap

Several roadblocks prevent the development of valuable medication. Research in the university setting often lays the foundation for preclinical research that pharmaceutical companies can use to develop effective medicines. However, little academic research published on neglected diseases actually progresses into useful products.[4] For example, a Medline search on trypanosomes brings up more than 13,000 papers, demonstrating the abundance of academic knowledge on the parasite; however, new drug developments have stagnated for trypanosomiasis, the disease associated with the parasite.[4] Pharmaceutical companies do not consider preclinical research for these diseases because of the low profitability in selling these types of medications.[5]

Even if pharmaceutical companies decide to invest in preclinical research on a disease, they lack financial incentives to develop the actual drugs. The costs of further research and production of these medications is greater than estimated profits, because the medications are primarily sold in developing countries. Developing countries lack the resources to purchase enough medications at a certain price, a formula which must be balanced for drug companies to make a profit.[5] As a result, millions of people around the globe die annually from neglected tropical diseases, such as sleeping sickness and blinding trachoma, which are unheard of in the United States and other developed countries. With the capacity for medical research severely inhibited in many low-income countries, the eradication of neglected diseases will depend heavily on high-income countries or middle-income countries, such as India4 or Brazil.[6]

The effects of these roadblocks on the developing world are extremely damaging. Currently, 10% of the world's expenditure towards health research and development is being stretched to cover 90% of the

Author Contact Information:
Correspondence should be addressed to John Chiosi at John.Chiosi@tufts.edu.

world's health problems, further perpetuating the health inequality gap between developing and developed nations.[3] This imbalance is further illustrated in Figure 1, where Africa, Asia, and the Middle East make up 72% of the world population, but only 13% of the world drug market. From an economic standpoint, the low purchasing power of developing countries combined with high costs in Research & Development encourages drug companies to focus on markets in wealthy countries.[7] Even when the gap in research is avoided and pharmaceutical companies develop medications for neglected diseases, further barriers prevent essential medicines from reaching the hands that most need it.

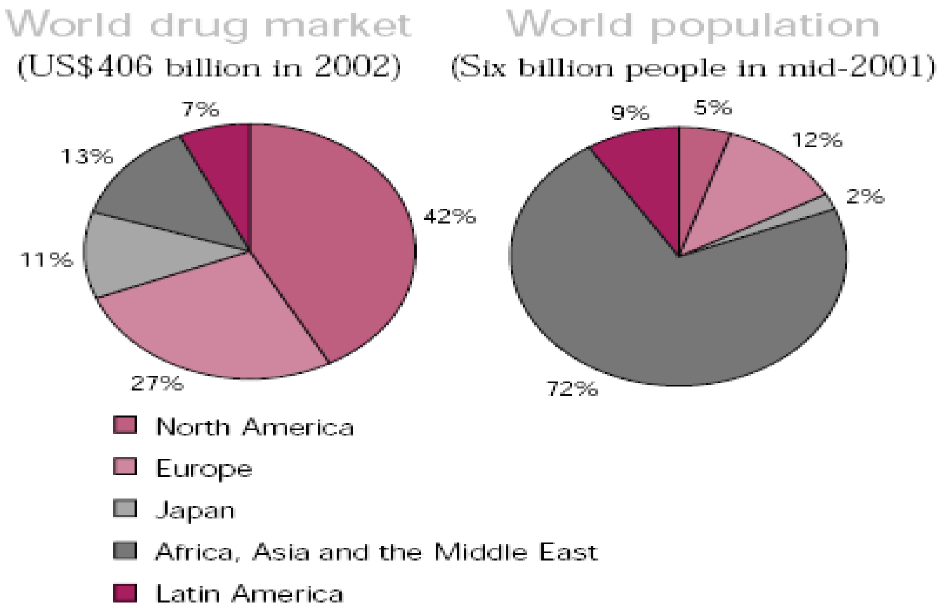


Figure 1. Global Pharmaceutical Market.7

The Access Gap

Although there are many major barriers creating the "access gap," the relatively high prices of drugs place a huge financial burden on developing countries. High prices can be traced back to pharmaceutical companies buying the patents of potential drugs from universities.[8] A patent is a very powerful tool because it gives drug companies the monopolistic rights to manipulate and change prices for a given period of time. Without competition, drug companies' interests are to raise prices and increase profits. These high prices have large opportunity costs for developing countries. For example, when the poor in India living on two dollars per day spend their earnings on medication, they forfeit their ability to purchase food. Sadly, the problem lies in the fact that ability to pay does not match the need for medication.

To deepen the burden even further, many poor governments do not provide sustainable public financing for medicines. Instead, in most low-income countries, individuals pay fifty to ninety percent of the medicinal costs out of their own pockets rather than relying on public insurance. The developing country's government should view essential medicines as a part of a person's right to healthcare and should therefore publicly manage healthcare funding for essential medicines.[9] In this obstacle, need is again poorly matched with ability to pay.

In order to combat these barriers, there must first be competition to decrease monopolistic pricing and second, the sustainable public financing must be implemented. The introduction of generic drugs creates lower prices that help patients afford the medications they need. The increase in public funding such as the Global Fund to Fight AIDS helps individuals pay for needed medications.[9]

The case study of the global AIDS epidemic can explain the benefits of access to essential medicines. Antiretroviral drugs have been proven to prolong lives and stabilize patient health. If institutions worked together, essential medicines could benefit a nation-state. For example, in Brazil, the government introduced a new nationalized healthcare plan for HIV/AIDS essential medicines.[10] Once local manufacturers introduced generic versions of patented medications success rates for HIV/AIDS dramatically improved: there was a fifty percent decrease in AIDS mortality and HIV incidence also decreased.[6]

As hopeful as these possibilities are, measures have already been taken to block these solutions. An example is TRIPS, the Agreement of Trade-Related Aspects on Intellectual Property. TRIPIS protects the patents of pharmaceutical companies to prevent the creation of generic drugs by any international entity. Countries such as India and South Africa who have attempted to supply their HIV-infected citizens with generic anti-viral drugs have been thwarted by TRIPS. This has left few resources and unaffordable pharmaceuticals for patients that have a dire need for the medications.[6]

Bridging the Gaps

Although roadblocks such as TRIPS stand in the way, there are many solutions to the problems of research and access gaps that do not target governments and drug companies alone. One source of research that goes to drug companies is from research universities who develop treatments for diseases. These universities can use their leverage as the source of research to play a role in closing the access gap and the research gap. One such statement that encourages research universities to close these health disparities is the Philadelphia Consensus Statement.[11] University signatories to the statement pledge to use their bargaining power to ensure that access is more equitable. One way to do this is through actions such as granting the rights for their research to generic drug companies that will sell the pharmaceuticals at low prices to countries in need. Research universities also pledge to close the research gap by changing their policies when it comes to research of neglected diseases. For example, the universities can create new opportunities for drug development or engage in public-private partnerships.

Both the research and the access gap are huge problems in global health. Millions of people are not receiving the care that they need and at least ten million people are dying a year because of this lack of medication and treatment. Although there are possible solutions, such as creating competition among drug companies and implementing public financing, there are also road blocks such as TRIPS. The Philadelphia Consensus Statement is one way to overcome these road blocks and get on the right track towards overcoming the global health problems of research and access gap. These problems must be addressed so that every human being has the right to health.

References

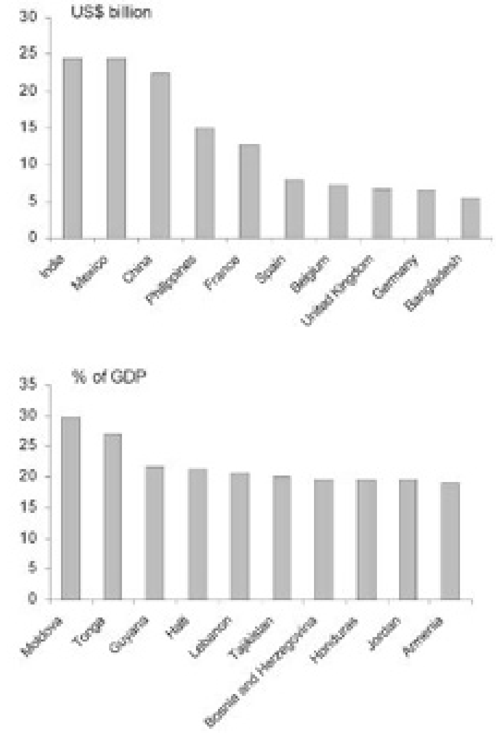
1. World Health Organization (2004). Equitable access to essential medicines: A framework for collective action. Geneva: World Health Organization. Available: http://whqlibdoc.who.int/hq/2004/WHO_EDM_2004.4.pdf. Accessed 14 March 2007.
2. United Nations (1948). "Universal Declaration of Human Rights." Available: http://www.un.org/Overview/rights.html. Accessed 14 March 2007.
3. "The Problem." Universities Allied for Essential Medicine. Available: http://www.essentialmedicine.org/the-problem/. Accessed 14 March 2007.
4. Marston, Hilary (2006). "The Research Gap." Universities Allied for Essential Medicines. Available: www.essentialmedicine.org/uploads/HilaryMarstonResearchGap.ppt. Accessed 14 March 2007.
5. Pécoul, Bernard (2004). "New Drugs for Neglected Diseases: From Pipeline to Patients." PLoS Med 1(1):e6. Available: http://www.dndi.org/pdf_files/new_drugs.pdf. Accessed 14 March 2007.
6. American Medical Student Association (2007). "Treat the People: Access to Essential AIDS Medication." AIDS Advocacy Network Issues. Available: http://www.amsa.org/global/aids/treatpeople.ppt. Accessed 14 March 2008.
7. Médecins Sans Frontières Access to Essential Medicines Campaign and the Drugs for Neglected Diseases Working Group (2001). "Fatal imbalance: The crisis in research and development for drugs for neglected diseases." Available: http://www.msf.org/content/page.cfm?articleid=032387D3-7D09-49E3-99FC231DBE03F7B7. Accessed 14 March 2008.
8. Hoen, Ellen't (2003). "Patents, Prices, and Patient." UN Chronicle Vol. 40. Available: http://www.un.org/Pubs/chronicle/2003/issue2/0203p13.html. Accessed 14 March 2008.
9. Quick, Jonathan (2003). "Essential Medicines Twenty-Five Years On: Closing the Access Gap." Health Policy & Planning Vol. 18: 1-3.
10. American Medical Students Association (2007). "Brazil Puts Patients Over Patents." AIDS Advocacy Network Issues. Available: http://www.amsa.org/global/aids/BrazilMerckFactSheet.doc. Accessed 14 March 2008.
11. Universities Allied for Essential Medicine (2008). "Philadelphia Consensus Statement." Available: http://www.essentialmedicine.org/cs/?page_id=3. Accessed 14 March 2008.

COMMENTARY

REMITTANCES: THE HEALTH AND WELL- BEING OF SENDERS AND RECEIVERS

Corey Kestenberg

As we look around our Tufts University campus and the Boston metropolitan area, we bear witness to the increasing trend of human migration that is taking place locally. Boston is home to many sizable migrant communities, including the Haitian, Chinese, and Puerto Rican communities. Although migration is seen locally, it is not only a local or national development—it is a worldwide trend. The migration of groups and individuals from less developed countries to more developed countries in search of work is a common practice.



Source: Author's calculation based on IMF Balance of Payments Statistics Yearbook 2007, World Development Indicators 2007, and World Bank Development Prospects Group data.

Figure 1. Top Recipients of Remittances, 2006. From: Ratha, D. (June 2007). "Leveraging Remittances for Development." Policy Brief program on Migrants, Migration, and Development. Migration Policy Institute.

Migration from one country to another is facilitated by geographic proximity, enabling family members to make the journey abroad while still remaining in contact with family members who they leave behind in their country of origin. Important corridors of migration have been established, including the one between Mexico and the U.S.[1] Economic migrants, or those who go abroad to work, are able to send money back to relatives in the form of remittances.

The World Bank defines remittances as money that is sent by migrant workers to their families in the home country.[2] Remittances have recently been a focus of discussion within governments and amongst international organizations. In 2006, $206 billion in recorded remittances were sent to developing countries.[3] This statistic reveals the importance of remittances to the economies and societies of the sending and receiving countries. Yet much of the interaction with remittances occurs on the small scale, between individuals and their families. While remittances can improve the health and overall well-being of individuals who receive them, the process of sending remittances can have a negative impact on the remittance senders.

Families who receive remittances benefit from a stable source of income that is not dependent on the fluctuations of the family's local economy. If a country's economy suffers from an economic downturn due to a natural or manmade disaster, the family will be able to support itself with the money that it receives from a family member abroad.[2] These families will be able to afford to buy food and water during the time when it is scarce. If their homes are damaged, they may be able to pay for temporary shelter that will give them some degree of safety. These are relief measures that families in poor countries without remittance income cannot afford.

Health disparities are visible between families with remittance income and those without it. Individuals who receive remittances can afford greater access to health services, education, and day-to-day necessities.[4] Research done in Sri Lanka has shown that children from families who receive remittances have a lower school drop- out rate and higher birth weights. This result shows the benefit of having more money to put towards education and healthcare.[3] In this way, people in developing countries can use remittance money to pay for necessities that government institutions do not cover.

Since the decision to remit is a personal one, deciding how to spend the remittance money only involves the input of family members. However, this individual decision can potentially turn into a multi-party decision when groups of migrants from

---

Author Contact Information:
Undergraduate student of Tufts University, Class of 2009. Correspondence should be addressed to Corey Kestenberg at Corey.Kestenberg@tufts.edu.

the same base community choose to remit. Members of the same community can choose to pool remittances in order to fund community projects. For example, Hometown Associations (HTA) from individual communities help organize the pooling and funding of projects.[2] The number of official Mexican HTAs within the U.S. has surpassed 700.[5] In the community of Sauz de los García in Zacatecas, Mexico, one HTA worked on a project to bring potable water to the community. It was able to gain support from the HTA members and was also able to receive extra money from a government finance matching program.[6] The utilization of HTAs to expand the scope of remittances helps make changes on the collective level.

Issues related to remittance receivers are discussed more frequently than issues related to remittance senders. Despite the lack of attention given to it, the health and well-being of remittance senders is equally important. While many claim that remittances help to raise the standard of living for receiving families, the impact of working abroad on migrants is less rewarding. These migrants are subject to the stresses of daily life and the pressure to make enough money to support their families. The poor standard of living of temporary migrants can be examined using general information on the financial earnings of Mexican migrants in the United States. While these migrants work for significantly higher wages than they would earn in Mexico, they live well under the national poverty line in America.[7] This means that during their temporary stay in America, immigrants are probably unable to afford nutritious foods and safe shelter. Migrant workers sacrifice their health for the benefit of the families they leave behind.

Immigrants from Mexico also experience a certain "tradeoff" when they travel to the United States for temporary work. Although they are able to find better work and raise their income, they may feel unhappy because they are away from their families and their social support systems.[7] A majority of migrant male workers leave behind their wives and children because immigration laws prevent them from migrating together.[8] This lapse in familial support may cause the men to feel alone and depressed, and they may resort to alcohol to numb their feelings and avoid the pain of their situation. In fact, psychological trauma appears to be more prevalent than physical trauma.[7] The lifestyle of economic migrants may not be sustainable because it can be physically and psychologically abrasive. In this situation, a migrant's ability to cope is challenged as the traditional family structure is disrupted.

Circular migrants who work in agriculture also face social challenges as they travel back and forth between a developed country and their native country. The case of Mexican migrants is again used as an example. The United States and Mexico are two vastly different countries. In particular, life in the United States is very structured, whereas life in Mexico is less formally organized. Migrants need to adjust to these different lifestyles so that they can respect the social norms in each country. Since jobs may only be held for several months at a time, the migrants need to quickly change their behaviors in order to fit the situation.[7] The cyclical pattern of changing lifestyles can still be difficult for immigrants to cope with, even if they are accustomed to making the repeated trips.

The conflicting effects of remittances on their senders and receivers make it difficult to be entirely in favor of or opposed to the sending of remittances. Many families today would not be able to survive if they did not have money being sent to them from a family member working abroad. However, if migrant workers were given the opportunity to support their families with work in their home country, they would probably choose to do so.

Remittances can be used to supplement the finances of developing communities. Furthermore, governments must recognize that migration and remittances are beneficial only when public policy helps support the people sending and receiving remittances. The challenges faced by a migrant will affect his or her decision to migrate for work: if personal costs outweigh the benefits, workers will choose not to migrate, and the trend in rising remittances will slow.

References

1. "Regional Fact Sheet: The Americas." International Migration and Development. United Nations.
2. World Bank. (2006). "Global Economic Prospects: Economic Implications of Remittances and Migration."
3. Ratha, D. (June 2007). "Leveraging Remittances for Development." Policy Brief program on Migrants, Migration, and Development. Migration Policy Institute.
4. Suleri, A.Q. and Savage, K. (24 Sept. 2006). "Money does the talking." Sustainable Development Policy Institute. Retrieved on July 26, 2007, from http://www.sdpi.org/SDPI_in_the_press/articles_2006/articles_sept_6.htm
5. "Pooling Resources through Hometown Associations." (31 May 2006). Inter- American Development Bank. http://www.iadb.org/news/articledetail.cfm?Language=EN&artid=3077&artType=WS
6. Orozco, M. and Welle, K. "Hometown Associations and Development: A Look at Ownership, Sustainability, Correspondence, and Replicability."
7. Guendelman, S. and Perez- Itriago, A. (Autumn, 1987). "Migration Tradeoffs: Men's Experiences with Seasonal Lifestyles." International Migration Review, 21(3), pp. 709-727.
8. Basok, T. (Spring, 2000). "Migration of Mexican Seasonal Farm Workers to Canada and Development: Obstacles to Productive Investment." International Migration Review, 34(1), 79-97.

Acknowledgements: Thank you to Dr. Manuel Carballo at the International Centre for Migration and Health, in Geneva, Switzerland, for mentoring me throughout the course of this research. Thank you also to Professor Astier Almedom for sharing with me her knowledge and direction in this field. Finally, thank you to Mr. and Mrs. Neubauer for providing the funding which ultimately enabled me to travel to Geneva to carry out this research.

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

Shamit S. Desai

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

Author Contact Information:
Undergraduate student of New York University, Class of 2008. Correspondence should be addressed to Shamit S. Desai at ssd240@nyu.edu.

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."
>
> – 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

1. Pogge, Thomas. Incentives for Pharmaceutical Research: Must they Exclude the Poor from Advanced Medicines? Speech Given at University of Toronto. Conference: Access to Medicines as a Human Right: What Does it Mean to Corporate Social Responsibility? Published in October 2006.
2. World Health Organization. Department of HIV/AIDS. HIV/AIDS Country Summary 2005: Burkina Faso. Geneva, Switzerland. 2005
3. Abelson, Reed. Glaxo Will Further Cut Prices Of AIDS Drugs to Poor Nations. New York Times. April 23, 2003.
4. World Health Organization. Department of HIV/AIDS. HIV/AIDS Country Summary 2005: United States of America. Geneva, Switzerland. 2005
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.

PUBLIC POLICY AND ASSISTED REPRODUCTIVE TECHNOLOGIES

Stephanie Feldstein, Yael Nobel, Rachel Sachs

Assisted Reproductive Technologies (ART) entail various ethical ambiguities and complications, and politicians have been wary of taking strong stances on these issues. Public policy regulations have therefore been muddled and inconsistent. As the number of people utilizing ART continues to grow, the need for a cohesive ideology to direct public policy legislation and judicial proceedings becomes increasingly clear. In this paper, we will discuss two prevalent issues in the debate over ART: first, ownership and parenthood, and second, distributive justice. We will address the specific forms of ART that are relevant to these overarching issues and suggest how public policy ought to respond to them. We will ultimately argue that all public policy relating to ART should be guided by the goal of maximizing the autonomy of the individual with regard to his or her reproduction.

A recent addition to Amazon.com's book collection is a children's story about a family of rabbits. A picture of two loving bunny parents hugging their bunny child sits cheerfully below the title, An Itsy Bitsy Gift of Life: An Egg Donor Story.[1] This book and others like it illustrate the growing prevalence of egg donation and other forms of assisted reproductive technologies (ART) in American society. In the year this book was published (2005), close to 15,000 donor eggs were transferred to women of all ages in the United States, hundreds more than in the previous year.[2] Indeed, the past decade has seen a consistent trend of increased availability and use of ART.

ART includes a variety of procedures intended to aid couples facing obstacles to natural reproduction. By far the most common of these is in vitro fertilization (IVF), in which the sperm and ova are combined in a petri dish instead of in the woman's body. If fertilization occurs, the resulting embryos are transferred into the woman's uterus. IVF may be performed using the intentional parents' own gametes or using donor sperm, eggs, or embryos. Variations on IVF include zygote intrafallopian transfer (ZIFT), in which zygotes are transferred to the fallopian tube instead of the uterus, and gamete intrafallopian transfer (GIFT), in which unfertilized ova and sperm are transferred into the fallopian tube and left to fertilize independently.[3] Embryos created in vitro may be used immediately or frozen for use at a later date. Any of these methods can be carried out by implantation in the intentional mother or in a surrogate mother.

Because ART entails various ethical ambiguities and complications, politicians have been wary of taking strong stances in this realm of issues. Public policy regulations have therefore been muddled and inconsistent. As the number of people utilizing ART continues to grow, the need for a cohesive ideology to direct public policy legislation and judicial proceedings becomes increasingly clear.

In order to satisfy this need, there must first be a clear distinction between the respective position of federal law, state law, and court jurisdiction. We contend that these roles with respect to IVF are as follows: legislation ought to be created in accordance with the existing societal ethical framework, and should respect and promote the moral edicts laid out by society. Furthermore, all of this legislation ideally ought to be instituted on a federal level, so people have access to the same reproductive opportunities and are subject to the same regulations regardless of their place of residence, which is not significant in this matter. All policy suggestions outlined in this paper will consequently refer to federal legislation.

In this paper, we will discuss two prevalent issues in the debate over ART: first, ownership and parenthood, and second, distributive justice. We will ultimately argue that all public policy relating to ART should be guided by the goal of maximizing the autonomy of the individual with regard to his or her reproduction.

I. Ownership and Parenthood

Within the broader topics of ownership and parenthood, there are three separate issues that each deal with a different type of ART: gamete ownership during egg and sperm donation; ownership of unimplanted embryos resulting from IVF; and ownership of implanted embryos, especially when a surrogate mother is used.

Ownership of Gametes

Issues surrounding egg and sperm donation range from legal worries, such as the definition of the family and parents, to ethical worries, such as the dangers of commodification. From a legal standpoint, the fact that the child's biological parents are not his "psychological" parents has forced society to decide "who will be considered to be the 'legal parent' of the child."[4] In the case of sperm donation, the 1973 Uniform Parentage Act (UPA), released by the National Conference of Commissioners on Uni-

Author Contact Information:
Undergraduate students of Princeton University. Correspondence should be addressed to Rachel Sachs at sachs@princeton.edu.

form State Laws (NCCUSL), defines the husband of the wife receiving insemination as the child's legal father.5 Donors are "legally absolved of all parental responsibility."[6] The UPA was the first attempt by the federal government to enact a single policy regarding parentage and ART that would ideally by adopted by all the states. However, only 19 states adopted it. The UPA was revised in the year 2000 to include egg donation, but only four states had adopted this revised UPA as of July 2004.7

Still, even states that did not adopt the UPA included ideas in their own legislation that were essentially identical to those expressed by the UPA about gamete donation and parenthood. While there ideally ought to be a uniform national policy, independent state legislation seem to have a formed a sufficiently consistent and uncontroversial approach to gamete donation throughout the country. Furthermore, the current policies work well to maximize the autonomy of all people involved: the intentional parents can be free to conceive a child without worrying about others attempting to claim parenthood, and the donors can be free to donate gametes and help infertile couples without assuming any parental responsibilities. We therefore do not consider it a priority to make a strong push for federal legislation at this time.

An ethical concern worth noting is that of gamete commodification. Some are concerned that the practice of paying donors actually serves to assign monetary value to gametes and therefore ought to be prohibited. As Ruth Macklin discusses, though, eliminating donor compensation would drastically decrease the supply of donor gametes available to infertile couples, and might even drive such donation underground, resulting in the formation of a "black market" for gametes.[8] While certain restrictions must certainly be placed on payments to donors – exorbitant sums may exploit the poor by coercing them to donate – some form of compensation must exist for gamete donation to realistically continue.[8] Macklin concludes that the best solution is to gear payment towards compensation for time and inconvenience, but not for the genetic material itself. In 1990, the American Fertility Society in fact stated that "there should be no compensation to the donor for the egg,"[9] and in 1993 further clarified their position by stating that "donors should be compensated for direct and indirect expenses associated with their participation, inconvenience, time, risk and discomfort."[9]

We suggest that the American Fertility Society's guidelines be put into law. Donors should be paid for their participation, inconvenience, and other related factors, but not for the number or quality of gametes received. This policy would both reduce accusations of commodification and increase gamete owners' ability to make an independent choice about whether and how often to donate.

Ownership of Unimplanted Embryos

Ownership of embryos, both unimplanted and implanted, is much more contentious than that of gametes. Unimplanted embryos are produced when intentional parents choose to freeze some of the fertilized eggs created during the IVF procedure. This allows couples to repeat implantation attempts at convenient later dates without having to undergo the stressful and expensive processes of ovary stimulation and egg "harvesting" again. While couples generally define ahead of time how their frozen embryos are to be used, "couples who successfully have children using IVF may effectively 'abandon' embryos that remain frozen."[10] In this case, the existence and identity of "owners" or "parents" can become extremely ambiguous.

This uncertainty allows for various issues to arise. One example can be seen in a California clinic in 1994, where doctors transferred numerous eggs and embryos of unknowing, un-consenting couples to other women. The doctors directing the clinic at the time were charged on various counts, but not with "embryo theft;" no law existed to explicitly ban this type of activity.[10] Such a law was later passed in the state of California, but not federally. Another example is the case examined by the Supreme Court of Tennessee in the trial of Davis v. Davis. In this case, a divorced couple disputed the fate of seven frozen embryos that had been created while they were married: the former wife wanted to donate the embryos to other couples, but the former husband wanted to discard them.[11] Noting that there was no law or consistent precedent on this issue, the court ultimately ruled in the former husband's favor.

Both of these situations demonstrate the need for some policy establishing reliable guidelines for dealing with frozen embryos in unclear cases. In order to most effectively promote individual parental autonomy, this legislation ought to mandate the creation of contracts at the beginning of the IVF process. These contracts must describe a course of action approved by all parties involved that will dictate who ought to be responsible for the embryos created through IVF, even under unexpected circumstances such as divorce or death. There can consequently be little confusion about the most appropriate way to manage frozen embryos.

Ownership of Implanted Embryos

The primary issue concerning the parenthood of implanted embryos is whether or not surrogacy contracts ought to be legally enforceable. Currently, only 25 states have passed laws about surrogacy, and the legislation is largely "conflicting and inconsistent."[12] Some of the laws ban compensation for surrogacy, others view written contracts as illegal, and the remaining 25 states lack legislation on the issue completely. Even in those states without legislation, though, existing laws against "baby-selling" present problems for parents wishing to employ a surrogate.[12]

One argument against making surrogacy contracts legally enforceable insists that "contract motherhood…commercializes reproduction" and effectively translates into baby-selling.[13] To avoid this problem, the government could establish legislation similar to that suggested earlier to prevent gamete commodification: allowing compensation for risk and inconvenience but not for the "goods" themselves.

A more powerful argument against enforceable surrogacy contracts comes from the increasingly ambiguous definition of the family. The egg for the surrogate pregnancy may come from the intentional mother, from the surrogate herself, or from a donor. Since it seems almost random to choose one of these as the child's only "real" mother, some believe that the surrogate should have some flexibility in her commitment to give the baby away after birth.[14] The New Jersey Supreme Court exemplified this view in its 1986 ruling on the Baby M case. In this trial, the surrogate mother (who was also the genetic mother), Mary Beth Whitehead, sought custody of the child, and she appealed a lower court's decision that declared the surrogacy contract was valid and awarded custody to the Sterns, the intentional parents. In 1988, the appeal court ruled that Whitehead was the legal mother of the child. Since the intentional father's sperm was used for insemination, he was named the child's legal father. But the intentional father's wife, who had planned to be the child's mother, was deemed to have no legal relationship with the child.[15]

Many philosophers and legal scholars have disagreed with this verdict and with its underlying mentality. Richard A. Posner, for example, believes that surrogacy contracts ought to be legally enforceable, largely because "such contracts would not be made unless the parties to them believed that surrogacy would be mutually beneficial...[and that] all the parties to the contract are made better off. The mutual benefits, moreover, depend critically on the contract's being enforceable."[16] Both parties agree of their own free will to the contract, so allowing the surrogate mother to back out of the agreement may be detrimental for multiple reasons: this action violates the surrogate's initial intent, it violates the intentional parents' initial intents and costs them large amounts of time and money, and it sets a bad precedent that will only deter other couples from utilizing this option and reaping the clear benefits offered by surrogacy.

Posner's view has become more popular over the past decades and was supported by the 1993 California Supreme Court case of Johnson v. Calvert. Anna Johnson, the gestational mother for the Calverts, sought custody of the child she had borne. However, the court ruled that the Calverts maintained custody of the child because the intent of the surrogacy contract was clear – that "the Calverts had intended to become parents and initiated steps to achieve this."[7] A similar case is that of In re Marriage of Buzzanca, which dealt with the Buzzancas' attempt to conceive a child using both a surrogate and donated gametes. The Buzzancas divorced before the child was born, and neither the Buzzancas nor the surrogate sought custody of the child after its birth. The California Court of Appeals ruled that the Buzzancas had intended to become the child's parents, and therefore custody ought to lie with them.[17]

After considering the goal of maximizing reproductive autonomy as well as the conflicting perspectives for and against enforcing surrogacy contracts, two conflicting but equally tenable options for legislation seem to arise. The first would attempt to maximize the autonomy of the intended parents, and it advocates that a policy ought to be instituted that declares the surrogacy contract legally binding. This would maximize parental and surrogate autonomy according to the notion that all had voluntarily consented to the initial agreement established in their contract. In this situation, to help minimize cases in which the surrogate mother does wish to appeal for custody, we would recommend that all parties receive extensive education on possible psychological issues that may arise. Intentional parents may be encouraged to use surrogates who have had children of their own, and thus may better understand the psychological issues involved in such a separation.

The second policy suggestion would focus on maximizing the autonomy of the surrogate mother by allowing her to change her mind and appeal for custody if she so chooses. Requiring contracts to be legally enforceable might be unnecessarily restrictive to surrogates, and allowing the surrogate to appeal increases her agency. This policy would not mean that a surrogate plea for custody necessarily means that she receives sole custody; it does, however, imply that her new interest in retaining parental rights will be considered and may carry some weight.

Even while these two possible routes for legislation directly conflict, they both serve to maximize reproductive autonomy in some way and are consequently both defensible. We therefore do not feel comfortable conclusively choosing one option over the other according to criteria outlined in this paper. This may be a possible source of the inconsistent policy existing today on this issue.

II. Distributive Justice

The second important realm of issues associated with ART is that of distributive justice, or who has access to available resources and technologies. Currently, ART is not subsidized in the United States by the government or by most insurance agencies. This is not true universally – in England, for example, one full round of IVF for infertile couples is paid for by the NHS.[18] In America, though, patients pay an estimated 85% of IVF costs. Since the estimated cost per live birth is $58,000 for IVF, this procedure is primarily limited to those wealthy enough to afford it.[19]

Is Reproduction a Right?

Is there a role for state or federal governments in subsidizing ART, perhaps grounded in the "right to reproduce?" While respect for individual autonomy generally does grant people the right to reproduce naturally as they see fit, this does not imply that accessing costly government resources is a right. As evidenced by the general lack of pre-natal care for the nation's poor, the current U.S. healthcare system clearly does not promote the right to reproduce. There is therefore is no basis for government subsidies for these procedures. Furthermore, because there is no current U.S. policy of universal healthcare, uninsured individuals do not have a right to any healthcare according to society's current structure. Subsidizing a nonessential (though by no means trivial) procedure would therefore be a violation of the existing ethical edicts demonstrated by existing legislation. There is a valid argument to be made that the ethics currently determining healthcare accessibility are flawed, but the courts would need to rule that healthcare is a universal right before public policy could justifiably direct large sums of money to provide IVF universally.

One alternative to help ease this distributive burden would be to require insurance agencies to subsidize at least some of the costs of IVF. This would make IVF more available to the many individuals who have insurance but cannot afford the high out-of-pocket expenses for IVF. Of course, this policy would carry its own problems, mainly shifting the distribution barriers further onto individuals without medical insurance, or even raising insurance costs to rates that cause more people to be uninsured.

ART and Exploitation

The other distributive problem with ART arises through the feminist assertion that women and their bodies are "exploited" through these processes. One argument is that paying women to be gamete donors is morally objectionable because it violates the Kantian imperative of never treating others as a means only. However, there are a few problems with this argument, as John Harris describes in Macklin's essay. Using others as a means to an end is acceptable, he writes, when "those others have autonomously accepted the project as their own and have not been coerced in some way into becoming an instrument."[20] Thus, the mutually beneficial relationship between the consenting paid surrogate or gamete donor and the recipient is not inherently coercive. Furthermore, since society tolerates adults' judgments regarding money and inconvenience of other sources of income (such as the costs and benefits associated with being a coal miner), it is rather paternalistic to violate the autonomy of women engaging in IVF by denying them this same ability to choose whether or not to participate.

Others may argue that surrogacy or gamete donation may unduly burden women of lower socioeconomic classes. However, because of the recipient's desire to receive good genes from healthy women, donors are as likely to be from the middle classes as the lower classes.[21] Thus, the distributive burden is overstated here.

Conclusion

In summary, our public policy proposals seek to maximize the individual's reproductive autonomy. Our stance on gamete donation, IVF, and surrogacy all place the government in a restricted regulatory role. We also believe that ART policy is not the forum to resolve distributive justice problems.

References

Editors Note: Parentheses indicate specific page from source that reference came from.

1. Javier, Carmen Martinez, An Itsy Bitsy Gift of Life: An Egg Donor Story, Amazon.com, 2005.
2. Center for Disease Control, ART Report 2005: Preliminary National Summary.
3. Ibid., 183.
4. Shapiro, Vivian B., Shapiro, Janet R., and Paret, Isabel H., "Complex Adoption and Assisted Reproductive Technology", The Guildford Press, New York, 2001. Chapter 8. pp. 173-200. (p. 177)
5. Grief, Karen F. and Merz, Jon F., Current Controversies in the Biological Sciences, MIT Press, Cambridge, Massachusetts, 2007, Chapter 4, pp. 77-99. (p. 89)
6. Shapiro, 188.
7. Greif, 90.
8. Ibid., 119.
9. Ibid., 107.
10. Greif, 92.
11. Supreme Court of Tennessee, Davis v. Davis, 1992.
12. Greif, 86.
13. Ketchum, Sara Ann, "Selling Babies and Selling Bodies", in Steinbock, Bonnie, Arras, John D., and London, Alex John, Ethical Issues in Modern Medicine, 6th edition, McGraw-Hill, New York, NY, 2003, pp. 625-630. (p. 625)
14. Shapiro, 196.
15. "New Jersey. In the Matter of Baby M, 537 A.2d 1227 (N.J. 1988)", in: A. R. Jonsen-R.M. Veatch-L.R. Walters, Source Book in Bioethics: A Documentary History, Washington, D.C.: Georgetown University Press, 1998, pp. 376-385. (p. 376)
16. Posner, R. A., "The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood", Journal of Contemporary Health Policy, 5 (1989), pp. 21-31. (p. 23)
17. Greif, 91.
18. BBC News, NHS to offer one free IVF cycle, Feb. 25, 2004, from http://news.bbc.co.uk/1/hi/health/3516941.stm.
19. Grief, 87.
20. Macklin, Ruth, "What is Wrong with Commodification?", New Ways of Making Babies, ed. by C. Cohen, Indianapolis: Indiana University Press, 1996, pp. 106-121. (p. 112)
21. Macklin, 113.

TUFTSCOPE
Mayer Campus Center
Tufts University
Medford, Massachusetts 02155
ISSN: 1534-7397
Website: http://ase.tufts.edu/tuftscope
Email: TuftScope@gmail.com