

Pogge's plans to "incentivize universal access to advanced essential medicines" are pragmatic and forward-thinking. He insists that we avoid the "philosopher's pipe dream"¹ in order to actually consider relevant and practicable policies for the two billion who currently lack access to medicine. His arguments²

A few points to consider:

1. Pogge is not discussing how to bring medicine to the two billion. He is, rather, discussing alternative schemes for the production of new "essential medicines." The current regime, he argues, is "morally highly problematic in the case of essential medicines"³ and causes "countless premature deaths and much severe suffering worldwide."⁴ In each of the sections from which these quotations are selected, we should note, Pogge is discussing the ethical and health failures of the current patent regime, wherein monopolies are granted for a period of time to the actor that claims discovery, thereby allowing her to "sell [the drug] at the profit-maximizing monopoly price typically very far above – as in 400 times greater than – its marginal cost of production."⁵ While these reforms he considers are no doubt needed and humane, they make no attempt to address the already existing (and malleable) lack of delivery to the two billion for whom patent laws are not a barrier to delivery. In other words, Pogge is trying to incentivize the development of *new* drugs to combat existing killers, rather than incentivizing the *treatment* of the two billion. He is not alone. The Gates Foundation's much-publicized efforts to find an HIV-vaccine, for instance, would still need to be administered if it ever becomes successful. The cost of producing billions of vaccines and paying for billions of inoculations, which Pogge does not acknowledge as a barrier to essential medical access, are high. In a world with vaccines for polio, treatment for tuberculosis and widespread knowledge about the benefits in antibiotics in treating infections, Pogge can only cite millions of deaths from these ailments *because existing medicines and treatments are made unavailable to the two billion*. Likewise, we do not need a costly miracle drug to stop starvation.

While we should have no doubt that the human costs of bigPharma's near complete R&D emphasis on non-tropical (and non-lethal) diseases is catastrophic, I fail to see how incentivizing *new medicines* is necessary until we have developed institutions to deliver *existing essential medicines*. We need not find a vaccine to prevent HIV transmission in order to prolong the lives of millions with HIV, after all; we need ARVs and clean water and food.

2. It has been shown in South Africa that the delivery of certain medicines to impoverished populations is cosmetic unless we address some very important background concerns. Namely, water. "Access" to medicines, we have learned, must take into account more than the pill's existence on the store shelf. "Access," in its contemporary neo-liberal sense, is much like "choice" in terms of abortion debates – neither takes account of pricing, distance, actual availability, and social costs. Knowing that taking ARVs with unsanitary water both causes illness and deactivates the ARV, we must conclude that basic rights (shelter, medicine,

¹ Incentivize at 3

² As represented in his "How to Incentivize Universal Access to Advanced Essential Medicines" and "Montreal Statement on the Human Right to Essential Medicines," *Cambridge Quarterly of Healthcare Ethics*, 15:2 (2006).

³ Incentivize at 5.

⁴ Incentivize at 4.

⁵ Incentivize at 3.

nutrition, etc) should be considered as one unit, inseparable. Robust health regimes cannot exist without the combination of these factors. Thus, “universal access to advanced essential medicines” must be complicated.

Diarrhea, Pogge notes, ends 1.8 million human lives a year. It is most commonly caused by viruses and bacteria that live in unsanitary water –of course we must medically treat the causative agents of the condition with the most advanced treatments available. The political causes, however, are not addressed by the author. While it is unfair to criticize an author for what s/he does not discuss, given that Pogge’s prescription relies on “its cost be[ing] born by the high-income countries,”⁶ I believe he has opened himself to a political attack, specifically in regard to his suggestion that “high income countries” might be willing to fund “\$45-90 billion annually”⁷ when these countries are the same that are quite unavoidably related to the lack of clean, affordable and available water. South Africa’s various Water Crisis Committees, the Cochabamba Water War, and Patrick Bond, one of this conference’s guests, have shown quite conclusively that industrial powerhouses like Bechtel and Suez (examples of the companies whose dividends and appreciation cause these high-income countries to be high-income) profit using the same monopoly powers as the pharmaceutical firms Pogge considers “pitted against the vital needs of poor patients.”⁸ We also know in Bolivia, Bechtel’s contract was a conditionality of an IMF loan to the city, and that privatization and cost-recovery are bedrocks in South Africa’s World Bank-advised macroeconomic system. Given that diarrhea is be a symptom of cholera, which Suez has actually caused in parts of South Africa because of its pricing schemes that make water unavailable to the poor and cheap to the rich, and given that the “high-income” countries did not become “high-income” by selling the best lemonade on the block, nor by entering markets honestly and without exploitation or coercion, is it realistic to imagine that some of the entities causing diarrhea deaths will begin funding its prevention? Perhaps it is. But, is it conceivable that water and other basic rights will be decommidified to the extent that someone on ARVs can undergo a safe treatment protocol? Would the French government pay to cure cholera when one of its bankrollers is so deeply involved in the spread of cholera?

When the author states “before TRIPs”, the “free availability” of “life-saving seeds and medicines” was “standard,”⁹ he is very much mistaken. New patent laws, however punitive, do not account for many of the deaths Pogge demands we prevent. AIDS, my generation’s headlining disease, most affects those already weakened. We commonly forget that it is a syndrome, and does not in itself cause death. Rather, it degrades immune systems and makes people more susceptible to other ailments. And this is where functioning health and funded sanitation and nutrition systems become crucial. Hundreds of thousands of HIV+ people die from pneumonia, TB, and other very treatable viruses and infections. The arguments presented to “incentivize access to advanced essential medicines” are important, but do not forward an agenda that would concretely deliver medicine and healthy backgrounds. Advanced medicines are unnecessary for the majority of ailments (malnutrition among them), and therefore I would comment that we spend more ink considering ways to

⁶ Incentivize at 9.

⁷ Incentivize at 8.

⁸ Incentivize at 2.

⁹ Pogge at 7, Montreal.

incentivize delivery of antibiotics, food aid, and water sanitation facilities. Without these basic requirements, the patent regime on ARVs is almost insignificant.