Viewpoint

Kenneth L. Adelman

Biting the Hand That Cures Them

"THE INFANT FORMULA BATTLE was impressive and something of an international thriller. But it was a cakewalk compared to what lies ahead in the field of pharmaceutical policies," so wrote Stanley J. Match, president of the American Public Health Association. And indeed, in May 1981, one week after the World Health Organization (WHO) had approved the infant formula code by 118 votes to 1 (the United States being the lone dissenter), consumer union representatives of twenty-seven countries gathered in Geneva to launch a drive for international regulation of the pharmaceutical industry.

Thus, it appears that the infant formula drive was just the opening skirmish in a much larger campaign. The stunning defeat it dealt to Western interests, health groups, and corporate enterprises opposing international regulation should have stirred them to muster their forces for the campaign yet ahead. And this larger campaign could reach beyond regulation of pharmaceuticals to encompass United Nations codes on hazardous chemicals, transborder data flow, and an array of so-called consumer protection activities. Victory in one realm raises expectations for victory in another.

United Nations Involvement

The drive for international regulation of infant formula and pharmaceuticals surely would exist in a world without the United Nations (UN). But it would not have an institutional, concrete locale. And it is the UN's organization and resources that give substance to what might otherwise be merely an abstract wish.

The mantle of legitimacy for such a drive is fashioned from the New International Economic Order, proclaimed in the 1972 United Nations General Assembly resolution that commits the United Nations to reordering the world's economic institutions. Added legitimacy is lent by Article 21 of the WHO Constitution, which gives the World Health Assembly,

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WHO's supreme body, "authority to adopt regulations concerning . . . the advertising and labeling of . . . pharmaceuticals and similar products moving in international commerce." Despite quiet mention by WHO's director-general that such regulations are unlikely in the near future, an item in WHO's 1982–83 budget providing funds for developing a proposal on the subject is a hint, perhaps, of things to come.

Besides providing the arena in which these efforts can be pursued, the United Nations also furnishes some concrete assistance. Nongovernmental organizations dedicated to international pharmaceutical restrictions receive financial, secretarial, and moral support from the United Nations' Non-Governmental Liaison Service (NGLS), which coordinates UN activities with outside groups. For example, the New York office of NGLS has hosted a "strategy session" of leading activists in the drug regulation drive. One of its program officers, Michael McCoy, sees the battle to "break the monopolies" of the pharmaceutical companies as one that "will make the breastfeeding issue look like a pebble in the pond. It's going to be a bigger

fight, a harder fight, a nastier fight." But a fight over what?

Drug Dumping

The most emotional issue concerns dumping—the charge that drugs banned from use in the affluent first world are dumped on deprived third world peoples. As Indian Prime Minister Indira Gandhi told the 34th World Health Assembly in May 1981, "dangerous new drugs [have been] tried out on populations of weaker countries although their use is prohibited within the countries of manufacture."

Mrs. Gandhi, it turned out, did not know the surface facts of the matter, much less the underlying reality. When asked at a later press conference for examples of such "dangerous new drugs," she was unable to give even one. Had she been better briefed, she might have named Upjohn Company's Depo-Provera, a synthetic hormone that is injected intramuscularly in women to prevent fertility for three months. The Food and Drug Administration (FDA) banned Depo-Provera from the U.S. market in 1978 "due to controversy concerning its carcinogenic potential." But exports continued, and before long a dramatic film aired on public television showed scenes of poor black mothers in the third world being injected with a substance that is presumably too dangerous for American women.

There is a side of the story the documentary did not tell. Before the FDA's action, the agency's Advisory Committee on Obstetrics and Gynecology had recommended approval of Depo-Provera. WHO itself had endorsed its widespread use, as has the Medical Board of the International Planned Parenthood Federation. Even the American Public Health Association's joint policy committee recommended against a resolution banning its use. None of this is terribly surprising, since Depo-Provera has been widely used for a considerable period of time with few adverse effects reported. It is legal in approximately ninety countries, with about half its overall sales occurring in developed countries and half in the third world.

As this case demonstrates, U.S. companies do sell drugs in developing countries that are banned in the United States. They also sell U.S.-banned drugs in the developed countries. And they sell drugs in the United States that are banned in some parts of the third world. Again, this should not come as a surprise. The fact is that national drug approvals differ markedly—in stringency, in speed, in approaches to a particular health condition or product. Some pharmaceuticals sail through the approval process in Britain or France but flounder in the United States, and vice versa. Untidy, most certainly (as the president of G.D. Searle would put it), but that is life in the real world. And in this world, health conditions and therefore health needs vary greatly from country to country, and scientific experts often disagree. If the United States cannot agree with other developed countries on what drugs to ban, it should not shock the world, nor trouble the conscience, that it cannot agree with Sri Lanka or Paraguay.

Dumping on Transnational Corporations

The drive for international pharmaceutical regulation is also an attack on the larger enemy, the transnational corporation. Rabina Khan of Pakistan, who works for the UN's director-general of development and international economic cooperation, calls pharmaceutical companies "transnationals at their worst" because of their alleged rapacious irresponsibility. Opponents of transnational firms, like opponents of colonialism, tend toward devil theories, and their devil is the profit motive.

In fact, the less-developed world has not been a very attractive source of profits for business, either in colonial times or now. As British scholar J. D. Fage points out in his superb *History of Africa* (1979), private entrepreneurs —always shrewder in money matters than governments—cut their losses during the colonial era mostly by staying away. At the height of colonialism, 80 percent of British and French and 90 percent of German foreign investments headed for the developed heartlands, rather than the colonial outposts. "Africa," Fage concludes, "was of little real importance to European traders and investors."

Similarly today, according to the Commerce Department's latest study on the subject (*U.S. Direct Investment Abroad*, 1977), American pharmaceutical companies put approximately 75 percent of their foreign drug-manufacturing investment into other developed countries. And what is left—the 25 percent in-

vestment in the developing world—yields only 14 percent of their income from total foreign investments. Moreover, drug manufacturing affiliates of U.S. companies in developing countries earned only a 3 percent return on their assets compared with 8 percent worldwide.

But preoccupation with accounting figures deflects attention from the many benefits that transnational corporations—perhaps the large drug firms most of all—have brought to the third world. Pfizer and Sterling Drug, for example, have been involved in major campaigns to control schistosomiasis in Brazil; and Ciba-Geigy, Ltd., established a large pharmaceutical research center in India explicitly to work on the diseases of developing countries. Efforts like these have produced vaccines and drugs for diseases that pose serious health risks only in the third world. More generally, the plain fact is that, especially in poor countries where other forms of health care are in short supply, drugs are the most cost-effective therapy for curing illness and prolonging life.

Dumping on Capitalism

The attack on multinationals, in turn, is for many merely part of a still larger attack on the capitalist economies of the West. A portion of the impetus, the energy, the will of the infant formula and pharmaceutical drives is clearly traceable to this source. Last November, for example, the Moscow Medical Workers' Union paid round-trip airfare to Moscow as well as hotel bills for representatives of 200 trade unions and organizations from fifty-seven countries. They met to organize labor against multinational drug companies, and specifically to push WHO into adopting a code of conduct to regulate the companies' marketing practices. Needless to say, the conferees blasted the West in general and praised the Soviet Union.

The anti-capitalist element of the movement is nowhere more apparent than in the accompanying campaign against drug patents. Again, the third world spokesperson is Prime Minister Gandhi, speaking to the World Health Assembly of her vision: a world "in which medical discoveries would be free of patents and there would be no profiteering from life or death." The idea, by no means a new one, has been percolating for some time in the United Nations and other third world–dominated arenas. For example, a 1980 report issued by the United Nations Industrial Development Organization (*Global Study of the Pharmaceutical Industry*) told how the "industrial property system—patents and trademarks—is one of the main constituents of a strategy of domination used by the industrialized countries to deter [sic] the scarce resources of the developing world." Developing nations, said the report, "believe that the patent legislation is a unilateral contrivance which provides full protection to the holder [as well as] a means to exploit the developing countries with no consideration to the public interest."

The point is so blatant, so glaringly misguided, that it needs no elaborate rebuttal—except to those who do not appreciate the wealth-creating effect in a capitalist system of the institution of property in general and proprietary rights in particular. In today's hocus-pocus multinational world where "rights" are created at an astounding rate, it is worth recalling that the prime document for real democracy in the world, the original U.S. Constitution, authorized the new government it established to create only one explicit right (Article I, Section 8): "To promote the progress of science by securing for limited times to authors and inventors the exclusive right to their respective writings and discoveries."

The New Colonialism

Perhaps most ironic in the campaign against infant formula and pharmaceuticals—no matter how tinged with anticolonialism such campaigns evidently are—is its new colonial attitude. Like the old colonialism, this new one presumes that indigenous peoples—now states—are incapable of governing themselves. They are, quite simply, not able to place their own restrictions on what they themselves consider harmful products or practices. Only developed, sophisticated peoples and international institu-

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est regulators. But, equally clearly, regulation is not working. What should be done?

First, although we now lack a detailed, workable prescription for a deregulation scheme that has a high probability of providing both effective competition and efficient coordination of operating and investment decisions, it may, indeed, be possible to write one. The stakes involved make it well worth a try.

Second, it is entirely possible that we already have at hand a less radical solution to some of the problems created by regulation—in particular, the purported lack of incentive to efficiency. If we were to allow free entry into the field of electric power generation, with utilities required to purchase from anyone who can sell power cheaper than the utility itself can produce it, we would get both the most efficient technologies and plants, and avoid such excessive construction as may be made possible only by the integrated structure of the industry. Moreover, if industrial and other large customers were free to shop for power and had assured access to a sufficiently large number of suppliers and to transmission facilities for any bargains they found, we could deregulate sales to those customers. Here, FERC could play an important role. It can test its authority to improve the efficiency of resource allocation by deregulating sales to wholesale buyers in situations where competition for such sales is likely to be effective. Or, it can continue to regulate, but insist on marginal-cost pricing.

Third, while we are thinking about and testing new ideas for some deregulation, we must continue efforts to make the existing system work better, to persuade regulators that the public interest is not served by keeping rates so low that an economic supply of power is threatened.

The issue of electric utility deregulation is clearly not so simple as that of airline deregulation. In the airline industry, potential entrants were queued up, assets were easily transferable from market to market, and entry lead times were short. Not so in the electric power business, where existing firms are trying to diversify out of the business, where assets don't have wings, and where entry times are as long as twelve years. But the status quo is so unacceptable to all parties at interest—regulators, consumers, and the utilities—that deregulation must be fully explored. ■

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tions can do that. At a recent international conference in London on economic development, the Pakistani director of the Third World Institute, Altaf Gauhar, compared the need for WHO to regulate international drug products with an adult's need to force a child to bathe.

The institutional infancy to which Gauhar refers can hardly consist of an inability to enforce drug restrictions. In areas where compliance cannot be ensured by drug companies' voluntary observance of the law (which there is no reason to believe is any less forthcoming in the undeveloped countries), the developed countries themselves are not notably proficient in enforcement. There may be more illegal drugs on the streets of Chicago than Istanbul. It is difficult, of course, for many third world countries to do their own testing to identify harmful drugs, although some—Singapore, for example—do have quite sophisticated drug approval agencies. But any underdeveloped country can adopt the drug approval decisions of some other nation—say, of Great Britain, France, or Switzerland—just as easily as it could adopt some newly created international approval mechanism. In fact, some have already done so. Even more to the point, there can hardly be any justification for an international scheme that will tell Germany and Italy what they must do, in addition to doing for Uganda what it cannot do for itself.

WHEN ALL IS SAID AND DONE, however, the fundamental point is that drug approval is neither (1) an exact medical science, nor (2) directed to the same medical conditions and necessities in all countries of the world, nor even (3) free from value judgments that are political and have nothing to do with science at all. With thousands of products to consider, it is no surprise at all to find the experts differing sharply, within the United States, among the various developed countries, and between developing and developed states. The drug industry is already one of the most strictly regulated industries in the world; international regulation would add another, and quite damaging, layer. Indeed, if there is any area that does not recommend itself to uniform international treatment, this one is it. ■