Corporate Social Responsibility and Business Ethics in the Pharmaceutical Industry

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I. The Demonization of the Pharmaceutical Industry

The pharmaceutical industry finds itself caught up in the "Perfect Storm." A variety of circumstances have conspired to place the pharmaceutical industry at the center of a maelstrom. It would be easy to dismiss or misidentify this maelstrom as the consequence of purely fortuitous and temporary economic factors, namely:

1. Falling profits
2. Patent Expirations
3. Competition from generic drugs, and
4. The dearth of new blockbuster drugs.

This would be a serious misperception. The fact of the matter is that the pharmaceutical industry is being demonized. The really significant forces contributing to the storm are parts of a concerted effort on the part of various interest groups to push their own agendas at the expense of pharmaceutical corporate pocketbooks. Together they have conspired to present a portrait of the pharmaceutical industry as profiteers who (a) spend obscene sums on marketing[1] instead of research, (b) engage in differential pricing at home and abroad in an effort to gouge the American consumer, and (c) deprive developing countries of life-saving medicines. As a result, the industry is under intense pressure to make medicines less expensive.

The success of the concerted effort to demonize the pharmaceutical industry is not the product of incontrovertible facts and formidable arguments on the part of the industry's critics. No. The success of the demonization is a result of the receptivity (perhaps one should say gullibility) of the public. And why are the public so receptive? The answer is that drugs are the most visible recurring expense and the one that consumers are asked to pay, in part, directly; this, coupled with the fact that the public has not yet come to terms with the economics of contemporary healthcare has led to a crisis. *In short the real crisis is the present inability and unwillingness of the public to understand the economics of contemporary healthcare.* For reasons which will become apparent as we proceed, the burden of the social responsibility of educating the public will fall on the pharmaceutical industry.

II. How Did We Get Here?

The problems that beset the pharmaceutical industry are not *sui generis* but part of the much larger healthcare debate. To attempt to solve the problem by purely business, legal, or political means would be to see the trees but to miss the forest.

Health-care practice and policy are based on a paradigm that is no longer meaningful. Past policy reflects a "Jurassic" period when doctors could do very little and costs were comparably low. It reflects a time when the emphasis was put on bedside manner, because there wasn't anything at the bedside except some posturing. I am old enough to remember a time when going to the hospital was viewed as a prelude to death. The most important obligation of the medical profession was non-maleficence (avoiding harm), not the principle of beneficence (doing good).[2] This produced a myopia about the cost of healthcare. This myopia about the cost of healthcare was reinforced by the generosity of employers, starting in the Second World War when they were forbidden to raise wages. Employers contractually absorbed the then modest cost of healthcare. The public myopia would be further reinforced by the rapid growth in the post war period of the welfare state.

The public has been led to believe that healthcare is a right; that a right (in the current politically correct sense of the term, not the sense in which the American Founders understood it) imposes a positive obligation on government to provide such goods or benefits. How, however, does this actually work out in practice? Governments can pretend to protect your newly discovered right by controlling the supply of healthcare. They can do this, paradoxically, by cutting off access. That is, they can, among other things, restrict the number of doctors, and they can reduce the supply of medical technology. The ultimate logic of these moves will result in waiting lists or rationing. Rationing is a way of privatizing costs without monetizing them. There is one exception to this practice: prescription drugs.[3] *The only way that government can manage the quantity or supply of prescription drugs is by insisting that patients pay some of the costs directly.* That is why drugs are the most visible recurring expense and the one that consumers are asked to pay, in part, directly. It is also not surprising that up until recently politicians have avoided including a prescription drug plan in Medicare.

We are getting a little ahead of ourselves in our account of why the public has not come to terms with the economics of contemporary healthcare. The past and to some extent current paradigm in the minds of the public is that healthcare should be inexpensive. This is an outmoded paradigm. Everything has changed dramatically. In the past half-century, medical technology, as in the case of technology in general, has totally transformed the landscape. There is an enormous and ever growing amount that medical technology can provide, but the costs have risen appreciably. Neither the medical community itself nor the public nor the formulators of public policy have appreciated the need for a **paradigm shift**.[4]

Up until now, the pharmaceutical industry has tried to defend itself by rightly pointing out its preeminent role in producing, promoting and providing access to the benefits of modern medical technology along with the need for protecting intellectual property rights. This defense has fallen on deaf ears. This problem cannot be solved through a public relations defense alone; it requires a coordinated offense. That offense has to embody a new paradigm. What is the new paradigm: preserving and improving health-care requires full commitment to free market economy in healthcare.

This will not be an easy or swiftly accomplished task. There are a number of vested interest groups who oppose thinking of healthcare as a commodity and who would want to maintain that healthcare is a special case in which the profit motive should play no role. Let me identify the major classes of opponents:

1. There is a deeply embedded and historically rooted anti-capitalist mentality among many intellectuals, journalists, and the medical technocracy.[5]
2. There are many irresponsible politicians whose political career and reelection depend upon manufacturing ever more victimized groups whose "rights" need protecting. There are precious few politicians who aspire to a leadership role (honor) in politics as opposed to a celebrity role or a power role. There is hardly anyone out there who has either the vision or integrity to play the responsible role in the healthcare debate.
3. Many healthcare professionals are in the same position as politicians in not being able to assume a leadership role. They are too often mere technicians or self-serving or self-deceived by mission statements written in a vacuum. They too do not see the big picture.
4. There are some consumer groups who are in general in favor of capitalism except in the case of their own specific interest.
5. There are some plaintiffs lawyers who are in general against capitalism except in the case of their own profession.

III. Where Do We Want To Be?

It is time for the public and the world at large to be clear on where it wants to be, how we have got close to it, and how we can get closer. If you will allow me to condense the history of the last 500 years into a one paragraph, I shall tell you what road we have been traveling. Since the Renaissance, the Western World (of which the U.S. is the preeminent example and leader) has been irrevocably committed to the Technological Project,[6] that is, the project to control the physical universe and make it responsive and subservient to humanity. I say irrevocably because there is now no serious possibility of giving it up. The essence of the TP is constant innovation.[7] Since 1989, the world has come to understand that the most efficient way of pursuing the Technological Project is through a free-market economy because it is just such an economy that maximizes innovation. I won't waste time giving you the technical reasons, because you can read them in Adam Smith. The spread of this realization that the Technological Project requires a free market economy is what globalization is all about. A free-market economy requires a limited government, i.e., a government which recognizes that its job is to serve the market which serves the Technological Project, a government which is itself under the law – that is what we mean by the rule of law and not men, and a government which enforces, adjudicates conflicts within, and maximizes the potential for, contracts. Finally, the only way of producing and maintaining a limited government is to have a larger cultural context in which individuals are personally autonomous, that is define their own lives and take responsibility for them.

The greatest achievement of the Technological Project has been to improve the longevity and quality of human life. Medical technology has been at the forefront of that project. Let me mention just a few facts:

1. From 1900 to 2000 life-expectancy increased in the Us from age 47 to age 78.
2. Since 1986, there has been a 40% increase in life expectancy in 52 countries due to the launch of new medicines.
3. The expense of new drugs often reduces the cost of hospital care expenditures.[8]
4. Old cures often have to be replaced by new cures.
5. New diseases and medical conditions develop all the time.
6. Most of the science Nobel prize-winners, especially in medicine, are from the US and Britain – the countries most committed to a free market.
7. Our most successful research universities are privately endowed universities, endowed by the philanthropy of a culture committed to wealth production through a free market economy.

Telling this story is what the industry has tried to do so far, but unsuccessfully. We need to tell it better and to get it across more successfully (i.e., we need a marketing strategy for ideas). To do so, we need to bypass the medical technocrats and go directly to the public. It is important to connect the story to profits. The public's perception of medicine as seen on TV always focuses positively on doctors instead of researchers and entrepreneurs. The medicines appear miraculously, and, of course, the doctors get all the credit. We might want to encourage switching the focus, perhaps through selective programming and advertising. We might want, for example, to contrast the way psychological dysfunction was treated in the era of Freud and psychoanalysis with current psychiatrists who give medications. We might want to highlight the number of world leaders who come to the US for medical treatment, and stress that it is no accident that the best care is available in the country most committed to a free market.

IV. How Do We Get There?

A. Short-term

1. Blow your horn

a. The pharmaceutical industry must learn to *market ideas* not just pills. It must do a better job of telling the story of how it has been at the forefront of medical advancement.

b. There is one misunderstanding that should be countered. Sometimes the original research on which modern pharmaceuticals are based was funded by the government. However, what the public has not been told is that (i) that original research lies dormant until the entrepreneurial spirit of the pharmaceutical industry and its willingness to risk massive investments develops it.[9]

2. **Acknowledge and promote Pharmaceutical Industry Social Responsibility by taking the lead on the total healthcare debate:**

    a. A Nobel laureate in economics, Ronald Coase,[10] has persuasively argued that every firm or corporation faces both political and social transaction costs. The existence of political transaction costs is one reason firms, and even whole industries, employ lobbyists. Social responsibility obligations would be an example of social transaction costs. Lest I be misunderstood, it is important to note that **corporate social responsibility** must be compatible with the bottom line. Bad public relations hurt profits; good public relations helps profits.
    b. The pharmaceutical industry, is, in some important respects, not like 'Britney Spears' or 'Coca Cola'; it is more like the defense industry. World-wide health threats are as much a matter of national defense as terrorist threats. The industry should not react to AIDS as if it were like arthritis or sexual dysfunction, and it should not simply placate special interest groups; AIDS is a serious epidemic; *but* like the defense industry, it should demand and get a profit from the government for its efforts in responding to such national threats. The defense industry is not asked to subsidize counter-terrorism; the pharmaceutical industry (which saves lives) should not be asked to subsidize dealing with epidemics.
    c. **The pharmaceutical Industry should and must take a leadership role in the healthcare debate.** It must do so because no other institution is able or willing to lead. Let's face it: medical personnel are pampered technicians with little understanding of economics or public policy in general; non-profit organizations are run by people who spend other people's money rather than having an appreciation of how wealth is generated; most politicians have little incentive to educate the public; many of those entrusted to educate the public do so within non-profit organizations and either share the common ignorance about creating wealth or are hostile to a free market or suffer from an obsolete anti-market mentality.

        To lead the way is not merely to react. The Pharmaceutical Industry should warn the public of the ever present possibility of newly emerging catastrophic health threats; it should rally support from groups that suffer from less chic maladies; it should remind everyone that the profit incentive is the key to innovation in medical treatment. It should, as a public service, endlessly and continually document how misguided public policy both domestically and in the UN has had an adverse effect on health and healthcare. It should name 'names'. Educating the public on healthcare is part of the cost of providing for healthcare; this cost has to be figured into any assessment of product cost and profits.
    d. The pharmaceutical Industry must accept reasonable limits on patents. The reason we have patents to protect intellectual property rights is to

encourage innovation by rewarding it with a temporary monopoly. But long-term monopoly undermines innovation. Keep in mind that given the time frame for testing new drugs, the real life span for patents in pharmaceuticals is 12 years instead of the usual 18. Let's have a serious discussion about the reasonable economic and technological limits to patents, but let us also tailor it to differences among industries and economic reality. It is important that the Pharmaceutical Industry not appear as the enemy of technological progress.

3. **Promote sound public policy: What will save the most lives and improve the most lives in the long run?**

   a. **WHO SHOULD PAY?** - Let us begin by recognizing our responsibility to take care of those who cannot take care of themselves. One group that needs protection is seniors. However, there are only a *relatively small number of seniors who lack drug coverage*. This is an access problem, not a price problem. Providing them with care is a public obligation, to be taken care of through taxes. It is absurd and counter-productive to penalize the people who make the care possible.

   b. **HOW LONG SHOULD WE PAY?** - We are caught in a time warp just as we were during the great depression, when, among other things we learned that economic and social transformations made it less and less likely that people would live among extended families and therefore did not have to worry about retirement. Our time warp is that we have only recently acknowledged that increasingly great healthcare means increasing costs. Some people were understandably unprepared. In the previous time warp *we rightly recognized the need for social security; at the same time, we wrongly made it a universal entitlement*. The RESULT is the present social security debacle. Let's not make the same mistake. Let's (i) advocate a program only for the relatively few caught in the time warp BUT with a 'grand-person' clause; (ii) advocate privatized long-term healthcare and prescription drug insurance for the rest; (iii) advocate refundable healthcare tax credits for uninsured individuals; and (iv) warn about what will happen if we make drug coverage a universal entitlement the way we did with social security. If we do this right we have responsible public policy; if we do political business as usual we get a pyramid scheme and eventual bankruptcy.

   c. **HELPING THE POOR**

      (i) Accept and promote the benefits of differential pricing internationally;[11] it's a way of helping the poor in other countries by making drugs more affordable for them.

(ii) Let us insist that richer countries like Canada contribute their fare share to the cost of the research and development costs that go into creating a new pharmaceutical product. Perhaps we can 'negotiate' with them to spend a certain percentage of GDP on basic research and then make that research part of the public domain. They get a free ride on defense; they should not get a free ride on healthcare. If we do not do this, we are consenting to a massive cost shifting to the U.S.

(iii) **OPPOSE DRUG REIMPORTATION**:[12] Differential pricing is one of the virtues of a market economy. To allow re-importation will create safety concerns, will cause the pharmaceutical industry to raise prices in poorer countries, or to cease sales in foreign countries altogether. If the latter occurs, some of those countries will violate intellectual property rights, and thereby undermine the whole relationship between markets and technological innovation. The only reason that the industry agreed to the 'shakedown' by the Canadian government was its lack of confidence in the U.S. government's willingness to protect intellectual property rights. The rest of the world is 'ripping us off', and we are allowing them to get away with it.

d. HOW TO LOWER PRICES AND FIX DISTORTIONS IN THE PRICING SCHEME

(i) Oppose single payer systems. Where there is only one buyer you lose all of the advantages of a competitive market.

(ii) OPPOSE PRICE CONTROLS. Price controls never work, they distort the market, create delays and lead to limited access.[13]

(iii) OPPOSE LIMITING PROFITS:[14]

(a) There is no consensus or economic meaning to the idea of what constitutes a 'just' profit. The idea of a 'just profit' is as meaningless as the idea of a just price or a just wage. Substituting the word 'fair' to get to a 'fair profit' doesn't help either. There is no consensus on what is 'fair'; to arrange distribution in terms of who will make the best use of resources involves a calculation that is in principle impossible to make (Hayek); to give everyone the same thing won't work because they will engage in trade and the original problem will return; to prevent the problem of the

return would require a planned and despotic economy and society. This is the same general argument against all redistributive schemes.

(b) If there were a political consensus it would have to be on a company's total bottom line because some products lose money;

(c) there would then have to be a reimbursement for losses – and this actually rewards the less efficient companies and encourages waste in Research and Development.

(d) It would lessen the incentives for innovation.

(e) It would discourage investors if other industries without profit caps were more profitable (and we could only avoid this if the entire economy were managed!)

(iv) The best way to lower prices is through *individual medical accounts*. Our present system of third-party payers (insurance companies, HMO's, Government) discourages both doctors and patients from being responsible consumers. Patients don't investigate alternatives; doctors sometimes prescribe more expensive medication that is less effective because of fear of malpractice suits; pharmaceutical companies therefore have no incentive to compete by offering lower prices instead of "me-too" products.

(v) The PI should make a concerted effort to clarify and to defend the importance of protecting intellectual property rights.

e. CONFRONT THE DISTRIBUTION PARADOX

(i) Even if it is granted that the technological project is best carried out within the framework of a free market economy, and even if it is granted that overall productivity is maximized, how do we know that the goods and services produced are distributed in the best manner possible? What we have is a debate about distribution. Free markets do not lead to equality of outcome.

(ii) What does it mean to have the best possible distribution? David Hume addressed this question several centuries ago. First, "best" involves a value judgment on which there is no consensus and not likely to be one. Second, to distribute goods and services on the basis of 'dessert' also involves a value judgment on which there is no consensus and not likely to be one. Third, to distribute goods and services on the basis of who is most likely to make the best use of them is to invoke a principle for which there is

known algorithm (anticipation of Hayek's anti-planning argument). Fourth, to make an initial equal distribution is to solve nothing, for, in time, the workings of a market economy will lead to an unequal accumulation. Fifth, to attempt to enforce a permanent equality will lead both to the undermining of the market economy (and a consequent loss of productivity) and to the imposition of a tyrannical regime.[15]

(iii) Distribution and production are integrally related. By its very nature, a free market economy (i.e., one without the central allocation of resources) can no more control distribution than it can control production. Are we then better off with a market economy? The only possible answer to this question is an inductive one. The societies with free market economies are the most productive overall and the members therein have more goods and services overall than their counterparts in societies without free market economies. World-wide migration patterns confirm that this is a widely held perception. Other relevant international developments also serve as corroboration.

4. **Go on the offensive: Denounce the bad guys**
    a. Identify and denounce Public Officials in the U.S. and Abroad who have misled the public and distorted the market.[16]
    b. Identify and denounce Health Officials at the UN who have exacerbated world-wide health threats.
    c. How should we deal with plaintiffs lawyers who profit from misguided suits: these especially should be castigated as inhibitors of future research; perhaps initiate a class-action suit based on the calculation of what it will cost to clean up the healthcare mess these attorneys are creating and the delay in new products that will cost a significant number of lives.

B. Long-term

1. Educate the general public on the economic realities of healthcare; politics will eventually reflect public opinion.
2. Promote awareness, especially in college students (who are the future journalists, teachers, politicians, doctors, and researchers) about the inescapable relationship between technological advance and a free-market economy.
3. Encourage the privatization of research institutes currently housed in universities, allow them to compete directly for government sponsored research, and avoid the economic inefficiencies of universities and the demoralizing climate.

[1] Very few people who make this sort of criticism take into account that (a) without marketing there is less or no profit because potential users need to be made aware of the existence of products, and, that (b) in an age where we are constantly bombarded with information about new products, producers and marketers need to go to extraordinary lengths some times to get attention.

[2] See Robert M. Veatch and Amy M. Haddad, *Case Studies in Pharmacy Ethics* (New York: Oxford University Press, 1999).

[3] The problems associated with price regulation of drugs in Great Britain is concisely delineated in Philip Brown (ed.), *Should Pharmaceutical Prices be regulated? The Strengths and Weaknesses of the British Pharmaceutical Price Regulation Scheme (Choice in Welfare 40)* (London: IEA, 1997).

[4] "Although there still is a 'physician-patient relationship', it is now set within a broader healthcare nexus. In this latter context, the rights and interests of economic agents, society and other parties are both routine and proper, not exceptional or *per se* morally distasteful." E. Haavi Morreim, *Balancing Act*. The New Medical Ethics of Medicine's New Economic (Dordrecht: Kluwer, 1991), p. 2.

[5] Arnold Relman, former editor of the *New England Journal of Medicine* maintains that "healthcare [is]…a social good rather than an economic commodity." Quoted in Jonathan Cohn, "Cosmetic Surgery," *The New Republic* (August 17, 1998), p. 25.

[6] See Rene Descartes, *Discourse on Method;* Francis Bacon, *Essays (A*mherst, N. Y. 1995) nos. 13, 16-17, and *The Great Instauration and New Atlantis*, ed. Jerry Weinberger (Arlington Heights, Ill. 1980); John Locke, *Second Treatise*, Chapter Three (The Right of Private Property), sections 26, 27, 34, and 40. From its very beginnings, the Project was tied to healthcare. Consider the following statement from Descartes' *Discourse on Method*, Part VI, "…make ourselves, as it were, the masters and possessors of nature….principally for the maintenance of health, which unquestionably is the first good and the foundation of all the other goods in this life…"

[7] See Naomi Aoki, "Brainstorm Center to Encourage Innovation, Pfizer Puts Its Corporate Muscle Behind an Entrepreneurial Unit in Cambridge Biotechnology," *Boston Globe* (Jan. 17, 2001).

[8] See Frank R. Lichtenberg, "The Effect of Pharmaceutical Utilization and Innovation on Hospitalization and Mortality," *National Bureau of Economic Research, Working Paper 5418*.

[9] See the discussion of the importance of the Bayh-Dole Act of 1980 in "Innovation's Golden Goose," *The Economist Technology Quarterly*, December 14, 2002, p. 3.

[10] Coase, R. H. "The Problem of Social Cost," *Journal of Law and Economics* (October, 1960). Coase, R. H., "The Nature of the Firm," in Putterman and Kroszner (eds.), *The Economic Nature of the Firm* (Cambridge: Cambridge University Press, 1997).

[11] John Carey, "What's a Fair Price for Drugs?" in *Business Week*, New York, April 30, 2201, p. 105.

[12] See Nina Owcharenko, "Missing the Point of Medicare Reform: Why Drug Reimportation is Bad Policy," WebMemo #304, June 26, 2003, www.heritage.com

[13] For a discussion of this issue in the EU context see Stephen Pollard, "Saving the European Pharmaceutical Industry: Price Regulation and Recommendation VI," *Center for the New Europe White Paper*. See also John R. Graham, "The Fantasy of Reference Pricing and the Promise of Choice in BC's Pharmacare," in *Public Policy Sources*, Number 66 (2002), published by the Fraser Institute – for a discussion of the Reference Drug Program in Canada.

[14] For many of the economic arguments see Patricia Munch Danzon, *Pharmaceutical Price Regulation: National Policies versus Global Interests* (AEI Press, 1997).

[15] Milton Silverman, Mia Lydecker, and Philip R. Lee, *Bad Medicine*: The Prescription Drug Industry in the Third World (Stanford: Stanford University Press, 1992) follow up their earlier critiques of the abuses of the pharmaceutical industry (*Prescription for Death*: The Drugging of the Third World, 1982). They concede that in most developing nations drug-regulation agencies are corrupt, weak, under-funded, and their workers poorly trained. Bribery is a way of life throughout the Third World. Their remedy is to suggest constant surveillance, continuous consultation among consumer advocates, the drug industry, government agencies, and the medical and pharmacy professions, with the World Health Organization leading the way. This is the perfect example of the kind of tyranny that replaces markets.

[16] See Robert Pear, "First Lady [Hilary Clinton] Sets Aggressive Tone for Debate on Health Care Plan," *New York Times*, May 27,1993, p. A1.