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Corporate Social Responsibility and the Pharmaceutical Industry:
Defining Big Pharma's Responsibility towards Access to Medicine

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Abstract

The interests of individuals and corporations are often in opposition. In the pharmaceutical industry, populations call for increased access to medicine and pharmaceutical companies defend their right to profit from their innovations. Recently, to address this dichotomy, corporate social responsibility (CSR) has developed as a concept bridging the gap between ethics and business, encouraging voluntary socially responsible action for firms to take on in respect of a duty towards society.

There is a need to define responsibilities in the issue of access to medicine: which actors should enact change and seek to enhance access? This research will focus on how pharmaceutical companies themselves are currently addressing access to medicine issues and paint a general picture of the industry as a whole, evaluating current market structures and prominent CSR discourse of firms. Health ethics arguments will be presented to outline moral behaviour of firms and will also serve to attribute responsibility to different actors, considering private firms' as well as governments' role in providing access to medicine. The research will lastly consider a way forward for this industry, by analyzing a common option –regulation, and a more creative one that would reshape the market –the Health Impact Fund proposal.

The results emanating from this ethical and practical discussion of pharmaceutical companies will show that firms have a responsibility to help due to their special knowledge and capacity, but that states ultimately preserve the main responsibility in guaranteeing access to medicine to their population. This research will also argue that firms cannot be expected to engage fully in CSR because the system only rewards profit-seeking behaviour. As regulation of the international pharmaceutical market is highly unlikely, this research will advocate for deeper reforms to promote ethical behaviour and reward firms that strengthen access to medicine. As this cannot be achieved through international regulations, an innovative approach such as the Health Impact Fund should be further explored, as it could increase benefits for all actors in the pharmaceutical industry.

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Introduction

Business and morality are not known to go together. The corporate world is highly competitive; morality and the defense of the vulnerable are normally left to entities without a drive for profit. Originally, businesses were intentionally left out of ethical responsibilities, perceived only as “subject in market economies to their ability to offer products or services that people are willing to buy”¹ and not fit to make decisions on moral issues. In the world of global health and pharmaceutical products, this has led to an opposition of firms’ right to profits and individuals’ right to health. The right to health is not globally recognized, but it is a concept defended by many authors, especially from the field of ethics, as will be demonstrated later in this research. The rise and prospering of multinational pharmaceutical firms (and other firms in general) has resulted in a ‘legitimacy gap’ through “discrepancies between evolving public expectations and the mainly financial market-driven objectives of business enterprises.”² Many specialists consider globalization as a driving force towards the commodification of health, which now holds a monetary value. From this perspective, the market of health and pharmaceutical products is not a common good under the auspice of the state, but a free market where liberal concepts of competitiveness, consumption and efficiency rule.³

This essay will investigate pharmaceutical firms’ responsibility in global health, specifically towards access to medicine, in an attempt to better understand how the pharmaceutical system works and how it addresses ethical ‘grey zones’. Discussions

¹ Maclean, Camilla and Crouch, Colin 2011 ‘Introduction: The Economic, Political, and Ethical Challenges of Corporate Social Responsibility’ in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 1.

² Leisinger, Klaus M. 2009 ‘Corporate Responsibilities for Access to Medicines’ in *Journal of Business Ethics* 85(1): 10.

³ Kay, A. et Williams, O. 2009 ‘Introduction: The International Political Economy of Global Health Governance’, in *Global Health Governance: Crisis, Institutions and Political Economy*. London: Palgrave Macmillan:6-7.

surrounding individual universal access to basic healthcare have taken root in multiple international fora such as the UN, as the international community increasingly recognizes a strong correlation between poverty and health and supports health as a basic component to the life of individuals.⁴ Private involvement in the provision of essential medicines has therefore become a prominent matter. While I acknowledge that corporate responsibilities extend beyond questions of access to medicine, this topic will remain my focus as pharmaceutical products are a crucial component of basic health. As Abbott and Dukes (2010) emphasize, “medicines and vaccines are throughout the world the most widely used tool for the prevention and relief of illness and the restoration of health.”⁵ It is paradoxical that even though the pharmaceutical industry has developed countless life-saving innovations that greatly improve health outcomes, almost 2 billion people worldwide lack access to basic medicines.⁶ Simple facts like these trigger questions regarding ethics and corporate social responsibility (CSR), which I wish to address in this research. As pharmaceutical companies are often portrayed as cold and soulless entities, it is important to proceed to a reflection that can help us define what we expect from these private firms and how we can ensure their behaviour respects our societal values of protection of individuals as well as their rights and liberties. As many authors have suggested, the pharmaceutical industry holds a unique capacity in helping individuals with regards to their health, which could lead to a responsibility for them to intervene but

⁴ Yaya, Sanni 2010 ‘Sens et direction pour les malades de l’indifférence: quelles priorités pour la santé publique dans le tiers-monde’ in Yaya (ed.) *Les Maux et les chose de la santé: acteurs, pratiques et systèmes de santé dans le tiers-monde*. Québec: Les Presses de l’Université Laval: 1.

⁵ Abbott, Frederick M. and Dukes, Graham 2009 *Global Pharmaceutical Policy: Ensuring Medicines for Tomorrow’s World*. Cheltenham, UK and Northampton, USA: Edward Edgar Publishing: 116.

⁶ Khosla, Rajat and Hunt, Paul 2012 ‘Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines’ in Forman, Lisa and Kohler, Jillian Clarke (eds.) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*. Toronto: University of Toronto Press: 26.

might not result in an obligation to act. This potential responsibility will be explored in this research, in parallel with other actors' responsibility in the field.

The role of states in ensuring the well-being of their citizens is not contested. It is widely accepted that public entities are responsible for health, which normally includes access to basic necessary life-saving drugs. The extent of governmental role can be explored, as well as how it acts upon other actors in the industry, such as non-governmental organizations and private pharmaceutical firms. While there is much that could be discussed about state action to enhance access to medicine worldwide, this research chooses to concentrate on the role of private firms with stakes in global health. Because they are private entities driven by profit, their role in the provision of a public good such as health is much more contested and hotly debated, both from an economical and an ethical perspective. I will provide some elements of discussion regarding states' role in access to medicine, mostly as it relates to pharmaceutical companies and global regulations.

In the first section of this essay, I will begin by providing a market overview of the pharmaceutical industry, especially explaining how it affects access to medicine. This will set the table for a consideration of current CSR, how firms apply it in their activities and how they are justifying their actions. The analysis of corporate ethics in practice will show the lack of a systematic approach regarding access to medicine issues. I will then take a look at some health ethics theories, which help to establish universal values underlying our actions and pinpointing unwanted behaviour. As such, this should provide guidelines to reflect on the special standing of health and how this is to be taken into consideration by private pharmaceutical companies as well as other entities participating

in this industry. This should also allow to explore the attribution of responsibility in the pharmaceutical industry as a whole, firstly by considering private pharmaceutical firms, and secondly by understanding states' obligations towards their population. In the last section, I will focus on possible ways the pharmaceutical industry could adapt to better respond to access to medicine problems. As many solutions can be suggested, I will debate the feasibility of these in light of the current system in place and the powers that influence it.

By the end of this research, I hope to have shown the current state of affairs for CSR in the pharmaceutical industry, addressing ethical and practical gaps. As there is no clear cut solutions to these systemic issues, I will suggest possible changes that are more innovative, as traditional approaches are confined to the current system and have so far not been efficient in initiating successful reforms.

Market overview

Structure of the pharmaceutical industry

To understand how pharmaceutical firms influence access to medicine worldwide and why it can be problematic, one must first look at the configuration of this industry. This section will provide an economical overview of the pharmaceutical industry to assess two factors making this market unique: the oligopolistic market structure and the good it provides –medicine. From these findings, key issues and dilemmas related to access to medicine will be apparent, and these will provide the grounds for further analysis.

The pharmaceutical industry has emerged over the past decades as a global oligopolistic market. Following important research breakthroughs and medical advances, the number of firms has consistently decreased, with each firm gaining bigger market shares. Pignarre (2003) illustrates this well by showing that a series of mergers between major firms has increased their size significantly: in 2002, the biggest pharmaceutical company was Pfizer with 11% of sales, while 15 years before, the biggest firm only held 5% of the market.⁷ The products offered by firms are also a testimony to market concentration: Eurasanté estimates that 80% of pharmaceutical firms' profits come from only 15% of products available.⁸ The oligopolistic features of the market gives individual companies power to influence customers beyond what is normal in other perfectly competitive markets, which is also amplified by the fact that these are multinational companies that can reach every country.

⁷ Pignarre, Philippe 2003 *Le grand secret de l'industrie pharmaceutique*. Paris: La Découverte: 85-86.

⁸ quoted in Hamdouch, Abdelillah and Depret, Marc-Hubert 2001 *La nouvelle économie industrielle de la pharmacie: Structures industrielles, dynamique d'innovation et stratégies commerciales*. Paris: Elsevier: 38-39.

The pressure on firms to increase their size can be explained by many factors and is generally attributed to high operative costs and research intensive products. The R&D process for pharmaceutical products is lengthy and expensive without guaranteed returns. Pignarre (2003) notes that bigger firms benefit from economies of scale by consolidating research activities, maximizing efficiency and gaining negotiation power⁹, hence firms have a tendency to merge and expand to increase their profit margins.

In addition to their specific market structure, the goods produced by pharmaceutical companies, medicines, are incredibly specialized and complex. Pharmaceutical products are only understood by people within the medical industry, but even doctors and pharmacists themselves do not possess sufficient information to fully grasp every drug's effects, safety and efficacy.¹⁰ Economically speaking, this means the provider (a pharmaceutical company) knows much more about the product than the purchaser (a health care specialist) and imperfect information about the product affects the relationship between the two. Highly specialized medicines are also very difficult to reproduce, meaning there are no readily available alternatives for the purchaser to turn to. Both these specificities of the products at hand make the market vulnerable to mismanagement and fraud, due to “knowledge gaps and information imbalances between manufacturers, regulators, health care providers, and consumers”¹¹ and lead to an unequal trade. The market is tilted in favour of pharmaceutical firms, which benefit from these imbalances and can influence price setting or regulations to their advantage. In

⁹ Pignarre, Philippe 2003 *Le grand secret de l'industrie pharmaceutique*. Paris: La Découverte: 86.

¹⁰ Management Sciences for Health 2011 *MDS-3: Managing Access to Medicines and Health Technologies*. Sterling, USA: Kumarian Press: 1.6.

¹¹ *Ibid.*

counterpart, other actors are unable to assess the quality or fairness of the trade, due to lack of information, power and alternatives.

Issues in the current system

As underlined by Abbott and Dukes (2009), the main issue surrounding pharmaceutical products lies in the “basic tension between exclusivity rules in the pharmaceutical market and the need to provide wider access to medicine.”¹² This need emanates from the common interest in health for a thriving society, but as the pharmaceutical industry developed in a private for-profit environment, little weight was given to social goals as the industry expanded. The economical, political and medical power accumulated by pharmaceutical companies over the years is now difficult to rescind or modify. These multinational private firms are now undeniably part of global health and health care systems, both at the national and international levels.

The simple fact that pharmaceutical products are private and not public sets the first barrier to access to medicine. The private market structure leads to incentives for firms to put profits first, not health,¹³ which is normal for private companies but not necessarily desirable for a product of public interest. The current system –an oligopoly of a small number of firms –leads to a lack of competition in the industry, resulting in R&D that is skewed towards profits rather than health needs. This market structure also give price-setting capabilities to firms, resulting in higher prices at the consumer end.

The first problem is the existing global research and development structure that is tilted towards favouring the production of profitable drugs over truly needed ones that are

¹² Abbott, Frederick M. and Dukes, Graham 2009 *Global Pharmaceutical Policy: Ensuring Medicines for Tomorrow's World*. Cheltenham, UK and Northampton, USA: Edward Edgar Publishing: 268.

¹³ World Health Organization 1997 *Public-Private Roles in the Pharmaceutical Sectors: Implications for equitable access and rational drug use*. Report DAP/97.12: 22.

more innovative. As 't Hoen (2009) notes, the pharmaceutical industry highly depends on patent protection, which was first implemented to secure firms' benefits after risky investments in innovation. However, the increase in patent protection has generated a situation where "the rate of innovation has fallen while the number of 'me-too drugs' of little or no therapeutic gain has increased."¹⁴ While firms have the normal economical drive to profit at lowest possible cost, it is the international system as a whole that fails to give the right incentives to develop medicines that are needed from a global health perspective. According to Pogge (2011), the current reward system for firms is only "tenuously related to health outcomes"¹⁵, meaning profits are not linked to whether or not a drug truly benefits individuals' quality of life. The direction taken by private pharmaceutical companies towards R&D therefore highly affects access to medicine in the sense that new drugs do not necessarily address the global burden of disease by offering new cures to understudied diseases, but are aimed at producing profit as easily as possible. This will be further explored in the section on the attribution of responsibility and how pharmaceutical firms R&D process has created the so-called 90/10 gap.

The second problem is the fact that drug prices are so high that they are prohibitive to access, especially in least developed countries (LDCs). The WHO (1997) deplores the fact that pharmaceutical market failures hinder equity of access to medicine: "Access to pharmaceuticals in the private for-profit sector is granted on the basis of willingness to pay. Those unable to afford drugs will be denied access to them."¹⁶

¹⁴ 't Hoen, Ellen F.M. 2009 *The Global Politics of Pharmaceutical Monopoly Power: drug patents, access, innovation and the application of the WTO Doha Declaration on TRIPS and Public Health*. Diemen, The Netherlands: AMB Publishers: XVIII.

¹⁵ Pogge, Thomas 2011 'Getting the Incentives Rights: The Health Impact Fund', for the *Friedrich Ebert Stiftung*: 7.

¹⁶ World Health Organization 1997 *Public-Private Roles in the Pharmaceutical Sectors: Implications for equitable access and rational drug use*. Report DAP/97.12: 24

However, pharmaceutical companies refuse to acknowledge the role of pricing in access to medicine and commonly defend their practices by stating that there is no clear link between drug prices and lack of access in poor countries.¹⁷ While it is true that pricing is not the only factor that influences access –a country would need proper health infrastructure to deliver the drugs, for example –high prices resulting from the market structure have a role to play in what treatments governments can afford and individuals have access to. As I go forward in this research, references to “access to medicine” will imply both these previously discussed issues: affordability and the range of products developed in R&D.

The issues afflicting the pharmaceutical industry are the product of a system that has allowed it to develop in such a way, without much oversight. To date, there are no international policies or regulations that surround global access to medicine effectively, only frameworks that protect private pharmaceutical companies’ right to profit from their research. As Doane (2005) suggests, big business isn’t necessarily to blame for the state of the world, “they (the companies) are simply acting within the confines of a marketplace that for the last decade or more, is myopically focussed on creating ‘shareholder value.’”¹⁸ Attempts at regulations, be they national or international, have mostly failed because countries with pharmaceutical industries decide to side with business rather than health or do not show concern with global issues of access to medicine.

¹⁷ Brown, Sherri A. 2006 ‘Global Public-Private Partnerships for Pharmaceuticals: Operational and Normative Features, Challenges, and Prospects’ *Simon Fraser University dissertation research*: 10.

¹⁸ Doane, Deborah 2005 ‘Beyond corporate social responsibility: minnows, mammoths and markets’ in *Futures* 37(2005): 227.

A recent attempt to regulate the global pharmaceutical market was seen with the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement but its public health clauses have not had the result of enhancing access to medicine in developing countries. Signed in 1994 at the birth of the World Trade Organization (WTO), the Agreement set out measures to protect intellectual property in all members countries. This represents a great change in the international trade system, while it is estimated that before 1994, only about 40 countries had such dispositions in place.¹⁹ The Doha Round of 2001 addressed public health and WTO agreements, seeking to clarify TRIPS mechanisms and their terms of use, as was requested by developing countries wishing to use the agreement's derogatory clauses for certain patented pharmaceutical products.²⁰ Although these clauses are present in the TRIPS agreement, it has been widely acknowledged that developing countries are unable to fully use them, mainly due to pressures from foreign governments of developed countries or pharmaceutical companies themselves. The TRIPS is a liberal agreement that advocates for an international pharmaceutical market within which WTO rules are applied uniformly. The hopes of the positive impact of inserting derogatory clauses have been stumped by the complexity for LDCs to act on them. In this regard, it can be considered that the implemented measures reflect Western ideals by favouring competitiveness and the protection of private corporations to the detriment of developing countries' concern for their population's health.

¹⁹ Varela, Marcelo D. 2004 'L'organisation mondiale du commerce, les brevets, les médicaments et le rapport nord-sud : un point de vue du sud' in *Revue internationale de droit économique*, 18(1): 82.

²⁰ Haakonsson, Stine Jessen and Richey, Lisa Ann 2007 'TRIPS and Public Health : The Doha Declaration and Africa' in *Development Policy Review* 25(1): 71.

In the current context, pharmaceutical companies are not *directly* committing harmful acts against individuals, however their market behaviour has direct consequences on their lives. Pharmaceutical companies' power over the market does lead to diminished access to life-saving medicines, mostly in the developing world, which has impacts on individuals' quality of life. Without being directly responsible for the lack of access to medicine, could pharmaceutical companies nevertheless be mandated to act in favour of wider global access to medicine?

Determining private firms' role in pursuing or helping achieve public goals is a challenge. Powerful multinational pharmaceutical companies are accountable to their investors, but the special good they provide means they should "expect to be treated with a high level of scrutiny and to meet a high level of accountability"²¹ to ensure their actions are ethical and respectful of individuals. It is understandable that these firms answer to their stakeholders as part of their obligations as private companies, but their effect on global health and individual lives raises questions concerning their responsibility in providing access to medicine beyond normal corporate duties.

Business ethics and corporate social responsibility

It is arguably primordial to look into business ethics because pharmaceutical companies are, above all, private entities. It is, however, not certain that business ethics – and the relatively recent concept of corporate social responsibility – require sufficient action of pharmaceutical companies in enhancing access to medicine. CSR is useful as it aims at identifying firms' responsibilities towards society, but it should be kept in mind that it is an idea that emanates from within the business world and is not binding in any

²¹ Fierlbeck, Katherine 2011 *Health Care in Canada: A Citizen's Guide to Policy and Politics*. Toronto: University of Toronto Press: 162.

way.²² It therefore does not necessarily reflect societal ideals of ethical behaviour, but only what companies are willing to act upon voluntarily.

CSR is defined many different ways by the multiplicity of actors that engage in it or wish to convince others to do so. The concept is now also being considered a possible form of corporate and economic governance for multinational companies that shape global relations and markets.²³ It generally includes the idea that a firm is foregoing its limited financial interest, going beyond what is required of it by law and investing resources in enhancing societal welfare. Ultimately, the fact that CSR is strictly voluntary reduces its potential to be applied uniformly across all firms and precludes it from being more than guidelines and recommendations. On the other side, to impose CSR would also have a negative impact on businesses, as illustrated well by Sternberg (2011):

“If accepted, conventional approaches to CSR would thwart not just business profitability, but the existence of business itself. And if imposed as a matter of public policy, CSR would seriously undermine both individual liberty and ethical conduct.”²⁴

The evolution of CSR

The newfound consciousness for a need to apply an ethical framework to businesses has led to much research and the development of CSR schemes integrated directly into business models. According to the Dahrendorf model, there are three categories of responsibilities for firms, which can be represented in a three-tiered

²² Leisinger, Klaus M. 2011 ‘Corporate Responsibility for Pharmaceutical Corporations’ in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 104-105.

²³ Maclean, Camilla and Crouch, Colin 2011 ‘Introduction: The Economic, Political, and Ethical Challenges of Corporate Social Responsibility’ in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 1-2.

²⁴ Sternberg, Elaine 2011 ‘How Serious is CSR? A Critical Perspective’ in Crouch and Maclean (eds.), *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 30.

pyramid.²⁵ The bottom tier represents a firm's core and essential responsibilities as private entities: to make profits and to follow laws and regulations. These most basic obligations are not optional and must be followed by each firm to stay in business. The middle tier regroups corporate responsibilities that go beyond legal duties but are still strategic decisions for good management, for example better working conditions and transparent management procedures. Although these are 'social' responsibilities, they do not necessarily induce financial losses for firms and may increase efficiency or productivity.²⁶ These second tier responsibilities, although optional, are mostly necessary in terms of business practices. The top tier represents the most advanced social responsibility for firms, actions that are perceived as being discretionary or done out of good will to enhance social welfare, performed without any consideration of necessity or duty.

As it concerns CSR theory, it is obvious that pharmaceutical companies' CSR actions targeting access to medicine issues would fall into the upper tier of the previously explained pyramid. This implies that these initiatives are entirely voluntary and there are no consequences in case of inaction, as CSR is entirely non-binding and only based on firms' decision to engage in it willingly.

The difference between second-tier and third-tier responsibility of firms is of importance when considering what pharmaceutical companies should do for access to medicine at large, and not only specifically for individuals in close contact with the company. CSR *mandates* responsible actions targeting a small circle of people directly involved with the firm, such as employees, and only *encourages* actions towards

²⁵ Leisinger, Klaus M. 2011 'Corporate Responsibility for Pharmaceutical Corporations' in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 104-105.

²⁶ *Ibid*:105.

indirectly affected people. Activities promoting and facilitating access to medicine are then considered (highly) optional and philanthropic and firms more often than not lack a comprehensive CSR strategy.²⁷ Because pharmaceutical companies refuse to recognize the role they play in prohibiting access to medicine, their CSR actions such as partnerships and donations are often announced as acts of goodwill and generosity and not social responsibility.

It is widely recognized that firms are not doing much innovative work regarding CSR, as the international system of capitalism and free market has not adapted over time and allows them to continue with their normal activities, while public organizations and populations are now requesting corporate involvement in social issues.

How CSR is used by pharmaceutical companies

When looking at how CSR is incorporated into businesses, it is important to consider why a firm would choose to go beyond the legally necessary and perform voluntary, socially responsible actions like enhancing access to medicine. As Nussbaum explains, the reasons are generally self-interested, even when the action has positive effects on society. Pharmaceutical companies can attempt to change their corporate image, motivate employees or strengthen their brand appeal, all through CSR²⁸. They engage in CSR in a pattern linked to bad publicity or threats of regulation of the industry. As Doane (2005) underlines, key drivers of CSR are “managing risk and reputation, protecting human capital assets, responding to consumer demand and avoiding

²⁷ Oxfam, VSO and Save the Children 2002 ‘Beyond Philanthropy: the pharmaceutical industry, corporate social responsibility and the developing world’ (Joint report). Oxford and London: 10.

²⁸ Nussbaum, Alexandra K. 2009 ‘Ethical corporate social responsibility (CSR) and the pharmaceutical industry: A happy couple?’ in *Journal of Medical Marketing* 9(1): 69.

regulations.”²⁹ CSR activities are then reactive to external pressures and do not emanate from an honest feeling for the need for ethical behaviour or the recognition of responsibility by firms. It follows that they would not engage in responsible actions beyond what they perceive as beneficial to them in the long term. They do not get involved in CSR strictly for the common good and certainly do not formally recognize that they have an obligation to help. In general, pharmaceutical companies continue to oppose and fight national governments’ decisions that cut into their profit, such as attempts from developing countries to produce or acquire cheap drugs in a sustainable way.³⁰ Although this can be difficult to accept, this is how the system is structured.

For critics of the pharmaceutical industry and proponents of CSR, access to medicine has become a prominent issue, as pharmaceutical companies are perceived as putting profits before health. Especially when it concerns HIV/AIDS drugs –which are recent and remain expensive –pharmaceutical companies are accused of “undermining poor people’s access to medicine through stubbornly defending their patents rights, and pricing drugs beyond the reach of the underdeveloped world.”³¹

Civil society has led many critical campaigns against pharmaceutical companies to denounce their influence on populations’ health and access to medicine. International organizations also widely recognize the private industry’s role in access to medicine, for example Millennium Development Goal 8 underlines the need for the “international

²⁹ Doane, Deborah 2005 ‘Beyond corporate social responsibility: minnows, mammoths and markets’ in *Futures* 37(2005): 217.

³⁰ Thomas, Caroline 2003 ‘Trade Policy, the Politics of Access to Drugs and Global Governance for Health’ in Lee (ed.) *Health Impacts of Globalization: Towards Global Governance*. New York: Palgrave Macmillan: 185.

³¹ Lee, Matthew and Kohler, Jillian 2010 ‘Benchmarking and Transparency: Incentives for the Pharmaceutical Industry’s Corporate Social Responsibility’ in *Journal of Business Ethics* 95: 652.

community to cooperate with pharmaceutical companies to provide access to affordable, essential drugs in developing countries.”³²

Many have also been critical of the quality of CSR initiatives, which at time remains questionable. At the same time, pharmaceutical companies already announce their CSR activities as achievements worthy of praise: “Pharmaceutical companies have sophisticated CSR programs devoted to ensuring societal sustainability [...] and deserve much credit to the increased access to medicines available today.”³³ They reject the need for any other public policies that could enhance access to medicine but infringe on their profits or R&D freedoms, claiming instead that efforts to promote access should address other “social, political and infrastructural barriers [that impede] the broad rollout”³⁴ of medication in poor countries.

As has been discussed in this section, CSR restricts responsibility to a small circle of directly affected individuals. Its main weakness lies in the fact that it considers commitments to CSR as optional and ‘charitable’, therefore not recognizing a moral responsibility for firms to act a certain way. The lack of an external accountability mechanism allows free interpretation and application of CSR within firms³⁵ and it currently seems out of reach to impose social standards to private companies.

³² Leisinger, Klaus M. 2011 ‘Corporate Responsibility for Pharmaceutical Corporations’ in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 105.

³³ Lee, Matthew and Kohler, Jillian 2010 ‘Benchmarking and Transparency: Incentives for the Pharmaceutical Industry’s Corporate Social Responsibility’ in *Journal of Business Ethics* 95: 650.

³⁴ Brown, Sherri A. 2006 ‘Global Public-Private Partnerships for Pharmaceuticals: Operational and Normative Features, Challenges, and Prospects’ *Simon Fraser University dissertation research*: 10.

³⁵ Khosla, Rajat and Hunt, Paul 2012 ‘Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines’ in Forman, Lisa and Kohler, Jillian Clarke (eds.) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*. Toronto: University of Toronto Press: 38.

CSR in practice: an analysis of two pharmaceutical companies' approaches

As we move on to consider what pharmaceutical companies actually do in terms of CSR, it is notable that this framework is generally weakened by the fact that it only *suggests* certain desirable behaviours to firms. As De George (2005) underlines: "Social responsibility language for the most part carries with it no non-self imposed obligations and so no broader accountability."³⁶ As he continues to explain, CSR is used by firms to receive praise when they demonstrate social engagement, but not blame when they don't. This makes it seem as though pharmaceutical companies' actions towards wider access to medicine are voluntary and do not stem from a deeper moral obligation and "fail to recognize legitimate demands of justice and the obligations imposed by human rights"³⁷.

Additionally, most pharmaceutical companies' response to the claim that they are responsible for access to medicine reiterates that the issue does not rest upon the industry alone, but that all stakeholders in global health share the responsibility.³⁸ The unwillingness of the industry to address its role in access to medicine is partly due to the fact that they believe public entities should be the ones mainly involved in promoting health while private firms are designed to make profits in exchange for the goods they produce. From a business perspective, it could also be considered risky for a company to accept responsibility once, as this would set a precedent and likely increase future expectations towards the firm. Pharmaceutical companies are therefore not willing to forego any liberties they hold under the current system. This system has given them high

³⁶ De George, Richard T. 2005 'Intellectual property and pharmaceutical drugs: An ethical analysis' in *Journal of Business Ethics* 15(4): 557-558.

³⁷ *Ibid*:559.

³⁸ Lee, Matthew and Kohler, Jillian 2010 'Benchmarking and Transparency: Incentives for the Pharmaceutical Industry's Corporate Social Responsibility' in *Journal of Business Ethics* 95: 647.

rates of return on investments³⁹ and made them powerful enough to successfully fight national policies that work against their interests and profits. In order to protect these advantages, pharmaceutical companies are now “significantly involved in public affairs, shaping government laws favouring market approaches and profits, administrative decision making, including private management of the welfare state and charitable sectors, including CSR.”⁴⁰

To illustrate how CSR takes form in practice, this section will look into two big multinational pharmaceutical companies, Pfizer and GlaxoSmithKline (GSK), and their CSR initiatives. The first is the world’s most profitable pharmaceutical company, with a yearly revenue of over \$55 U.S. billion⁴¹. The latter is also one of the top 5 pharmas in the world and is known for having good CSR initiatives and to be a leader in the industry⁴². I will look at how these companies are engaged in access to medicine issues and what arguments they put forward in doing so.

Corporate social responsibility reports are authored by firms themselves. They are therefore not neutral and use marketing strategies to present firms’ activities in a positive light, for example using words like ‘empowerment’, ‘integrity’ and ‘patient focus’. It is also notable that while they do provide information on CSR-related involvement, they do not go in depth and mostly do not address issues of governance and management that can be the most important component of actual change in company behaviour. These reports

³⁹ Lauzon and Hasbani’s research finds that the pharmaceutical industry has returns on investment of around 30% after taxes, significantly more than any other industry.

⁴⁰ Crouch in Givel, Michael 2013 ‘Modern Neoliberal Philanthropy: motivations and impact of Pfizer Pharmaceutical’s corporate social responsibility campaign’ in *Third World Quarterly* 34(1): 173.

⁴¹ Pfizer 2012 *Pfizer Annual Review 2012*. Retrieved from http://www.pfizer.com/responsibility/corporate_responsibility_report: 15.

⁴² Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accessmedicineindex.org/index-publications>: 81.

can be useful to see what discourses are adopted by pharmaceutical companies, but they must also be read with a critical eye. Additionally, third-party evaluations help decipher information to see the real value of a company's CSR engagement.

The analysis of pharmaceutical companies' CSR reports will be intertwined with third-party analysis, both from academia and a practical benchmarking report issued regularly that reviews progress on access to medicine, the Access to Medicine Index. These analyses are important for public knowledge of private companies' activities and their neutral evaluation, as benchmarking "reveals industry shortfalls, affects decisions of investors and by those to whom the program is aimed."⁴³

The Access to Medicine Index is the most comprehensive third-party analysis available. It proceeds to a ranking of top pharmaceutical firms based on their CSR initiatives. For Hans Hogerzeil (2013), global health specialist for the World Health Organization, the Access to Medicine Index's 2012 report shows that "companies are becoming more organized in their approaches to global access, more are using tiered pricing schemes for a broader range of products in more countries"⁴⁴, which offers medicines at a discounted price in poorer countries. Fairness in access can also further be ensured when firms set different prices within a country according to a patient's ability to pay.⁴⁵ There is, however still room for improvement. The Access to Medicine Index defines a variety of fields in which pharmaceutical companies can tackle access to medicine through corporate social responsibility activities. These fields are: general

⁴³ Lee, Matthew and Kohler, Jillian 2010 'Benchmarking and Transparency: Incentives for the Pharmaceutical Industry's Corporate Social Responsibility' in *Journal of Business Ethics* 95: 641.

⁴⁴ Hogerzeil, Hans V. 2013 'Big Pharma and Social Responsibility – The Access to Medicine Index' in *The New England Journal of Medicine* 369(10): 898.

⁴⁵ Jack, Andrew 2012 ' "World's pharmacy" faces new challenges from Western drug companies' in *BMJ* 345(6207): 2.

access to medicine management, public policy and market influence, R&D, pricing, manufacturing and distribution, patents and licencing, capability advancement in product development, and product donations and philanthropic activities.⁴⁶ These general areas widely encompass all CSR activities.

However useful the Index may be, a global health specialist points out that its main source of data is the pharmaceutical companies themselves; it does not necessarily reflect the “view from the ground.”⁴⁷ Accordingly, this means that the Index is at risk of becoming yet another exhibit of pharmaceutical companies’ public relations (PR) and marketing success without having concrete results to show for it, and may not be as neutral as we think.

GlaxoSmithKline

GSK’s declared corporate mission is to improve quality of human life by enabling people to do more, feel better and live longer.⁴⁸ According to many authors and reports, including the Access to Medicine Index, GSK is at the forefront of the pharmaceutical industry’s CSR initiatives, particularly in activities relating to access to medicine. Oxfam has praised GSK for having “a more integrated and explicit approach to CSR than other firms, including an independent committee that advises on CSR issues –which is unique – and one of only two firms to have a stated policy on access to medicine.”⁴⁹ This access policy is implemented by the firm’s Developing Countries and Market Access unit,

⁴⁶ Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accessmedicineindex.org/index-publications>: 6-7.

⁴⁷ Reed, Tim 2008 ‘The new Access to Medicine Index’ in *The Lancet* 372 (Sept. 13th): 890-891.

⁴⁸ GlaxoSmithKline 2012 *Corporate Social Responsibility Report*. Retrieved from <http://www.gsk.com/responsibility/responsibility-reports-and-resources/reporting-archive-and-resources.html>: 1.

⁴⁹ Jones, Ian W., Pollitt, Michael G. and Bek, David 2007 *Multinationals in their Communities: A Social Capital Approach to Corporate Citizenship Projects*. New York: Palgrave Macmillan: 262.

which centralizes all of GSK's activities in least-developed countries (LDCs) into one team with the expressed goal of "building a lower-price/higher-volume business to reach more patients."⁵⁰ The mere existence of this unit embodies GSK's commitment to access to medicine on an ongoing basis.

Another of the main activities that puts GSK ahead of the pack is its broad tiered pricing scheme. As stated in its 2012 CSR report, "capped prices on our patented medicines and vaccines in the world's poorest countries [...] are no more than 25% of their price in the UK."⁵¹ This exemplifies a strong commitment to enhancing access through corporate measures that are integrated directly into GSK's business model. As well, because the goal of providing access in LDCs is claimed publicly and outlined clearly, it is applied uniformly across GSK activities –as opposed to firms that develop tiered-pricing schemes on an *ad hoc* basis.

The Access to Medicine Index (2012) also underlines GSK's transparent approach to the patent process and its support of extending deadlines for LDC compliance with TRIPS requirements, which forces countries to implement patent protection on their territory.⁵² The Index notes that while this is not a risky move for pharmaceutical companies to make –as these markets do not represent important profits –no firms other than GSK have taken the opportunity to support an extended deadline for LDCs.

By way of philanthropy, the Access to Medicine Index places GSK first, while GSK itself declares £206 million in "community investment", constituted from monetary

⁵⁰ Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accessmedicineindex.org/index-publications>: 30.

⁵¹ GlaxoSmithKline 2012 *Corporate Social Responsibility Report*. Retrieved from <http://www.gsk.com/responsibility/responsibility-reports-and-resources/reporting-archive-and-resources.html>: 18.

⁵² Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accessmedicineindex.org/index-publications>: 60.

donations but mostly in-kind or product donations.⁵³ The breakdown of these donations is less precise, but it does seem to address access to medicine for low-income patients and programs targeted at tropical diseases such as HIV/AIDS, malaria and tuberculosis. GSK goes beyond simple philanthropy by committing to re-invest 20% of profits from LDCs back in a variety of health infrastructure initiatives directly in those countries, which represents approximately \$6 million on an annual basis.⁵⁴ Although these funds do not represent a big amount of money for a firm as profitable as GSK, this redistribution scheme is an interesting mode of operation that does not rely purely on philanthropy, but is geared towards re-investing into a community in which a firm has reaped profits, which is a commendable responsible corporate initiative.

Although GSK is recognized as a champion of CSR within the pharmaceutical industry, its track record is not all positive. Jones et al. (2007) note some inconsistencies between policies:

“GSK publicizes its efforts to increase access to essential medicine in poor countries. At the same time, it is an influential member of PhRMA, which lobbies aggressively for WTO rules and national laws restricting people’s access to low-cost drugs in developing countries.”⁵⁵

Furthermore, even though GSK is considered a leader in CSR, the company has not acknowledged direct responsibility when it concerns access to medicine worldwide. Paul Hunt, special UN rapporteur on the right to health, emphasizes that GSK explicitly rejects that “pharmaceutical companies have right-to-health responsibilities that exceed

⁵³ GlaxoSmithKline 2012 *Corporate Social Responsibility Report*. Retrieved from <http://www.gsk.com/responsibility/responsibility-reports-and-resources/reporting-archive-and-resources.html>: 27-31.

⁵⁴ Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accessmedicineindex.org/index-publications>: 77.

⁵⁵ Jones, Ian W., Pollitt, Michael G. and Bek, David 2007 *Multinationals in their Communities: A Social Capital Approach to Corporate Citizenship Projects*. New York: Palgrave Macmillan: 261.

those dictated by the ethics and law implicit in shareholder primacy.”⁵⁶ While this is disconcerting, GSK’s refusal to acknowledge a right to health aligns with other pharmaceutical companies’ position. To this effect, Khosla and Hunt (2012) note that “while a number of pharmaceutical companies report on their corporate responsibility activities, few make specific references in their corporate mission statements to human rights in general, or the right to health in particular.”⁵⁷

Pfizer

The analysis of Pfizer’s CSR report is more difficult than for GSK. What Pfizer identifies as its CSR report is in fact an annual report containing messages to stakeholders and financial performance reviews. The space attributed to access to medicine issues is limited, while the data and numbers presented are vague and mostly overpowered by marketing techniques. From a comparison point of view with GSK’s report, Pfizer’s Annual Review offers a more PR-oriented document without going into details in CSR projects, their structure and their results.

In its 2012 reports, Pfizer presents its units of organizations within the company and their focus, without any mention of LDCs.⁵⁸ It does however identify strategies targeting emerging markets such as India, China and Mexico. For these markets, Pfizer aims to offer more access to some of its established products such as Lipitor (for

⁵⁶ Illingsworth, Patricia 2012. ‘Corporate Social Responsibility and the Right to Essential Medicines’ in Forman, Lisa and Kohler, Jillian Clarke (eds.) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*. Toronto: University of Toronto Press: 76.

⁵⁷ Khosla, Rajat and Hunt, Paul 2012 ‘Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines’ in Forman, Lisa and Kohler, Jillian Clarke (eds.) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*. Toronto: University of Toronto Press: 28.

⁵⁸ Pfizer 2012 *Pfizer Annual Review 2012*. Retrieved from http://www.pfizer.com/responsibility/corporate_responsibility_report: 23.

cholesterol), Norvasc (for high blood pressure) and Viagra (for erectile dysfunction).⁵⁹ For what is to be considered Pfizer's CSR report, the focus on marketing these specific drugs seems out of place, especially as there are no mentions of enhancing access to medicine in a broader manner than simply by selling brand-name blockbusters in more markets (even though the report suggests lowering prices to some extent).

The report's extensive financial reporting and performance indicators finally make it difficult to consider it a CSR report rather than a general annual report. One has to go back to 2009 to obtain a report from Pfizer that is in fact entitled "Corporate Social Responsibility Report" and contains more substantive information on the firm's approach to access to medicine.

The Access to Medicine Index places Pfizer 7th (middle of the pack) in the product donations and philanthropy category. While this is commendable, Givel (2013) notes that "all seven of Pfizer's major CSR organizational actions were voluntary, discretionary and limited corporate philanthropy efforts."⁶⁰ Pfizer's strong engagement in philanthropy can also be considered a well-thought out corporate decision aligned with its own business goals. Werhane and Gorman (2005) show that it is in fact to a company's advantage to collaborate with other stakeholders to enhance access, as "a hands-on approach to drug distribution in LDCs protects company patents"⁶¹ and therefore preserves markets and profits.

⁵⁹ Pfizer 2012 *Pfizer Annual Review 2012*. Retrieved from http://www.pfizer.com/responsibility/corporate_responsibility_report: 27.

⁶⁰ Givel, Michael 2013 'Modern Neoliberal Philanthropy: motivations and impact of Pfizer Pharmaceutical's corporate social responsibility campaign' in *Third World Quarterly* 34(1): 176.

⁶¹ Werhane, Patricia H. and Gorman, Michael E. 2005 'Intellectual Property Rights, Access to Life-Enhancing Drugs, and Corporate Moral Responsibilities' in *Ethics and the Pharmaceutical Industry*. Cambridge, USA: Cambridge University Press: 279.

To this extent, it can be observed that, while Pfizer does participate in philanthropy aimed at widening access to medicine, it does so in a very calculated manner and does not integrate access to medicine goals within its business model as much as GSK does. In a general way, Pfizer's CSR achievements are much less present than GSK's in the Access to Medicine Index and the company is often quoted as an example of lack of meaningful involvement in CSR. The Index does, however, underline that Pfizer's tiered pricing efforts have improved since the last report in 2010, especially when it comes to geographical coverage of the scheme, which now spans over more countries.⁶²

Overall, a brief analysis of these two firms' CSR schemes clearly shows the gaps in implementation of responsible action by pharmaceutical companies. What is even more worrisome is the fact that they firmly reject any direct responsibility in providing access to medicine.

Ethical arguments: health justice

CSR seems to fall short of our expectations for multinational firms. Business ethics is a corporate concept, grounding its reasoning in economical principles. As such it lacks a strong moral basis and leaves some ethical issues unresolved. Despite its role in the production of life-saving medicines, the pharmaceutical industry is still criticized for its negative impact on equitable access to medicine. It attracts praise for developing HIV drugs, yet their high price makes them out of reach for the people who need it the most. Pharmaceutical firms have undeniable power in global health and although they are

⁶² Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accessmedicineindex.org/index-publications>: 51.

private entities, they should act according to clearly elaborated ethical values, seeing as they influence a very crucial and basic public good: health.

This section will lay the groundwork for the analysis of responsibilities in the pharmaceutical industry. Having explained the pharmaceutical industry's functioning and its challenges regarding global health issues, I now want to look at moral arguments that can provide a strong basis for moral action in health. I will briefly explore some paths and ideas pulled from various authors of health justice as approaches to justify the importance of health and mandate action by all, but specifically by pharmaceutical companies. Although strong ethical arguments can support health for all and should encourage access to medicine, the configuration of the current system in place and the fairly new concept of CSR fall short of ethical expectations.

The main justification for the industry's responsibility derives from the good that is produced: medicine that is a key component to health. It is the special standing of this good that will allow to establish the obligation of pharmaceutical companies to engage in socially responsible action that is not optional. As De George (2005) reminds us, "the common impetus should be that of benefiting patients and the common good rather than only protecting intellectual property rights."⁶³

To build this argument, it is useful to go beyond the perception of health as a human right. Although a human-rights based approach can seem strong at first glance, Taket (2012) points out that "when questions of health distribution across the income spectrum or the causes of health failures are not themselves human rights, recourse to

⁶³ De George, Richard T. 2005 'Intellectual property and pharmaceutical drugs: An ethical analysis' in *Journal of Business Ethics* 15(4): 562.

ethical reasoning will always provide greater nuance and subtlety.”⁶⁴ I will therefore suggest grounding our moral argument in the capabilities approach, particularly Venkatapuram’s development of it, supporting a minimum threshold argument as a first step towards a stronger defense of health. I will also include ideas on global justice and equal access to opportunities.

Health as a capability

Venkatapuram’s capabilities approach has a wider and deeper reach and is a more malleable concept than a rights-based approach, which predetermines goals independently of individual circumstances and variations. Venkatapuram (2011), synthesizing previous authors’ claims, states:

“When health is properly understood as achieving vital goals, and the entitlements to the capabilities of achieving these vital goals are duly recognized as basic political principles grounded in freedom and equal dignity, the health of citizens does become the first priority of social justice, and one of the most basic values of society.”⁶⁵

The capabilities approach does not predetermine a way of life, it simply ensures an individual has the capability to lead a life that is fully human, whichever way he wishes. The capabilities approach is flexible, as health is not defined in a static way, but is adaptable to all contexts. Based on arguably universal values of dignity and equal respect, the theory can also be applied to every individual regardless of political or cultural affiliations.

According to Venkatapuram (2012), “allowing citizens to die prematurely or suffer impairments when they are preventable reflects a lack of concern for basic

⁶⁴ Taket, Ann 2012 *Health Equity, Social Justice and Human Rights*. New York: Routledge, 202: 149.

⁶⁵ Venkatapuram, Sridhar 2011 *Health Justice*. Cambridge: Polity Press: 72.

capabilities and freedoms, and does not show equal concern and respect”⁶⁶. This applies to society as a whole, as the author does not go further in attributing responsibility to specific actors. However, as will be emphasized further in this research when attributing responsibility, Sen underlines the ‘effective power’ argument, where “the possession of the capability to assist someone who has constrained basic capabilities in itself produces an obligation to at least consider helping.”⁶⁷ Through this argument, pharmaceutical companies should acknowledge the positive effect their industry could have on the health of individuals worldwide and consider helping. A more in depth analysis of their capacity to help might require pharmaceutical companies to greatly enhance access to the medicine they produce. If this is not possible, it should to the least have them refrain from hindering national governments’ efforts to promote and facilitate access to medicine for their citizens. That is to say, pharmaceutical companies should not challenge national decisions to derogate from patents or to issue compulsory licenses. If lowering prices is not considered a viable demand on the industry, *not hindering* national health decisions is definitely feasible.

A minimal threshold of health as the first goal

As we recognize the importance of health capabilities, taking a practical approach to their realization means incremental steps. It is not necessary to immediately thrive for the elimination of inequities, but we should at least seek to offer all individuals a minimal set of basic capabilities. According to Yaya (2010), “equity implies giving individuals equal capacity to be in good health in respect of human diversity, individual autonomy, as

⁶⁶ Venkatapuram, Sridhar 2012 ‘Health Inequalities, Capabilities and Global Justice’ in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 81.

⁶⁷ *Ibid*: 80.

well as providing sanitary interventions for disadvantaged people.”⁶⁸ This minimum threshold is widely seen to include some basic access to medicine, which is an important component of health. This does not entail access to the full range of all existing drugs, only access to basic curative drugs that allow individuals to function from day to day and get treatment on an *ad hoc* basis. Access to medicine is therefore included in basic health care as a part of health capabilities. This also aligns with Shue’s idea that subsistence rights should be seen as a priority, as they are a precondition to moral autonomy and can be considered non-subjective and universal.⁶⁹

The importance of including health and access to medicine in the minimum threshold lies in the consideration of subsistence rights as non-subjective and universal. According to Shue, these rights –including health –should apply to all without distinction, as they protect the capability to enjoy other rights and liberties.⁷⁰ Additionally, they are non-subjective and would therefore be agreed upon by all, as their definition does not prescribe a certain way of life but rather ensures that all have the means to live fully according to their own values and goals. Shue also defends the necessity of subsistence rights as a means for a person to be able to exercise his autonomy and enjoy his fundamental rights and liberties. One must first see his basic material needs satisfied, which includes health⁷¹, which therefore constitutes a pre-condition to autonomy.

⁶⁸ translated from: Yaya, Sanni 2010 ‘Sens et direction pour les malades de l’indifférence: quelles priorités pour la santé publique dans le tiers-monde’ in Yaya (ed.) *Les Maux et les chose de la santé: acteurs, pratiques et systèmes de santé dans le tiers-monde*. Québec: Les Presses de l’Université Laval: 13.

⁶⁹ translated from: Chung, Ryoa 2007 ‘Domination, vulnérabilité et inégalité d’accès aux soins de santé’ in *Philosophiques* 34(1): 140.

⁷⁰ Woodward, P.A. 2002 ‘Shue on Basic Rights’ in *Social Theory and Practice* 28(4): 648.

⁷¹ translated from: Chung, Ryoa 2007 ‘Domination, vulnérabilité et inégalité d’accès aux soins de santé’ in *Philosophiques* 34(1): 139.

Accepting a minimal threshold for health and individual capabilities is an idea that has been explored in practice by the World Health Organization with its creation of an essential drugs list. This list and its wide acceptance have led the international community to support the “idea that world health as a whole is best served by first making a basic range of well-proven drugs universally accessible”⁷² and can represent a step forward in recognizing that access to basic medicines should not be a matter of geography or financial resources, but of equal consideration and the defense of capabilities.

Global justice and equity

The previous discussion of the importance of health capabilities must be built as a societal argument to effectively mandate wider efforts to increase access to medicine. This can be done by acknowledging that health is not purely natural or a matter of luck, but also widely socially determined.⁷³ Access to medicine policy should then seek to restore health capabilities for all in order to correct unfair societal health distribution. Paired up with a minimum threshold argument, this does not mean that we need to eliminate all inequalities, but we must ensure basic capabilities while recognizing that society itself is the cause of a broad spectrum of inequities.

It can feel counter-intuitive to defend the idea that international relations constitute a distinct sphere of justice at the global level, because, as Chung (2007) mentions, there is “no apparent universal social contract or ethos governed by common

⁷² Abbott, Frederick M. and Dukes, Graham 2009 *Global Pharmaceutical Policy: Ensuring Medicines for Tomorrow's World*. Cheltenham, UK and Northampton, USA: Edward Edgar Publishing: 277.

⁷³ Daniels, Norman 2009 ‘L’extension de la justice comme équité à la santé et aux soins de santé’ in *Raisons politiques* 34: 19.

institutions.”⁷⁴ If one might be compelled to agree that justice should be observed within national borders and remains vague at the global level, Venkatapuram (2012) clearly establishes, with reference to authors such as Sen and Nussbaum, that “every human being [...] has pre-political entitlements arising out of their human dignity that their own society as well as other societies must respect.”⁷⁵ Ethical obligations are not concentrated within borders or attenuated by distance, which should mean that pharmaceutical companies, as participants in this global system, also hold obligations towards basic capabilities, including the capability to be healthy, at a global level.

The principles of global justice are also put forward by multiple authors denouncing a globally unjust system and the perpetuation of iniquities within it. Lage (2011) addresses this head on by stating that “inequity in access to medications is just one component of this larger problem, and its ultimate solution will mean confronting the formidable economic and political challenges of our time.”⁷⁶ This problem –relating to globalization, the North-South divide, etc. –is then part of the larger debate concerning global equity and justice. Ultimately, an obligation borne by all actors not to perpetuate injustices follows, as they have profited from an unjust system and continue to do so. This extends to pharmaceutical companies, which have been able to maintain above average profits without addressing the inequalities in access to medicine they might be encouraging through their business activities. Even though it is possible to attribute moral

⁷⁴ translated from: Chung, Ryoa 2007 ‘Domination, vulnérabilité et inégalité d’accès aux soins de santé’ in *Philosophiques* 34(1): 141.

⁷⁵ Venkatapuram, Sridhar 2012 ‘Health Inequalities, Capabilities and Global Justice’ in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 79.

⁷⁶ Lage, Agustin 2011 ‘Global Pharmaceutical Development and Access: Critical Issues of Ethics and Equity’ in *MEDICC Review* 13(3): 17.

responsibility to pharmaceutical companies, the practical ways of addressing access to medicine issues are most unclear.

Attribution of responsibility between actors

One of the most common arguments used by pharmaceutical companies to defer responsibility is that public entities are the ones responsible for the health of their citizens. From this point of view, it is then useful to explore ethical arguments that tackle the attribution of responsibilities between entities participating in the pharmaceutical industry and exerting influence on access to medicine. Many arguments from the domain of health ethics can be used to support a need to address access to medicine issues. I will attempt to show how these apply to pharmaceutical companies in particular. However, not all responsibilities fall directly or exclusively on pharmaceutical companies, as governments and the international community also provide parts of the answer.

Brock is fast to identify what she calls the seven failings of the pharmaceutical industry. Relating to access to medicine, she lists high prices, a neglect of diseases concentrated among the poor and wastefulness in policing patent law, which can all relate back to the structures of the pharmaceutical industry.⁷⁷ While she does not explore these problems in depth, she does elaborate a useful framework of responsibility attribution and makes an important distinction between outcome and remedial responsibility.

“Outcome responsibility ‘starts with agents and asks how far they can reasonably be credited and debited with the results of their conduct’ whereas, ‘remedial responsibility starts with patients –people who are deprived or suffering –and asks who should shoulder the burden of helping them.’”⁷⁸

⁷⁷ Brock, Gillian 2012 ‘Global Health and Responsibility’ in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 106.

⁷⁸ *Ibid*: 112.

With these definitions, it can be determined that pharmaceutical companies are not necessarily outcome responsible for people's lack of access to medicine: they do not forbid access nor cause individuals' lack of financial resources. Nonetheless, pharmaceutical companies might bear some responsibility, as even without a causal link between them and an individual's restricted access to medicine, a remedial responsibility could be attributed to pharmaceutical companies because they are *capable* of helping in a significant way.

The pharmaceutical industry's specific responsibilities

As the previous section defined why health is special and should be accessible to all, it follows the need to make the link with the pharmaceutical industry and its responsibilities in promoting access to medicine and health. Its special role can be perceived as stemming from its niche expertise, but also from the fact that it has thrived – and continues to – in an unjust system that systematically disadvantages other groups in favour of the pharmaceutical industry.

A first source of the pharmaceutical industry's responsibility can also quite simply come from its position in the world. As an industry of a very limited number of firms that hold a great amount of resources, both financial and other, it constitutes a very powerful cluster of entities. According to Dukes (2006), “the pharmaceutical industry, having a position of global power and wealth, has thereby also assumed worldwide the moral duties that go with the station.”⁷⁹ In this optic, the pharmaceutical industry – and all firms that compose it – should accept high ethical standards and participate in the common good due to their global advantage, in order to avoid creating inequities.

⁷⁹ Dukes, Graham 2006 *The Law and Ethics of the Pharmaceutical Industry*. Amsterdam: Elsevier: 266.

A stronger argument for pharmaceutical firms' involvement in access to medicine lies in their special capacity to help. Some will argue that pharmaceutical firms do not need to extend the service they provide to enhance access to medicine. Concerning the pharmaceutical industry's special knowledge in medicine, Leisinger (2009) argues that "successful pharmaceutical companies contribute to the respect, protection, and fulfillment of the right to health [...] in the context of normal core competence business activities. [...] this return on investment for society is substantial."⁸⁰ According to this argument, pharmaceutical companies' contribution to the common good is already met by the simple fact that they engage in research and development that produces drugs that improving health.

This seems, however, to be a very low demand to place on these firms, as the development of medicine is highly profitable. It also has to be noted that firms engage in R&D according to expected profits, therefore not always prioritizing drugs that most enhance global health. The decision of firms to proceed with R&D is highly calculated and, while it does provide some important cures for widespread ailments, it is also a process that is skewed towards producing profitable drugs targeted at developed countries' chronic diseases.⁸¹ In effect, this is often described as the 10/90 gap, where only 10% of research is devoted to conditions that represent 90% of the disease burden worldwide, and understudied diseases are mostly prevalent in under-developed countries.⁸²

⁸⁰ Leisinger, Klaus M. 2009 'Corporate Responsibilities for Access to Medicines' in *Journal of Business Ethics* 85(1): 13.

⁸¹ MacDonald, Théodore H. 2009 *Removing the Barriers to Global Health Equity*. Oxon, UK: Radcliffe Publishing: 87.

⁸² International Policy Network 2004 *Diseases of poverty and the 10/90 gap*. London: 4.

Most authors however believe that pharmaceutical companies can and should do more to help. De George (2005), mirroring Singer's well-known metaphor, underlines that there is an obligation to help others in serious need to the extent that one can do so with little or moderate cost to oneself.⁸³ In the context of pharmaceutical companies, it could then be argued that enhancing access to medicine in needy countries could be done relatively easily and without great consequences for multinational pharmaceutical firms. Increasing accessibility would not jeopardize their already above average profit margins, also taking into account the fact that most of this profit does not originate in developing countries anyway. This puts firms in a good position to reduce pricing or donate essential medicine to national governments or perform any other action that could reduce disparities in access across the world.

The capacity to help seems the most compelling argument to justify the responsibility of pharmaceutical companies to act. As Nagel explains, "the importance of the 'effective power argument' is that it greatly extends the moral motivation behind the duty to rescue beyond the immediate situation of peril to the improvement of well-being while also diminishing the moral importance of borders."⁸⁴

State responsibilities

The role of the states in access to medicine remains central. It is general economic knowledge that negative externalities produced in certain markets lead to a need for state intervention. In the pharmaceutical context, firms' effect to the detriment of access to medicine can be seen as an externality: "By definition it is difficult for the market to

⁸³ De George, Richard T. 2005 'Intellectual property and pharmaceutical drugs: An ethical analysis' in *Journal of Business Ethics* 15(4): 554.

⁸⁴ Venkatapuram, Sridhar 2012 'Health Inequalities, Capabilities and Global Justice' in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 80.

correct what may be perceived as negative consequences flowing from a firm's activities that are outside the range of its price calculations.”⁸⁵ This situation is driven by firms' profit-seeking behaviour, which leads them to practices that are harmful to the greater good, in this case, global health. As private companies have no interest in addressing these externalities voluntarily, as they represent a loss of profit, it is the state's responsibility to act in the interest of its population.

National governments obviously have a role to play in access to medicine, as they are the entity that (normally) defends and supports the common good of their people. This obligation is not surprising. It might also be extended to further enact changes in the global system which is not functioning as we would like it to. As has been explained previously, the current system perpetuates global inequities. Brock (2012) maintains the importance of “focus[ing] on governments and their responsibilities because the governments are *de facto* the primary agents of justice in the world we currently inhabit.”⁸⁶ It is useless to ask the pharmaceutical industry to reform itself in a way that would be detrimental to it, and national governments are the recognized entities that can regulate firms' activities. Their main responsibilities would therefore be to create a more just system which would defend wider access to medicine in an equitable way.

As will be explored in the next section, it is quite difficult for national governments to agree on international regulations concerning the global pharmaceutical system. Although governments might not be able to effectively regulate, there are other options for them to live up to their responsibilities to encourage access to medicine, even

⁸⁵ Maclean, Camilla and Crouch, Colin 2011 'Introduction: The Economic, Political and Ethical Challenges of Corporate Social Responsibility' in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 3.

⁸⁶ Brock, Gillian 2012 'Global Health and Responsibility' in *Health Inequalities and Global Justice*, EDU: 111.

with limited resources. As Flanagan and Whiteman (2006) show, there is a “necessity of active, multifaceted, and innovative government participation in pressuring companies to engage meaningfully in CSR-related actions, [...] not rely[ing] upon voluntary corporate social responsibility.”⁸⁷ These options include government incentives in pharmaceutical R&D or subsidies for certain programs that benefit society, for example.

In a general manner, it could be thought that, because health is special and basic access to medicine constitutes a minimum threshold to lead a life with sufficient capabilities, all actors have a common responsibility towards global citizens. As Dukes (2006) states, “humanitarian considerations alone would suggest that much of society – and certainly all players in the international pharmaceutical field – should be concerned with these problems.”⁸⁸ Although states receive most of the direct responsibilities, pharmaceutical companies should, to the least, refrain from engaging in harmful actions and provide access when they can do so at minimal cost to themselves.

Exploring solutions

The final step in this analysis of pharmaceutical firms’ responsibilities is determining how issues concerning detrimental private behaviour relating to access to medicine can be addressed. It has been shown that these firms are partially responsible for health outcomes, or to the least have a duty not to cause harm. Although the firms are not at fault for participating in a system that enables them to act in certain deplorable

⁸⁷ Flanagan, William and Whiteman, Gail 2006 ‘AIDS is not a Business: A Study in Global Corporate Responsibility – Securing Access to Low-cost HIV Medications’ in *Journal of Business Ethics* 73(1): 73.

⁸⁸ Dukes, Graham 2006 *The Law and Ethics of the Pharmaceutical Industry*. Amsterdam: Elsevier: 268.

ways, changes in the system should be considered to enhance access to medicine and push pharmaceutical companies to act more in line with the public interest in health.

While it is clear that pharmaceutical companies are part of the solution, many authors acknowledge that the firms themselves cannot and will not be the main drivers of change towards more socially responsible actions in access to medicine policies. The solutions to this issue mostly consider governments as the entities with the actual power to implement non-voluntary standards that would be regarded as ethical.⁸⁹ Self-regulation of pharmaceutical firms will always be done at a minimum (in order to avoid regulation or a bad reputation) but will never become an intrinsic part of how a firm operates because it goes against the main *raison d'être* of private firms, that is profits. Even though it is possible to attribute some responsibilities for pharmaceutical companies to improve access to medicine, they need to be given an incentive to do so.

Traditional approaches

Many approaches can be put forward to increase pharmaceutical firm compliance with societal ideals.

Nussbaum (2009) is a proponent of self-regulation; she believes pharmaceutical companies would go so far as to engage in self-regulation due to a lack in public regulation and firms will eventually recognize their duty to act responsibly because of a strong moral case for the wide provision of access to medicine. It is unclear how she expects pharmaceutical companies to start engaging with self-regulation, as she herself acknowledges that CSR is not profitable for firms.⁹⁰ She simply states that every firm

⁸⁹ Leisinger, Klaus M. 2009 'Corporate Responsibilities for Access to Medicines' in *Journal of Business Ethics* 85(1): 5.

⁹⁰ Nussbaum, Alexandra K. 2009 'Ethical corporate social responsibility (CSR) and the pharmaceutical industry: A happy couple?' in *Journal of Medical Marketing* 9(1): 72.

should participate in order to create a level playing field, but the incentives for this go unexplained. She also does not address the free-rider problem: if one firm decides not to self-regulate to maximize its profits, all other firms will have an incentive to also shirk their responsibilities.

Therefore it seems solutions might come down to either stronger regulations to force pharmaceutical companies to put in place mechanisms for enhanced access to medicine in poor countries or creating public-private partnerships. Regulations can seem a good idea *a priori*, but they would require a binding international framework with the power to reprimand unruly firms. While it is probably this structure that would best serve global interests and address inequalities, it is doubtful that countries would ever come to an agreement concerning a truly progressive framework. The hopes for a global scheme of regulation surrounding access to medicine are bleak. As Abbott and Dukes (2009) state, “when political considerations enter into the dialogue, with a particular government apparently more concerned about the well-being of its national pharmaceutical industry than the welfare of its people or those of other nations, cross-border cooperation may seem a distant dream.”⁹¹ In fact, one international intellectual property agreement, the trade-related intellectual property arrangements, or TRIPS, is already in place and does contain a provision for derogating to patents in situations of crisis. This agreement has shown, over the years, that even with a clause to justify enhancing access to medicine in exceptional situations, rich countries and big pharma can

⁹¹ Abbott, Frederick M. and Dukes, Graham 2009 *Global Pharmaceutical Policy: Ensuring Medicines for Tomorrow's World*. Cheltenham, UK and Northampton, USA: Edward Edgar Publishing: 276.

and do make it difficult (if not almost impossible) for small under-developed countries to appeal to this clause.⁹²

For the time being, cooperation between public entities or NGOs and private pharmaceutical companies might be seen as the most effective way to enhance access to medicine. While this is not the optimal solution, it is a step that can offer results through the current system. This cooperation, fueled by incentives for pharmaceutical companies to participate, can redirect efforts to produce and distribute important medicines and strengthen access. This multi-stakeholder approach, already explored through compacts and partnerships, has long been present as an effort to “find a proper relationship between the interests of society at large and those of the pharmaceutical industry.”⁹³ It is, however, dependent on both sides’ good will and an agreement that truly is favourable to the common good is not always a given, as some projects are not well designed or fall prey to pharmaceutical companies’ vested interests.

An alternative approach to responsibility: creating new research incentives

Beyond traditional approaches are more innovative solutions that think outside the box by challenging the status quo. A number of these have been suggested over time that could create tools, or incentives, for pharmaceutical companies to invest in R&D and delivery of medicines that have been identified as important for global health. This would put the emphasis on a common good perspective, rather than the present system based on a bottom-line cost/profit calculation that encourages firms to focus on lowly innovative drugs for well-off people.

⁹² Brock, Gillian 2012 ‘Global Health and Responsibility’ in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 106.

⁹³ Dukes, Graham 2006 *The Law and Ethics of the Pharmaceutical Industry*. Amsterdam: Elsevier: 83.

Restructuring the way the system works is a hefty project, especially considering the relatively unregulated nature of the global pharmaceutical industry. In this section, I want to present one alternative that has been elaborated and seems possibly viable, as well as better representing corporate responsibility ideals and societal values concerning health.

The Health Impact Fund proposal

An interesting proposal has been put forward by many authors as they search for ways to transform the system for it to produce outcomes that reflect societal goals of health while still offering profits that would entice pharmaceutical companies to conduct R&D. The Health Impact Fund (HIF) was elaborated by multiple academics and researchers over the years, with Thomas Pogge leading the way in terms of promoting it as the best approach to reform the research incentives system and offering broader access to medicine all over the world.

As Pogge (2012) explains, the HIF would create a two-track framework for companies to profit from drug development and marketing. While the first track retains the current patenting system format, the second option would be the HIF, “a pay-for-performance mechanism that would offer innovators the option –no obligation –to register any new medicine [and] agree to make it available, during its first decade on the market, wherever it is needed at no more than the lowest feasible cost.”⁹⁴ In return, the submitting pharmaceutical firm obtains annual financial rewards based on the product’s global health impact. The fact that HIF offers rewards based on global impact would also

⁹⁴ Pogge, Thomas 2012 ‘The Health Impact Fund: Enhancing Justice and Efficiency in Global Health’ in *Journal of Human Development and Capabilities* 13(4): 543.

encourage pharmaceutical companies to increase access to their medicine by participating in the delivery and provision, as well as following up with patients after initial contact.

Selgelid (2008) agrees with the structure of this suggested system and believes pharmaceutical companies would participate in it willingly. In fact, it would represent a new source of profits for companies that would not otherwise have invested in R&D towards neglected diseases. The new structure offers financial rewards for firms capable of influencing global health outcomes through drugs that would have great impacts on populations, therefore boosting possible profits for cures for under-researched diseases.⁹⁵ All the while, Pogge's proposal recognizes that patents should not be abolished for all medicines and the reward system would go unchanged for most drugs, as these do already induce research as they offer profits for firms.

This innovative system is an interesting proposal to change incentives related to pharmaceutical R&D. It also offers an approach that does not require a wide reform of the system, but only that a parallel structure be put in place to enhance R&D and then subsequently address access to medicines issues for neglected diseases.

The main obstacle to this proposal is the funding component. Without long-term commitments from a variety of countries and organizations, the HIF would not attract submissions. Pogge (2011) suggests countries foot the bill, claiming a contribution of 0.03% of GNI would make the fund viable.⁹⁶ However low this threshold may be, some countries might be reluctant to participate and this would create disequilibrium in who invests in this system and who reaps the benefits. For Pogge, it is obvious that the fund would create global advantages, but his confidence rests on high moral expectations of

⁹⁵ Selgelid, Michael J. 2008 'A Full-Pull Program for the Provision of Pharmaceuticals: Practical Issues' in *Public Health Ethics* 1(2): 137.

⁹⁶ Pogge, Thomas 2011 'Getting the Incentives Rights: The Health Impact Fund', for the *Friedrich Ebert Stiftung*: 6.

international compassion and cooperation. He recognizes the costs of this program would be borne by rich countries, but maintains that “by funding innovation through health impact incentives rather than through patent-protected mark-ups, affluent populations avoid the need to exclude the poor”⁹⁷, which in itself should convince rich countries to invest. As important as this global justice argument may be, it is not guaranteed that countries would accept this argument and support the idea. Other benefits mentioned could go some way in convincing developed countries to participate, such as lower unit costs, changes in promotion patterns, and increased accessibility even in rich countries.⁹⁸ The simplest argument to encourage developed countries to participate might be the fact that the HIF would fuel their pharmaceutical industry’s R&D activities and be good for economic growth.

Another difficulty identified by Selgelid (2008) is that of evaluating a drug’s health impact.⁹⁹ The HIF offers to reward pharmaceutical companies based on their drug’s impact on global health. This entails extensive analysis and the elaboration of a set process to analyze drug effectiveness, while isolating effects from other factors. Such a process is sure to be challenging, but establishing a fixed evaluation scale could at least ensure some regularity in impact evaluations and offer standardized suggestions to the worth of new drugs for global health outcomes. To address this issue, Pogge (2012) suggests the rollout of a small scale HIF project because “the best way to reassure

⁹⁷ Pogge, Thomas 2012 ‘The Health Impact Fund: Enhancing Justice and Efficiency in Global Health’ in *Journal of Human Development and Capabilities* 13(4): 544.

⁹⁸ Pogge, Thomas 2011 ‘Getting the Incentives Rights: The Health Impact Fund’, for the *Friedrich Ebert Stiftung*: 4.

⁹⁹ Selgelid, Michael J. 2008 ‘A Full-Pull Program for the Provision of Pharmaceuticals: Practical Issues’ in *Public Health Ethics* 1(2): 138.

governments and innovators on this point is to conduct a ‘pilot’ of the HIF concept.”¹⁰⁰
This would also allow to test out the structure of this imagined system to ensure its overall effectiveness.

All in all, the HIF proposes to change the R&D incentive and medicine delivery methods in developing countries. Without modifying the system deeply, the funding of this alternative would enable companies to profit from products that are under-developed today because they do not offer economic profitability in the current reward system. The HIF does not actually make pharmaceutical companies recognize their responsibility towards access to medicine *per se*, but it nudges them to make decisions aligned with public goals by shifting the incentives of R&D and drug provision, which in the end might be a more effective way to increase access.

¹⁰⁰ Pogge, Thomas 2012 ‘The Health Impact Fund: Enhancing Justice and Efficiency in Global Health’ in *Journal of Human Development and Capabilities* 13(4): 553.

Conclusion

This research started off by describing the limited scope of CSR initiatives in the pharmaceutical industry. Some firms, like GSK, are proof that voluntary CSR can lead to meaningful involvement in the promotion of access to medicine. However, GSK is an exception and most firms, such as Pfizer, report only vaguely on their CSR commitments and choose projects according to their bottom-line interest. Private pharmaceutical companies refuse to recognize the role they play in access to medicine and individuals' right to healthy and autonomous lives.

CSR is a voluntary scheme known to be weak. It only addresses firms' direct effect on individuals, but does not take into account their role in global trends, in this case, the lack of access to medicine. Because multinational pharmaceutical companies have a clear influence over their market and provide a unique and life-saving product, they should bear some responsibility towards ensuring access to medicine.

While it is true that pharmaceutical companies could be more involved in promoting access to medicine, this research has shown that they are not the only ones to bear responsibility towards this issue. States remain the main warrantors of their population's safety and well-being, which includes basic health provisions.

Ultimately, all actors including pharmaceutical companies have to respect certain ethical principles based on the right to a full life. A minimal threshold of health should include access to certain medicines considered essential, in order for individual to have full autonomy. Although public entities are mostly responsible for health, this research has argued that the pharmaceutical industry has a direct influence on the well-being of individuals and should help increase access to medicine because it is in a better position than other actors to do so. Still today, requirements on pharmaceutical companies to limit

their negative impact on access to medicine are low, and measures to encourage them to increase access are considered voluntary and philanthropic. This should be changed to guarantee individual autonomy and basic rights.

This research has shown that pharmaceutical companies' limited CSR initiatives are more PR than an actual endorsement of responsibility towards access to medicine issues. While this is deplorable, it is also understandable that private firms do not participate in activities that reduce their profit. In order to modify the behaviour of private actors within the market, one has to tackle the system as a whole. My research has provided thoughts on traditional suggestions of regulation, but considers an innovative approach such as the HIF more potent in addressing systemic issues. The HIF is an innovative way to work within an industry that is split into "two distinct pharmaceutical markets [...] based on group behaviour, culture, or economic characteristics and their potential to enhance industry profits."¹⁰¹ It is an option that benefits both developing countries through enhanced access to medicine and pharmaceutical companies through new profit sources. This proposal seems logical and well-founded, but still lacks a real trial to test its efficacy on a wide scale. Before implementing this system, HIF proponents will have to convince pharmaceutical companies and countries to participate in a trial to fully show the benefits the system has to offer.

The last element I wish to underline is the need for a truly and absolutely global strategy. Whether through international regulations or a reformed patent system, access to medicine needs to be tackled by all actors in the pharmaceutical industry. Without a total consensus, some countries or firms will always be able to shirk their responsibilities to

¹⁰¹ Petryna, Adriana and Kleinman, Arthur 2006 'The Pharmaceutical Nexus' in *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham and London: Duke University Press: 3.

increase their profit margins, precluding populations in need from access to essential life-saving medicine. A solution remains to be seen, as global international agreements are rare and more often than not perpetuate unequal power relations.

Bibliography

't Hoen, Ellen F.M. 2009 *The Global Politics of Pharmaceutical Monopoly Power: drug patents, access, innovation and the application of the WTO Doha Declaration on TRIPS and Public Health*. Diemen, The Netherlands: AMB Publishers, 136 p.

Abbott, Frederick M. and Dukes, Graham 2009 *Global Pharmaceutical Policy: Ensuring Medicines for Tomorrow's World*. Cheltenham, UK and Northampton, USA: Edward Edgar Publishing, 308 p.

Access to Medicine Foundation 2012 *The Access to Medicine Index 2012*. Retrieved from: <http://www.accesstomedicineindex.org/index-publications>: 143 p.

Brock, Gillian 2009 'Health in Developing Countries and Our Global Responsibilities' in Angus (ed.) *The Philosophy of Public Health*. London: Ashgate, 73-83.

Brock, Gillian 2012 'Global Health and Responsibility' in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 102-118.

Brown, Sherri A. 2006 'Global Public-Private Partnerships for Pharmaceuticals: Operational and Normative Features, Challenges, and Prospects' *Simon Fraser University dissertation research*: 19 p.

Chung, Ryoa 2007 'Domination, vulnérabilité et inégalité d'accès aux soins de santé' in *Philosophiques* 34(1): 133-152.

Cochrane, James 2000 'Narrowing the gap: access to HIV treatments in developing countries. A pharmaceutical company's perspective' in *Journal of Medical Ethics* 26: 47-50.

Daniels, Norman 2009 'L'extension de la justice comme équité à la santé et aux soins de santé' in *Raisons politiques* 34: 9-30.

De George, Richard T. 2005 'Intellectual property and pharmaceutical drugs: An ethical analysis' in *Journal of Business Ethics* 15(4): 549-575.

Detomasi, David Antony 2007 'The Multinational Corporation and Global Governance: Modelling Global Public Policy Networks' in *Journal of Business Ethics* 71: 321-334.

Dukes, Graham 2006 *The Law and Ethics of the Pharmaceutical Industry*. Amsterdam: Elsevier: 409 p.

Dunfee, Thomas W. 2006 'Do firms with unique competencies for rescuing victims of human catastrophes have special obligations? Corporate responsibility and the AIDS catastrophe in sub-saharan Africa' in *Business Ethics Quarterly* 16(2): 185-210.

Doane, Deborah 2005 'Beyond corporate social responsibility: minnows, mammoths and markets' in *Futures* 37(2005): 215-229.

Fierlbeck, Katherine 2011 *Health Care in Canada: A Citizen's Guide to Policy and Politics*. Toronto: University of Toronto Press: 382.

Flanagan, William and Whiteman, Gail 2006 'AIDS is not a Business: A Study in Global Corporate Responsibility – Securing Access to Low-cost HIV Medications' in *Journal of Business Ethics* 73(1): 65-75.

Givel, Michael 2013 'Modern Neoliberal Philanthropy: motivations and impact of Pfizer Pharmaceutical's corporate social responsibility campaign' in *Third World Quarterly* 34(1): 171-182.

GlaxoSmithKline 2012 *Corporate Social Responsibility Report*. Retrieved from <http://www.gsk.com/responsibility/responsibility-reports-and-resources/reporting-archive-and-resources.html>: 73 p.

Haakonsson, Stine Jessen and Richey, Lisa Ann 2007 'TRIPS and Public Health : The Doha Declaration and Africa' in *Development Policy Review* 25(1): 71-90.

Hamdouch, Abdelillah and Depret, Marc-Hubert 2001 *La nouvelle économie industrielle de la pharmacie: Structures industrielles, dynamique d'innovation et stratégies commerciales*. Paris: Elsevier, 280 p.

Health Action International 2001 'Public-Private 'Partnerships': Addressing Public Health Needs or Corporate Agendas?' *Seminar Report*. Amsterdam: 33 p.

Hogerzeil, Hans V. 2013 'Big Pharma and Social Responsibility – The Access to Medicine Index' in *The New England Journal of Medicine* 369(10): 896-899.

Illingsworth, Patricia 2012. 'Corporate Social Responsibility and the Right to Essential Medicines' in Forman, Lisa and Kohler, Jillian Clarke (eds.) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*. Toronto: University of Toronto Press: 75-89.

International Policy Network 2004 *Diseases of poverty and the 10/90 gap*. London: 12 p.

Jack, Andrew 2012 '“World's pharmacy” faces new challenges from Western drug companies' in *BMJ* 345(6207): 3 p.

Jones, Ian W., Pollitt, Michael G. and Bek, David 2007 *Multinationals in their Communities: A Social Capital Approach to Corporate Citizenship Projects*. New York: Palgrave Macmillan: 359 p.

Kay, A. et Williams, O. 2009 'Introduction: The International Political Economy of Global Health Governance', dans *Global Health Governance: Crisis, Institutions and Political Economy*. London: Palgrave Macmillan: 1-23.

Khosla, Rajat and Hunt, Paul 2012 'Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines' in Forman, Lisa and Kohler, Jillian Clarke (eds.) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*. Toronto: University of Toronto Press: 25-45.

Lage, Agustin 2011 'Global Pharmaceutical Development and Access: Critical Issues of Ethics and Equity' in *MEDICC Review* 13(3): 16-22.

Lauzon, L.-P. and Hasbani, M. 2006 *Analyse socio-économique: Industrie pharmaceutique mondiale. Pour la période de 10 ans 1996-2005*. Montréal: Chaire d'études socio-économiques de l'UQAM, 34 p.

Lee, Matthew and Kohler, Jillian 2010 'Benchmarking and Transparency: Incentives for the Pharmaceutical Industry's Corporate Social Responsibility' in *Journal of Business Ethics* 95: 641-658.

Leisinger, Klaus M. 2005 'The corporate responsibility of the pharmaceutical industry: Idealism without illusion and realism without resignation' in *Journal of Business Ethics* 15(4): 577-594.

Leisinger, Klaus M. 2009 'Corporate Responsibilities for Access to Medicines' in *Journal of Business Ethics* 85(1): 3-23.

Leisinger, Klaus M. 2011 'Corporate Responsibility for Pharmaceutical Corporations' in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 95-117.

MacDonald, Théodore H. 2009 *Removing the Barriers to Global Health Equity*. Oxon, UK: Radcliffe Publishing, 296 p.

Maclean, Camilla and Crouch, Colin 2011 'Introduction: The Economic, Political, and Ethical Challenges of Corporate Social Responsibility' in Crouch and Maclean (eds.) *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 1-28.

Management Sciences for Health 2011 *MDS-3: Managing Access to Medicines and Health Technologies*. Sterling, USA: Kumarian Press.

Nussbaum, Alexandra K. 2009 'Ethical corporate social responsibility (CSR) and the pharmaceutical industry: A happy couple?' in *Journal of Medical Marketing* 9(1): 67-76.

Oxfam, VSO and Save the Children 2002 'Beyond Philanthropy: the pharmaceutical industry, corporate social responsibility and the developing world' (Joint report). Oxford and London, 28 p.

Petryna, Adriana and Kleinman, Arthur 2006 'The Pharmaceutical Nexus' in *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham and London: Duke University Press: 1-32.

Pignarre, Philippe 2003 *Le grand secret de l'industrie pharmaceutique*. Paris: La Découverte, 178 p.

Pfizer 2009 *2009 Corporate Social Responsibility Report*. Retrieved from http://www.pfizer.com/responsibility/corporate_responsibility_report. 64 p.

Pfizer 2012 *Pfizer Annual Review 2012*. Retrieved from http://www.pfizer.com/responsibility/corporate_responsibility_report: 84 p.

Pogge, Thomas 2011 'Getting the Incentives Rights: The Health Impact Fund', for the *Friedrich Ebert Stiftung*: 9 p.

Pogge, Thomas 2012 'The Health Impact Fund: Enhancing Justice and Efficiency in Global Health' in *Journal of Human Development and Capabilities* 13(4): 537-559.

Reed, Tim 2008 'The new Access to Medicine Index' in *The Lancet* 372 (September 13th): 890-891.

Selgelid, Michael J. 2008 'A Full-Pull Program for the Provision of Pharmaceuticals: Practical Issues' in *Public Health Ethics* 1(2): 134-145.

Sternberg, Elaine 2011 'How Serious is CSR? A Critical Perspective' in Crouch and Maclean (eds.), *The Responsible Corporation in a Global Economy*. Oxford: Oxford University Press: 29-54.

Taket, Ann 2012 *Health Equity, Social Justice and Human Rights*. New York: Routledge, 202 p.

Thomas, Caroline 2003 'Trade Policy, the Politics of Access to Drugs and Global Governance for Health' in Lee (ed.) *Health Impacts of Globalization: Towards Global Governance*. New York: Palgrave Macmillan: 177-190.

Varella, Marcelo D. 2004 'L'organisation mondiale du commerce, les brevets, les médicaments et le rapport nord-sud : un point de vue du sud' in *Revue internationale de droit économique*, 18(1): 79-117.

Venkatapuram, Sridhar 2011 *Health Justice*. Cambridge: Polity Press, 270 p.

Venkatapuram, Sridhar 2012 'Health Inequalities, Capabilities and Global Justice' in Lenard and Straehle (eds.) *Health Inequalities and Global Justice*. Edinburgh: Edinburgh University Press: 65-82.

Werhane, Patricia H. and Gorman, Michael E. 2005 'Intellectual Property Rights, Access to Life-Enhancing Drugs, and Corporate Moral Responsibilities' in *Ethics and the Pharmaceutical Industry*. Cambridge, USA: Cambridge University Press: 260-281.

Woodward, P.A. 2002 'Shue on Basic Rights' in *Social Theory and Practice* 28(4): 637-665.

World Health Organization 1997 *Public-Private Roles in the Pharmaceutical Sectors: Implications for equitable access and rational drug use*. Report DAP/97.12: 127 p.

Yaya, Sanni 2010 'Sens et direction pour les malades de l'indifférence: quelles priorités pour la santé publique dans le tiers-monde' in Yaya (ed.) *Les Maux et les chose de la santé: acteurs, pratiques et systèmes de santé dans le tiers-monde*. Québec: Les Presses de l'Université Laval: 1-36.