Medicines and health care represent an ultimate arena for the application of marketing because our needs in that province of experience are deep and subject to the sort of manipulation at which marketing excels. In the United States, marketing has created an ‘Overdo$ed’, ‘Overtreated’ ‘Rx Generation’ (the titles of just three recent bestsellers). Meanwhile, in most of the rest of the world people suffer from diseases whose incidence would be dramatically reduced if they had ready access to the medicines already in use in the west fifty years ago. The overconsumption of pharmaceuticals in affluent countries, and the degradation of health services for poor people in most other countries, are related. Critics such as Paul Farmer point out that the principal culprit in causing growing health inequality is the relinquishment of formerly public administrative responsibilities to market forces; market forces are a form of ‘structural violence’ that brings together opportunistic profit-taking and inept or uncaring state planners to produce a dangerous combination of international exploitation and indifference.

We can greatly advance our understanding of market forces by studying the powerful, organised design of ‘big pharma’, the world’s wealthiest industry, as it confronts the world’s healthcare infrastructure in an attempt to standardise and control its sources of profit.

Nineteen of the twenty top earners in the pharmaceutical industry are American or western European firms. The industry is moreover globalising and concentrating through mergers, leading to a replication and amplification of the managerial practices common to these firms. At the nucleus of these practices and the aspiration to global dominance is marketing, the conceptual tool with which expansion is conceived and enacted.

A marketing-driven focus is to be contrasted with a needs-oriented one. A needs-oriented outlook, which is what marketers claim actually organises their work, would be characterised by a firm’s careful reading of the needs
of consumers and the opportunities and obstacles entailed in meeting those needs. A marketing-driven outlook, by contrast, begins with an inward focus. The goal is to satisfy company requirements, the most important of which is growth at all costs. The distinction is subtle but quite real. In the case of pharmaceuticals, a needs-oriented approach would be one in which firms listen to experts – physicians, epidemiologists, pharmacologists and public health workers, as well as patients – en route to developing cures. The marketing-driven firm searches for ‘unmet needs’ that conform to company-defined values and which do not necessarily overlap with needs as the medical community defines them.\(^3\)

Since the early 1990s, pharmaceutical sales have grown considerably, both in absolute volume and as a percentage of world healthcare expenditures. Estimated 2008 worldwide revenues reached US $775 billion, representing a compound annual growth rate of roughly 10 per cent per year from 1999 onwards. The steep rise in pharmaceutical spending contributes to the escalating costs of health care. Pharmaceuticals account for 18 per cent of healthcare expenditures worldwide, a percentage that has grown in double digits in recent years and which appears to conform to a general rise in the dependence of biomedicine on pharmacological interventions at least since the Second World War.\(^4\) While just a handful of wealthy countries account for the bulk of pharmaceutical expenditures at present, emerging market regions are increasing their pharmaceutical spending rapidly.\(^5\)

This expansion can be explained as a result of two related processes. The first is medicalisation, a term that medical anthropologists use to describe what happens when previously non-medical phenomena come to be classified in terms of illnesses, disorders or potential disorders, and thereby come under the purview of medical treatment. Strategic medicalisation, or what some writers call disease-mongering, is:

\[\ldots\text{ the effort by pharmaceutical companies (or others with similar financial interests) to enlarge the market for a treatment by convincing people that they are sick and need medical intervention… The market for treatment gets enlarged in two ways: by narrowing the definition of health so normal experiences get labelled as pathologic, and by expanding the definition of disease to include earlier, milder, and presymptomatic forms (e.g., regarding a risk factor such as high cholesterol as a disease in itself).}\]

The second process is what João Biehl and others refer to as ‘pharmaceuticalisation’, the adoption by individuals and healthcare administrators
of so-called ‘magic bullet’ solutions – meaning the use of pharmaceuticals – to treat most ailments. Strategic pharmaceuticalisation begins with drug companies seeing their products not as complementary to other forms of therapy, but in competition with them. Success is defined relative to the industry’s ability to instil overconfidence in drugs, resulting in a reduction in other forms of therapy. If we see strategic medicalisation and pharmaceuticalisation as key elements in the commodification of health, we begin to perceive the managerial intentions and practices that exert the greatest force over health care today.

GLOBAL HEALTH CARE
THROUGH THE LENS OF MARKETING
As pharmaceutical expansion is global in scope, in what follows I will discuss three processes that correspond to conventional analyses of the broadening and deepening of capitalism, but with particular application to the contemporary pharmaceutical industry: (1) Seeking to expand the market for one’s products by exporting to new markets, and by deepening consumption in existing ones. (2) Muscling into local healthcare policy and administration to guarantee country environments well adapted to pharmaceutical market growth. (3) Seeking to lower costs through foreign sourcing of raw materials – in this case clinical trial subjects.

Pharmaceuticalisation I: stimulating demand
Most industries have moved toward the realisation that the most profitable resource to be extracted even from poor countries is not raw materials or labour, but the readiness to consume. To capitalise on this potential, firms take two allied approaches. First, they seek to influence exchange environments (distribution channels, treatment guidelines, reimbursement policies) to enhance the flow and profitability of their drugs. Second, they invest in doctor and consumer awareness campaigns, referred to as ‘education’, to stimulate demand directly. Here I will point out a few features of demand stimulation in pharmaceuticals.

Medicines were traditionally thought to be inelastic goods, meaning that promotion (or lowering prices) would not lead to an appreciable expansion of consumption. No one who does not have high blood pressure, for instance, will start taking antihypertensive medicine because of a billboard advertisement, nor will people who already take it increase their dosage. Doctors prescribe these drugs to patients who require it, and we assume that doctors are informed by scientific studies, not advertisements.

This is often not true. Each link on the entire medical information chain – from research funding, scientific journal publications, FDA approval, public
health therapy guidelines, product labelling, the scientific programming at medical conferences, to medical education in medical schools and clinics – is the focus of concerted persuasion campaigns. The money spent to hire prominent academic doctors (‘key opinion leaders’) to publicise the results of corporate-ghostwritten research at medical schools and in sponsored ‘satellite symposia’ at professional conferences may constitute the largest single component of marketing costs, at 20 per cent of the total. By comparison, 14 per cent is spent on advertising. Some areas of medicine, such as psychiatry, have proven more vulnerable to marketing encroachment than others, but all of medicine has been deeply affected.

What this all means is that physicians rather than laypeople are the principal targets of pharmaceutical propaganda. The average physician has neither the training nor the time to evaluate the merits or veracity of scientific research reports or the claims of key opinion leaders. The industry exploits this ignorance to our collective detriment. In the meantime, the practice persists partly because most doctors discount the possibility that they are not masters of their own field of knowledge and practice. Without necessarily understanding all the ways in which private interests (including those of HMOs and insurance companies) affect medicine in the US, the public has reportedly lost much of its past trust in doctors. Ironically, this presents an opportunity for the drug industry to develop a direct relationship with consumers, who increasingly turn to sources other than their doctors for information about their health.

In other parts of the world, dismantling public health services in favour of a dependency on pharmaceutical solutions achieves the same result: a shift in the information source away from experts and into the waiting arms of pharmaceutical sales agents. Drug companies devote large resources to shaping the information we see when we search for symptoms or the name of a medical condition on the internet. Wikipedia, for example, is a prime site of pharmaceutical company manipulation. The result is that many patients visit their physicians with a request for specific medicines and diagnostic tests already on their lips. At risk of estranging these patients, who in a privatised medical world are valued customers, even reluctant physicians acquiesce.

Aiding the trend towards self-diagnosis and medication is the prevalence of drugs developed to treat invisible disorders (i.e., those for which we have no symptoms) such as hypercholesterolemia or pre-diabetes, producing what Jeremy Greene describes in his book, Prescribing by Numbers, as ‘the modern predicament of the subjectively healthy but highly medicated individual’. Greene is not suggesting that the risks the drugs are used to ‘manage’ are fictitious. However, the continued expansion of their use depends on
the ability of pharmaceutical companies to set the threshold for what is considered to be the risk of disease. Should a blood pressure reading of 140/90 be diagnosed as hypertension, or 130/80? The difference may appear negligible as regards a given individual, but for the pharmaceutical industry the difference is worth many billions of dollars. As Greene puts it, ‘The diagnostic process is now as much a negotiation between the pharmaceutical industry and guideline-setting committees as it is a negotiation between doctor and patient’.

For the bridge between marketing efficiencies, consumer perceptions and motivations for purchase to be completed, the abstract realm of symbolic production must also be linked to powerful, expandable emotions. Fear, and its antidote, risk reduction behaviour, has proven an ideal marketing vehicle because it permits the conversion of seemingly healthy, symptomless people into sick ones, in need of medication and constant measurement. Risk management has come to stand in for prevention, though the two are not the same. Both the risk management and the lifestyle models of pharmaceutical use call for long-term therapy. This is the basis for ‘blockbuster’ drugs, products with annual sales of over $1 billion, which have competed successfully against the pursuit of both cures and strategies of prevention. The profits from blockbusters have come to rival those of all the other drugs combined in a pharmaceutical company’s product line. In 1991 blockbusters accounted for 6 per cent of the overall pharmaceutical market. This figure tripled to 18 per cent by 1997, and in 2001 accounted for 45 per cent of the market. The top ten drugs alone, constituting less than a quarter of one percent of the drugs available in a growing pharmacopeia, accounted for over $60 billion in annual sales in 2006.

The industry finally claims an exclusive connection to the subjective experience of illness on grounds that it has an intimate understanding of quality-of-life issues, an aspect of the illness experience it alleges the medical profession disregards. This is the segue to promulgating marketing-defined concepts of need, including risk management, lifestyle appeal, consumer choice, and a trust that the West’s branded medicines are efficacious and the most advanced. Because winning over consumers entails gaining voluntary conformity from them, the challenge facing pharmaceutical marketers is how to meet human suffering on its home ground, i.e. in the subjective experience of illness, and to incorporate that into the depersonalised, privatised calculus of ‘growing the market’ for pharmaceuticals.

Risk management, lifestyle appeal, and consumer choice may sound quite removed from the concerns of much of the developing world: AIDS, tuberculosis, malaria, and cholera are not ordinarily targets of marketing
because they are diseases suffered mainly by poor people, and/or because the drugs available to treat them are no longer on patent. However, many developing country (and increasingly affluent country) economies are typified by the coexistence of rich and poor, an inequality that extends directly to healthcare access. But developing country health budgets also increasingly face a two-tier health challenge. The indigent suffer from infectious and diarrheal diseases, malnutrition and the like, while their more affluent countrymen suffer from cardiovascular disease, cancer, allergies, depression and other 'diseases of affluence’ – so called because their prevalence (and diagnosis) increase with economic prosperity. As in any consumer product area, the affluent are the primary targets of marketing. However, in this case, it is public rather than personal budgets that are being accessed, and the demands of the wealthy have a way of taking precedence to those of the poor.

**Pharmaceuticalisation II: policy initiative**

If stimulating demand for pharmaceuticals in the wealthy nations drives the agenda for human resource extraction elsewhere, global marketing aspirations animate the campaign to influence the scientific, administrative and ethical standards by which health care is to be viewed domestically in any given locale. The ability to supply drugs to the global body, as it were, is contingent upon altering both the policies and attitudes regarding patented drugs.

Pharmaceuticalisation is promoted abroad by the lobbying efforts of PhRMA (Pharmaceutical Research and Manufacturers of America) and with the aid of industry-advocated trade mechanisms such as the ICH (International Council on Harmonisation). Pharmaceuticalisation has already had dubious effects upon public health efforts in many countries, particularly in the area of mental health. For governments facing structural adjustment and other imposed economic belt-tightening, an emphasis on pharmaceuticals appears a faster, often cheaper solution than clinical engagement and care giving. But like other neoliberal economic reforms, as a public health initiative pharmaceuticalisation also represents a giant step backwards from addressing the structural causes of disease prevalence.

In his study of global health politics in Brazil, Biehl investigates the negotiation between the neoliberal state and market forces that results in the pharmaceuticalisation of public health in that country. He reports on the transactions between the Brazilian government and the pharmaceutical industry in the effort to develop a biotechnology policy that would stanch the destruction being wreaked by AIDS. The Brazilian government managed
both to ‘challenge the patent and pricing structures of global pharmaceutical companies’ and to coordinate an alliance of partners, including pharmaceutical companies, to accomplish some of its objectives. Yet it is clear to Biehl how pharmaceutical companies ‘engage in biopolitics, gaining legitimacy and presence in both state institutions and individual lives through drugs’, and pharmaceuticalisation proceeds in Brazil as planned. There may be all manner of public/private partnerships proposed and accepted by the Brazilian government, but in the end there remains a competition between business and government for the simple reason that many of their goals do not coincide.

This competition between business and public health goals was very evident to me in my investigation of the introduction of SSRI antidepressants in Japan in the early 2000s. The elements of the ground-preparing pharmaceuticalisation programme, greatly aided by PhRMA’s participation, included: (1) rhetorically accentuating the alleged deficiencies in the treatment of Japanese sufferers from mental disorders; (2) coordinating the efforts of supposedly competing firms to ‘make the market’; (3) deploying transnational institutions such as ICH and patient advocacy groups to help impose global criteria for Japanese healthcare reform that served the pharmaceutical industry’s interests; (4) provoking, through lobbying the Ministry of Health, Labor and Welfare, internal debates about healthcare reform and Japanese drug company competitiveness. These and related campaigns amounted to an attempt to influence an entire society’s attitudes concerning treatment seeking and public provision in treating mental illness. While the putative aim of these activities was to introduce standards of global excellence to Japanese mental health care, the ulterior goal was to press for the privatisation of the pharmaceutical market so that the predominantly foreign purveyors of the new drugs would be free to install their accustomed system of marketing and pricing in the Japanese market.

Pharmaceuticalisation thus functions as a three-way bridge among the universalising assertions of biomedical science, the moral imperative to treat the world’s sick, and the subjective experience of illness. The pharmaceutical industry claims privileged access to each of these domains. It boasts about how much it spends on R&D, and its enactment of clinical trials, and waves the frayed banner of twentieth century pharmacological successes, saying, ‘See, we are the saviors of mankind!’ This is simultaneously an ethical claim. And the industry coordinates efforts (among patient advocacy groups, for instance) to lobby public health authorities that hesitate to pay top dollar for the latest pharmaceuticals, rebuking them for withholding the fruits of progress from suffering constituents.
Resource extraction

Corporations have always sought to lower costs by searching abroad for low-cost labour and cheaper inputs for their manufacture. This was a driving motive behind colonialism. In the pharmaceutical industry, R&D costs have grown for a variety of reasons, among them the expanding uses to which clinical trials are put. For instance, a drug might be tested for many possible indications at once; if successful, this greatly expands the commercial potential of the drug. At the same time, as citizens in affluent countries have become overmedicated, they are less useful as trial subjects. Drug effects are best measured on ‘treatment naïve’ populations. Drug companies and their subcontractors therefore take much of their research to developing countries (and to down-and-out populations in the US\(^21\)), where ‘treatment naïve’ subjects are plentiful and cheap.

Developing host countries may also be less equipped to enforce codes intended to safeguard research subjects. Contract research organisations (CROs) in such countries can often evade ethical codes. The crimes Pfizer was alleged to have committed in Nigeria when testing their drug Trovan in the 1990s are reminiscent of both colonial resource extraction and the 19th-century practice of ‘exporting’ inhumane labour practices abroad when they had been outlawed at home.\(^22\) In the case of clinical trial research, the practice outlawed at home is the use of prisoner populations for drug testing.

The globalisation of clinical trials raises a number of thorny dilemmas. From a scientific standpoint, the use of research subjects in developing countries can be problematic because patients’ medical histories are often incomplete. Criteria for evaluating drug effects may vary cross-culturally, a bias associated both with how local medical partners are accustomed to making diagnoses and with patient reporting habits. For drugs intended to treat neuropsychiatric conditions, for instance, the problems of cultural translation in diagnosis and results reporting can make a hash of the research.

The ethical-legal problems are more complex still. There is no clear legal precedent for foreign claimants successfully suing American or European companies when they have committed or participated in human rights violations abroad. The task of constraining pharmaceutical research subcontractors into ethical conformity has been left to the international community to deal with through such unenforceable pacts as the Helsinki Declaration, which offers guidelines for biomedical research involving human subjects. However, the existence of a universally accepted ethical code does not by itself ensure adherence to it. The translation of an ethics code into an ethics regulation is itself as tricky as any other translation of theory into practice in human society, and enforcing regulations is yet another problem.
Adriana Petryna has pointed out that the variability in the way ethical codes end up being applied in the real world (as contrasted with the prescriptive certainty of the written codes) opens up an indeterminate gap into which entire populations may fall. It is a gap that trial research companies and others can exploit.23 And there is, moreover, no mechanism for obliging companies to make drugs affordable to the populations on whom they have been tested.

THE MISPLACED FAITH IN MARKET COMPETITION

One way of describing marketing’s functional responsibility is that of bridging supply and demand – bringing into alignment the consumer’s inclination to buy (broadly taken) with the corporation’s requirement to sell, and overcoming structural market barriers that might inhibit the sale of one’s products. In the case of pharmaceuticals, the distribution chain is especially complex because many of the intermediaries necessary to convey the product to the end user are not commercial actors, like those in the distribution channel for most other consumer products. Commercially-defined value must therefore somehow come to be equated with medical value. If the length of the supply chain is long enough, as it is for pharmaceuticals (and, of course, for global commerce generally), the work and expense of bridging supply and demand comes to overshadow those of other functions in the corporation. Marketing grows, and its habits and outlook become the focus of the corporation itself. In the pharmaceutical industry, we can point to the rise of blockbuster drugs two decades ago as the moment when the traditional research orientation of the large drug companies became completely subordinated to marketing.24

It should therefore not be surprising to learn that the medical merits of blockbuster drugs are mostly unremarkable. Merrill Goozner says, ‘Three out of every four drug applications involve drugs that either replicated the action of medicines already on the market or were new formulations that at best added minor conveniences for patients and doctors’.25 A 2006 US Government Accountability Office Report to Congress stated, ‘Innovation in the pharmaceutical industry has become stagnant’.26 Industry commentators are likewise cognisant of this decline in innovation and are fearful for the long-term profitability of pharmaceutical companies, a subject I will return to below.

The corollary of the scientifically uninspired quest for blockbusters is that marketing budgets have overtaken those of research and development (R&D). Marc-André Gagnon and Joel Lexchin conclude that the US pharmaceutical industry spends nearly twice as much on marketing as on
R&D. My research suggests that this figure must be revised sharply upwards because much of what is classified as R&D spending (including competitive drug trials, publication planning, and post-marketing surveys) is devoted to efforts to improve market share or to maintain hold on the profits associated with impending patent expiries. These can be labelled ‘adjunct-to-marketing’ R&D as opposed to ‘exploratory’ R&D activities. Together with ‘me-too’ drug research (replicating existing drugs with minor variations), adjunct-to-marketing R&D greatly overshadows the conduct of exploratory science in all the major pharmaceutical companies. Indeed, quibbling over the relative investment numbers of marketing vs. R&D may be beside the point, because realistically, the two have already been integrated under the direction of marketing.

While the public seems not to question the notion that any product that succeeds in the market must be innovative, the reality is that the most successful pharmaceutical products today bear the mark not of scientific innovation but of effective marketing. Pfizer’s Lipitor, for instance, was the sixth statin (cholesterol-lowering medication) on the market, but with an estimated $1.3 billion invested by Pfizer in 2002 alone (one hundred times the health budget for Haiti in the same year) to increase the public’s awareness of the dangers of hypercholesteremia, the entire statins market enjoyed double digit growth for half a decade. Sales of Lipitor topped $14.3 billion in 2006. Awareness campaigns create a multiplier effect in health care; increased demand stimulates even more demand. This is one important cause of the spiralling costs of health care in markets such as the US where direct-to-consumer advertising is legal and widely employed.

Competition has become the primary focus for companies, and its yields are often not innovative products focused on consumer needs, but products whose virtue is that they bear differentiating characteristics from those marketed by other companies. A crowded ecology of competitors in the market, all of whom share comparable access to technology, managerial resources and methods for investigating the consumer’s unmet needs, has brought about a competitor-directedness that is an inversion of the professed marketing goal to ‘create, communicate, and deliver value to customers’. The search for ‘breakthrough’ products is replaced by a ‘structural hole’ logic of unmet need-seeking that is as well satisfied by meaningless product/brand differentiation as by real invention.

In this way, competition in the pharmaceutical industry has come to resemble brand-based rivalries in the ‘fast moving consumer goods’ (FMCG) industries such as toiletries, packaged foods and cosmetics. In fact, there is a rallying cry among pharmaceutical industry consultants that to maintain
its profits the industry needs to emulate FMCGs. Thereby, the same inane and useless competition-borne innovation visible in the multi-billion dollar rivalrous extravaganza of ‘the cola wars’ comes to predominate also in the pharmaceutical industry. The ‘statin wars’, which is how the advertising-heavy rivalry among me-too cholesterol-lowering medications has been described, is the pharmaceutical equivalent to the cola wars. What comes to matter more than competition for drug innovation is brand distinctiveness, or ‘brand value’. Brands are the perfect or pure example of marketing value as distinct from other more objective forms of value, in so far as a brand’s importance lies entirely in consumer perceptions, and not in any tangible benefits of the product itself. If what current industry leaders say is an accurate barometer the pharmaceutical future portends more and not less emphasis on brands and marketing-based consumer segmentation.

There is another consequential attribute of industrial competition particular to the pharmaceutical industry because of the way it brings its goods to end-users. As pharmaceutical companies seek to broaden their marketplace to include new and ever larger client populations, the definition of who is to be regarded as a competitor has come to mean more than other firms offering similar products. The competition now includes regulators, payers, providers, patient-consumers and anyone else who poses an obstacle to successful sales. The underlying conception that drives this practice can be found in ‘distribution channel management’, in which the principle is that one key player, known to marketers as the ‘channel captain’, must control the chain from manufacturer to consumer. In this respect, marketing authorises a predatory expansion that, by treating all publics as competitors to be wooed, subdued and incorporated into collaboration, often against their own interests, crowds out the possibility of true service and innovation being delivered. Just as the engagement with industrial competitors can be agonistic and secretive, if sometimes collaborative, the engagement with consumers and intermediaries en route to reaching them has also become covertly agonistic and evasive, even as the language used to describe these relationships is dipped in honeyed words such as ‘trust’, ‘shared decision-making’, ‘value co-creation’, and the like.

Finally, as suggested by the Japanese case cited earlier, competition between firms does not preclude oligopolistic collaboration within the industry. For physicians as for the public, the existence of several competing pharmaceutical companies serves as a specious guarantee that the race to a cure is genuine and unbiased, while also appearing to function as a bulwark against monopolistic power. However, as the perceived risk associated with competition from external stakeholders has grown, pharmaceutical
companies have taken similar approaches to remove obstacles facing them in the marketplace, and the industry has become an arena in which outcomes are no longer the result of salutary rivalry with other firms, bearing the fruit of inevitably unpredictable but always innovative and progressively more affordable results. True competition and its purported benefits are often replaced by a form of intrinsic collaboration that has developed between corporations, a ‘collaborate with your competitors – and win’ cartelisation that renders the commercial world an environment reliable for profit-taking. Sometimes the collective action results from the competitive, homogeneous field-effect of several firms simultaneously backing comparable products through corresponding marketing channels; sometimes these firms actually work in concert to establish the groundwork – the trade structures – for future sales, which will eventually proceed on a more purely competitive basis. As reported in my research on the new SSRI-class antidepressants in Japan: ‘In the words of a manager at one of the pharmaceutical companies in question, “It takes a whole industry to make a market. . . . It’s going to take all of us”’.  

The work of an industry trade group such as PhRMA – whose worldwide mission is ‘to conduct effective advocacy for public policies that encourage discovery of important new medicines for patients by pharmaceutical/biotechnology research companies’ – produces a pattern of collaborative alliances among putative competitors that can be called ‘competitive integration’, and is a force as formidable as vertical integration.

EMERGING MARKETS AND MASS ‘NICHEBUSTERS’

Many industry pundits express concern over the prospect of shrinking profits as blockbusters go off patent and few new drugs promising high profits are in the pipeline. This alarm may be premature. The recent proposal to medicate children for high cholesterol is an example of blockbuster extension with imminent fulfillment. On 7 July 2008 the New York Times reported: ‘The nation’s pediatricians are recommending wider cholesterol screening for children and more aggressive use of cholesterol-lowering drugs starting as early as the age of 8 in hopes of preventing adult heart problems.’ Long before parents are educated about good childhood nutritional practices, before funds are redirected into schools for improved physical education programmes, and certainly before the long-term effects of the use of statins on the young are understood, one might hazard the prediction that many American children will be placed on specially-patented cholesterol-lowering drugs.

Nevertheless, there are two post-blockbuster era developments on the
horizon. One is the rush to work out business plans in emerging markets. The so-called ‘pharmerging countries’ of Brazil, Russia, India and China are the current targets, because of their size and because of the rise of a globally affluent segment in each of them that can become profitable over-consumers of lifestyle and risk management medicines, i.e. mainstream blockbusters. Second, many industry executives are preparing for the age of ‘personalised medicines’, which are therapies targeted at specific individual disease profiles. The good news thus far about personalised medicines comes from their projected tendency to concentrate on diseases such as cancer rather than, say, erectile dysfunction or ‘restless leg syndrome’. The bad news is that unchecked testing for disease markers will usher in a new wave of medicalisation that will contribute to our anxieties and to industry profits in equal proportion. In addition, the biotech industry, on which we are relying for discoveries, has a poor track record for internally-generated discoveries.³⁸

Where there are objective cures, there is less ambiguity for the marketing professional to exploit. In the meantime, the pharmaceutical industry is preparing the way for a ‘mass customisation’ era of personalised medicine along marketing lines. Next Generation Pharmaceutical, a trade magazine, reports:

Analyst Datamonitor, in its recent report From Blockbuster to Nichebuster, concludes that niche therapies will drive future drugs growth and incentivize R&D investment. Dependence on blockbuster-generated revenue is set to fall from 2004-2010 according to the report, as the industry turns to a ‘nichebuster’ strategy, utilizing increased licensing activity, R&D collaborations and small-scale M&A [merger and acquisition] deals to harness innovation and provide access to niche markets with a high unmet need. The shift into niche markets is helping drive a more personalized approach to therapy. Central to the development of the nichebuster model is the raised importance of personalized therapies, which is being driven by increased used of diagnostics. This trend is helping to clarify market segmentation and will boost the size of the total drug industry.³⁹

Placing one’s ear to the ground of industry conferences and trade publications, one can see the anticipated direction of personalised medicine: More integration of marketing and R&D,⁴⁰ which positions segmentation research as a precursor to more marketing-driven assessments of need; more
diagnostic tests and strategic medicalisation; more industry consolidation (for example, to incorporate test-equipment firms); and the consequent expansion of the yawning chasm between those who have access and insurance coverage and those who do not.

REDEFINING VALUE IN HEALTH?
Any discussion aimed at realigning existing arrangements, much less granting oversight responsibility to governments, will be denounced by free market devotees as meddling in the private sector. Nevertheless, the point has been reached where neither the interests of public health nor the private consumer/patient is being served by an industry that has, formally or otherwise, been entrusted to deliver a significant portion of our health treatments.

Distribution and consumption of pharmaceuticals are spread throughout the world. Discovery and dissemination, however, are highly concentrated in the West. Marketing-drivenness is entrenched at the core of the industry. No casual reform will root it out. Public health infrastructures around the world are burdened by the expense of drugs they may be obliged to purchase at patent-protected prices. Many lives have been sacrificed to the specious justification that firms must protect their profits, or they will be unable to continue the research necessary to discover new cures. Partnerships with drug companies aimed at reducing this burden, or even at cultivating domestic drug industries, may contribute to rather than hold in check the global marketing-driven juggernaut.

Journalists, academic researchers, and at last lawmakers are pressing the pharmaceutical industry to reform. In response, there is both retrenchment and apparent compromise. Retrenchment means propaganda to convince the public that the industry’s priority is to heal the world, not make a profit from it. ‘Industry branding’, so called, is one such collective effort (and another instance of industry-wide collaboration rather than competition). Compromise takes two forms. One is image-boosting giveaways of free drugs and similar programmes designed to demonstrate good corporate citizenship. Drug giveaways have recently gained popularity as a means to improve corporate images in Europe and America, where the drug industry’s reputation is said to be lower than that of the oil industry and just above that of tobacco.

In an enlightening paper that discusses Novartis Corporation’s wrangle with the Indian government and citizen groups over the pricing of its cancer drug Glivec, Stefan Ecks takes a strong anti-market stance worth quoting in full:
[G]lobal corporate citizenship is not a brake on free-wheeling capitalism, but rather a strategy of extending and accelerating it by new means. Different from what Bourdieu might have predicted, GCC is not ‘a programme for destroying collective structures which may impede pure market logic’, but a programme aimed at fostering collective structures that enhance profitability, such as pro-corporate patient activism. It does not destroy social bonds to give free rein to capitalism in all spheres of life, but it creates new social bonds to distract from less obvious market mechanisms… I think it would be more ethical by corporations to tone down the claim of being a ‘good citizen’ and to state in simple capitalist terms why they are doing what they are doing. If medicines such as Glivec are not ‘free gifts’ but part of a global pricing strategy, this should not be disguised through a rhetoric of good citizenship.  

The second apparent compromise follows the same masking pattern in a different way. This is deployment of what are called ‘value co-creation’ efforts, which is a putative attempt to include consumers in the design and marketing process for new pharmaceutical products. The up-to-date marketer is encouraged to regard value not as something created inside a company and then sold to outside constituents, i.e., consumers. Rather, value co-creation, according to marketing professors C. K. Prahalad and Venkat Ramaswamy, occurs in the interaction between company and consumer, ‘Co-creation is about joint creation of value by the company and the customer’.  

In light of the pharmaceutical trends described in this essay, we might prefer to view this new managerial buzzword for creating value as a source of ‘productive consumption’, to add a third sense to Marx’s explanation of that expression in his Grundrisse.  

In a recent study of the pharmaceutical industry’s attempts to enhance ‘patient lifetime value’ by improving compliance rates in drug therapies through a value co-creation campaign operating under the name ‘shared decision-making’, I concluded: ‘The marketer’s approach to shared decision-making regards the consumer’s private considerations and behaviors as objects of intervention. The marketer is a shareholder in the consumer, not a healer.’ For as long as value continues to rest in something controlled ultimately by the producer of that value, ‘value co-creation’ remains only a camouflage for marketing-driven aspirations.  

The most entrenched barriers to pharmaceutical company expansion, particularly outside the privatised United States, are the guardians of public health. Public health authorities control the approval and reimbursement
evaluations for new drugs. If a national health bureaucracy or ministry of health somewhere determines that a company’s patented drug is worth five cents instead of five dollars a pill, the effect on profitability is exactly as it seems. This predicament pertains to the publicly-insured portion of private healthcare markets as well, meaning that in the US, Medicare, Medicaid or the Veterans’ Administration must be persuaded to adopt a high value attitude towards one’s drug.

Thus confidence in the market mechanism is possible only if no discussion of power in the relation between public and private authority over health care and its provisioning is entertained. I believe there to be an inherent and unbridgeable gap between the respective goals and principles behind the two – a ‘fundamental conflict between what is just and what is profitable’. But a de facto overlap between the two spheres has emerged in institutional, resource and managerial dimensions, an overlap that has been embraced in the belief that combined, the two systems, public and private, can avail themselves of the best practices of the other for an enhanced outcome.

As a result the managerial techniques and outlooks of private industry have been widely adopted by public sector providers. Under the sway of managerial models, private non-profit providers, non-governmental organisations, foundations, governments and all manner of other social sector institutions have come to conceive of themselves as strategic enterprises operating in a competitive environment. In short, public sector administrators have been convinced to think like a business. They have become goal-rather than process-oriented and they have come to measure their success by market-oriented criteria of return on investment (‘ROI’) and customer satisfaction. The exchange of personnel and resources across public/private institutions further blurs the distinction between the two. The question thus becomes not whether we are speaking of private vs. public health care, but whether any given health-providing organisation enjoys the independence that will allow it to be devoted to the public good without substantial interference from ROI criteria, and whether it can deploy non-business-oriented governance and service models in its work.

NOTES


4 We can learn much from a commercial and geographical breakdown of these numbers, such as that generics comprise about 7 per cent of the market (but of growing importance in terms of sales volume) or that the US market accounts for about half of the world’s pharmaceutical spending. There is insufficient space to explore these facts here.


10 Ibid., p. 219.


13 This estimate is based upon reports published by IMS Health and available at http://www.imshealth.com.


18 Ibid., p. 1102.

19 Ibid., p. 1093.

20 Kalman Applbaum, ‘Educating for global mental health: American pharmaceutical companies and the adoption of SSRIs in Japan,’ in A. Petryna,


37 Anticipating the failure to renew patents on statins by ‘ever-greening’ strategies, some of the big players appear to be preparing two alternate strategies. One is to lobby for converting the statins to over-the-counter status. This would enable marketers of drugs such as Lipitor and Zocor to switch to consumer brand strategies and thereby make a profitable end-run around generic competition. The second incipient plan is to lobby to have the statins delivered through public drinking water, in the same way that fluoride is.


As quoted from a 2002 pharmaceutical executive roundtable: ‘More and more, marketing is backward integrating into the clinical trial process because the customer is becoming part of it. The other trend is the forward integration of researchers into the new technologies on the marketing side.’ Wayne Koberstein, Cavan Redmond and Larry Star, ‘When worlds collide: the unleashed power of marketing/R&D collaboration’, *Pharmaceutical Executive*, 1 September 2002, available from http://pharmexec.findpharma.com.


Kalman Applbaum, ‘“Consumers are patients!”: Shared decision-making and treatment non-compliance as business opportunity’, *Transcultural Psychiatry*, 46(1), 2009, p. 124.