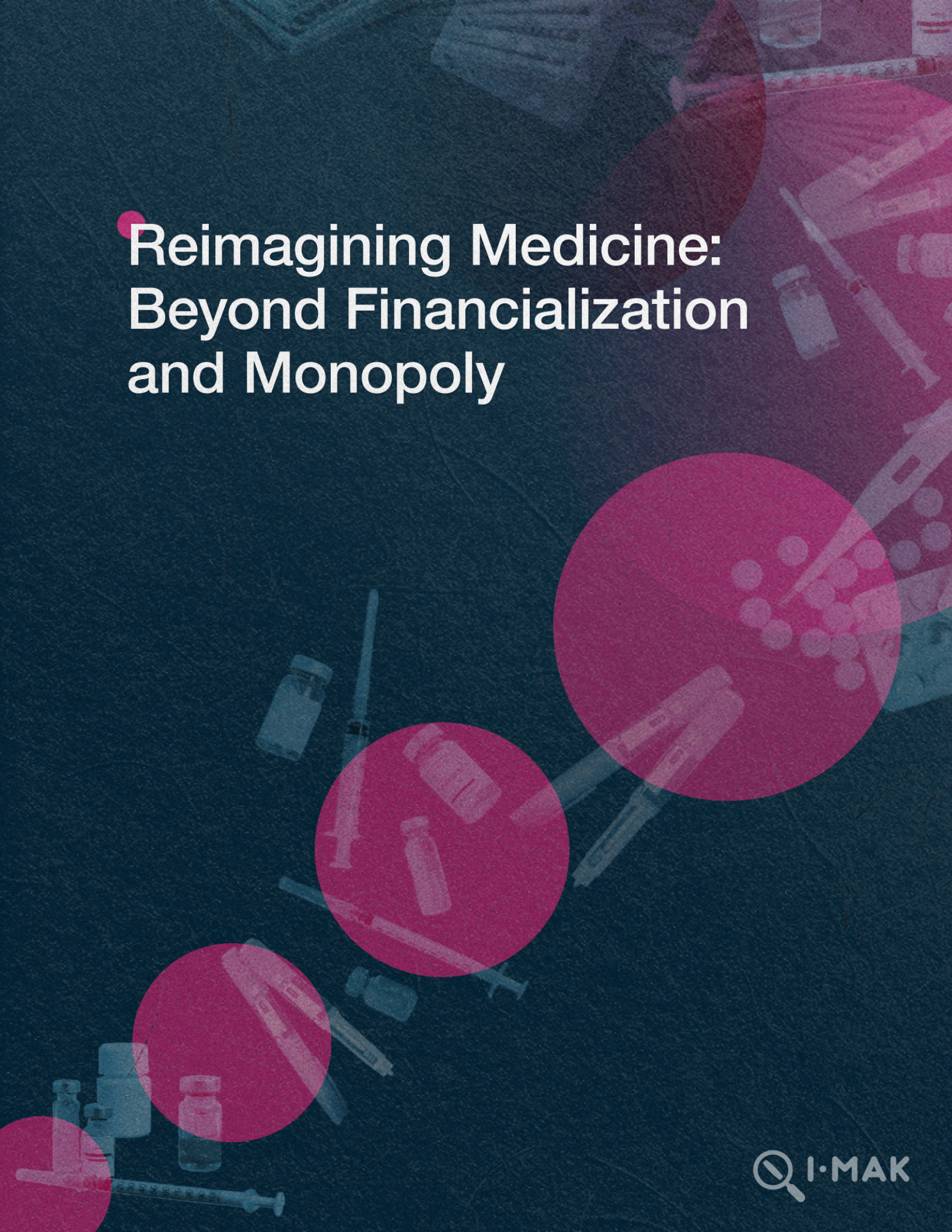
Reimagining Medicine: Beyond Financialization and Monopoly



I·MAK

Reimagining Medicine: Beyond Financialization and Monopoly

From HIV to hepatitis C to COVID-19, financialization, patents, and structural racism have defined who gets access to life-saving medicines. GLP-1 drugs expose this pattern—and point to a new path toward public, equitable models of medicine.

I. Introduction

The fall of the Bretton Woods monetary system in the early 1970s is widely recognized as the accelerant for prompting a surge in financial liberalization and deregulation driven by the ideology of neoliberalism and globalization.[1] Since then, and starting in the United States, there has been a shift to what social scientists have termed financial neoliberalism, finance capitalism or the concept of financialization.[2]

It was also around this time that one of the central figures of the neoliberal movement, economist Milton Friedman, would give birth to the shareholder value maximization revolution which dominates today's corporate management practices. Known as 'A Friedman Doctrine', it asserts that the sole responsibility of business people and corporations is to conduct business in accordance with the desires of the shareholder and that the role of the CEOs and corporations is to make as much money as possible. In Friedman's view, the corporate executive should have neither social responsibility nor a social conscience.[3]

Neoliberalism's financialization of capitalism, including shareholder value maximization, has changed the way pharmaceutical companies conduct business. Today, the largest shareholders in many of the leading U.S. pharmaceutical companies worldwide are institutional investors such as the Vanguard Group, Blackrock, State Street, and Capital Research.[4] These dominant shareholders shape the business decisions of pharmaceutical industry executives to achieve goals set by the financial sector. A recent report following an investigation by the U.S House Committee on Oversight and Reform into pharmaceutical pricing and business practices of the world's largest pharmaceutical companies shows that these companies spent over $577 billion on stock buybacks and dividends between 2016 and 2020. This amounted to $56 billion more than they spent on research and development (R&D).[5]

Yet, despite pharmaceutical companies increasingly spending more on share buybacks and dividends, or de-risking investment by buying up smaller companies with promising drug candidates instead of heavily investing in their own R&D, their reliance on intangible assets have increased vastly over the last few decades. This can be attributed to the ever expanding property rights economics of intellectual property under neoliberalism,

1 Transnational Institute. *Financialisation: A Primer.* September 2018.

2 Palley. T, Fincancialization: *The Economics of Finance Capital Domination*. Palgrave Macmillan; 2013

3 Friedman M. A Friedman doctrine: the social responsibility of business is to increase its profits. *The New York Times*. September 13, 1970.

4 Busfield J. Documenting the financialisation of the pharmaceutical industry. *Soc Sci Med*. 2020;258:113015. doi:10.1016/j.socscimed.2020.113015

5 Committee on Oversight and Reform. *Drug Pricing Investigation, Industry Spending on Buybacks, Dividends and Executive Compensation*. Staff Report; July 2021

including the lowering of standards that determine what is deserving of a patent. These are systems that the pharmaceutical industry has helped to shape and globalize, and continues to. Through intangible intellectual property assets, such as patents, pharmaceutical companies extract monopoly rents and higher prices for longer periods without necessarily increasing productivity or making riskier long term investments. This fits perfectly with the financialized business model as it allows for life cycle management strategies to maximize revenue and profits that ultimately enrich the CEOs and shareholders in the short term.

As a consequence of this financialized business model that seeks to maximize revenue and profits, structural racism is perpetuated. The barriers to and rationing of treatment caused by high prescription drug prices are an integral part of how systemic racism plays out in health care. While 25 percent of white Americans report not taking prescription medications as prescribed due to cost, the number rises to 30 percent among Black Americans and 42 percent among Hispanics.[6] With Black Americans almost twice as likely to be uninsured, the situation is further compounded as they are not able to avail themselves of so-called patient assistance programs that pharmaceutical companies tout. This is because 97 percent of these programs exclude people who do not have insurance, the goal being to sell drugs at high prices and leveraging the higher total insurance payments.[7]

In order to resolve structural racism in health and access to medicines, it is necessary to address the economic system of neoliberalism that is at its root. It can be argued that the neoliberal form of capitalism that has financialization at its heart is a continuation of racial capitalism[8], or at least they are symbiotic with the structural inequalities that neoliberalism exploits. In the words of Professor Jodi Melamed, “capital can only be capital when it is accumulating, and it can only accumulate by producing and moving through relations of severe inequality among human groups – it does this by displacing the uneven life chances that are inescapably part of capitalist social relations onto fictions of differing human capacities, historically race.”[9]

Where neoliberalism differs is in being more concealed and sophisticated, presenting itself as race-neutral, meritocratic, and “colorblind” by hiding behind concepts such as the “free-market competition” and “market-value.” This framing allows the setting of the rules of the system that enable high prices of medicines to inevitably focus on white wealthy payers and create “sacrifice zones” which abandon communities of color that are unlikely to be profitable or commodified in the near future.[10] Simultaneously, with the privatization of public life that neoliberalism has engendered, such as in housing, education and healthcare, it makes it more difficult to advance publicly organized remedies to address the legacies of racial inequality.[11] Only by tackling these issues can the pharmaceutical system be reimagined to achieve equity and the freedom for everyone to access the medicines they need.

II. The long shadow of financialization: from HIV to Hepatitis C to COVID-19

The inequities now emerging around GLP-1 drugs are not unprecedented. Over the past three decades, earlier generations of “breakthrough” medicines—from HIV antiretrovirals to hepatitis C (HCV) cures to COVID-19 vaccines—have followed a similar trajectory: the rapid development of products based on public research

---

6 Fadeyi-Jones T, Hurley C, Johnson-Cusack G, LaRoche C, Mitchell D, Solomon-Mitchell N. *High Prescription Drug Prices Perpetuate Systemic Racism: We Can Change It*. Patients for Affordable Drugs Now; December 14, 2020.

Franklin & Marshall College, Center for Opinion Research and the Initiative for Medicines, Access & Knowledge (I-MAK). *Understanding Americans’ Top Concerns on Drug Pricing: Corporate Greed and Patent Reform*. Published October 2025. Accessed October 31, 2025. https://www.i-mak.org/survey

7 Fadeyi-Jones T, Hurley C, Johnson-Cusack G, LaRoche C, Mitchell D, Solomon-Mitchell N. *High Prescription Drug Prices Perpetuate Systemic Racism: We Can Change It*. Patients for Affordable Drugs Now; December 14, 2020.

8 Kundnani A. The racial constitution of neoliberalism. *Race & Class*. 2021;62(1):3-28.

9 Melamed J. Racial capitalism. *Crit Ethn Stud*. 2015;1(1):76-85.

10 Gonzalez G, Mutua A. Mapping racial capitalism: implications for law. *J Law Polit Econ*. 2022;2(2):301-324.

11 Kundnani A. The racial constitution of neoliberalism. *Race & Class*. 2021;62(1):3-28.

and funding, monopoly pricing protected by various forms of intellectual property, including patents, and restricted coverage that left communities of color least able to access or afford treatment. These examples demonstrate how the financialization of pharmaceuticals—treating patents and exclusivities as financial assets for shareholder return—has consistently produced structural racism in health outcomes, with Black, Hispanic, and Indigenous communities excluded from timely access to life-saving therapies or forced to endure greater hardship to obtain them.

HIV/AIDS

When highly active antiretroviral therapy (ART) became available in the mid-1990s, it transformed HIV from a near-certain death sentence into a chronic condition. Yet the launch prices of these regimens—often exceeding $10,000 annually at the time—were prohibitive.[12] Medicaid uptake was slow and patchy, and private insurance coverage varied widely. Uninsured and underinsured patients, disproportionately Black and Hispanic, were least able to access treatment.[13] Federal programs like the Ryan White HIV/AIDS Program were created to address these gaps, but coverage remained uneven, and access delays persisted.

Research has consistently shown racial disparities in HIV care. Black and Hispanic patients have faced later diagnoses, slower initiation of ART, and worse viral suppression rates compared to white patients.[14] Today, inequities remain evident in preventive treatment: pre-exposure prophylaxis (PrEP) is far more widely used among white gay and bisexual men than among Black or Hispanic men, despite the latter groups bearing the highest HIV incidence in the United States.[15]

At the root of these inequities is the financialization of HIV treatment, where patents, exclusivities, and pricing power became instruments of wealth extraction. Patents guaranteed monopoly pricing for brand-name regimens,[16] and Gilead Sciences—long the dominant force in the HIV market, with roughly 85% of its revenue derived from HIV medicines–exemplified how these protections translate into financial strategy. Rather than reinvesting its earnings into equitable access or next-generation breakthroughs, Gilead spent three times more on shareholder dividends and stock buybacks than on research and development, deepening the divide between public health need and private gain.[17] This model transformed racialized illness into a financial asset class, rewarding firms for monetizing human vulnerability while structural racism and underinvestment in public health determined who would be left waiting for care.

The HIV market also offers an early example of how patents became financial instruments in their own right. As early antiretrovirals neared the end of exclusivity, companies filed new patents on fixed-dose combination (FDC) drugs bundling existing compounds into single pills to extend monopoly control.[18] These follow-on patents on combinations such as Atripla and Genvoya effectively reset exclusivity periods, delaying generic competition and keeping prices high long after the core drugs were discovered.[19]

---

12 Farmer P. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* University of California Press; 2004.

13 Cunningham WE, Markson LE, Andersen RM, et al. Prevalence and predictors of highly active antiretroviral therapy use in patients with HIV infection in the United States. *J Acquir Immune Defic Syndr*. 1999;18(3):118-126.

14 Palella FJ, Delaney KM, Moorman AC, et al. Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. *N Engl J Med*. 1998;338(13):853–860.

15 Huang YA, Zhu W, Smith DK, Harris N, Hoover KW. HIV preexposure prophylaxis, by race and ethnicity — United States, 2014–2016. *MMWR Morb Mortal Wkly Rep*. 2018;67:1147–1150.

16 UNAIDS. *Access to HIV Treatment: A Case of Racial and Economic Inequity.* UNAIDS; 2000

17 Roy V. *Capitalizing a Cure: How Finance Controls the Price and Value of Medicines*. University of California Press; 2023

18 't Hoen EFM. *Private Patents and Public Health: Changing Intellectual Property Rules for Access to Medicines*. Health Action International; 2016.

19 Kapczynski A. The Cost of Price: Reimagining Access and Innovation in the Global HIV/AIDS Pandemic. *Yale LJ*. 2019;128(6):2322–2387.

Through this evergreening strategy, drug makers turned patent portfolios into long-term revenue assets, using legal and financial engineering to sustain monopoly pricing and restrict access, particularly for low-income and minority patients in the U.S. and globally.[20]

HEPATITIS C

The introduction of direct-acting antivirals (DAAs) like Sovaldi in 2014 was heralded as a medical revolution, offering cure rates above 90%. But the $84,000 price tag for a standard 12-week course put the treatment far out of reach for many.[21] Medicaid programs and private insurers, overwhelmed by projected costs, imposed strict rationing policies, limiting coverage only to patients with advanced liver disease—a practice known as "warehousing."[22]

These restrictions fell hardest on communities of color. Black and Hispanic Medicaid enrollees were disproportionately denied early treatment despite higher rates of HCV related complications.[23] Incarcerated populations—predominantly Black and Hispanic that were disproportionately affected by HCV—were largely excluded from treatment entirely.[24] Moreover, Southern states with large Black populations enacted the most restrictive Medicaid criteria, compounding racial inequities in access.[25]

Financialization and intellectual property protections were at the heart of this crisis. Gilead Sciences maintained a tight patent estate around Sovaldi and subsequent DAAs,[26] preserving monopoly pricing and reaping tens of billions in profits. Public health priorities were subordinated to shareholder returns: between 2014 and 2016, Gilead redistributed $32.6 billion to shareholders—roughly three times its $11 billion R&D budget during the same period, demonstrating how profits from publicly funded science were financialized rather than reinvested in equitable access.[27] Racially unequal access to curative therapy became the predictable outcome.

COVID-19

The Covid-19 pandemic offers a more recent illustration of how scientific advances intersect with inequity. Black and Hispanic communities suffered disproportionately high rates of infection, hospitalization, and death.[28] Yet during the initial vaccine rollout in late 2020 and early 2021, access lagged in these same communities. Barriers included digital registration systems inaccessible to those without reliable internet, vaccination sites concentrated in wealthier and whiter neighborhoods, and transportation challenges.[29] These inequities layered onto existing mistrust rooted in systemic racism and past medical exploitation.[30]

---

20 Médecins Sans Frontières (MSF). *AIDS: Patent Barriers on Fixed-Dose Combinations*. MSF Access Campaign; 2021.

21 Lo Re V, Gowda C, Urick PN, et al. Disparities in absolute denial of modern hepatitis C therapy by type of insurance. *Ann Intern Med*. 2016;165(11):704–706

22 Barua S, Greenwald R, Grebely J, Dore GJ, Swan T, Taylor LE. Restrictions for Medicaid reimbursement of sofosbuvir for hepatitis C virus infection in the United States. *Ann Intern Med*. 2015;163(3):215–223.

23 Yehia BR, Schranz AJ, Umscheid CA, Lo Re V. The treatment cascade for chronic hepatitis C virus infection in the United States: a systematic review and meta-analysis. *PLoS One*. 2014;9(7):e101554.

24 Beckman AL, Bilinski A, Boyko R, Camp GM, Wall AT, Wang EA. New hepatitis C drugs are very costly and unavailable to many state prisoners. *Health Aff*. 2016;35(10):1893–1901.

25 Canfield SM, Regenstein M, Ryan J. Racial and ethnic disparities in access to hepatitis C treatment under state Medicaid programs. *Health Aff*. 2021;40(5):775–782

26 Public Citizen. *Gilead's Capture of the Hepatitis C Market*. Public Citizen; 2015.

27 Roy V. *Capitalizing a Cure: How Finance Controls the Price and Value of Medicines*. University of California Press; 2023

28 CDC. *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*. Centers for Disease Control and Prevention; 2021.

29 Nawas GT, Zeidan RS, Edwards CA, El-Desoky RH. Barriers to COVID-19 Vaccines and Strategies to Improve Acceptability and Uptake. *J Pharm Pract*. 2023 Aug;36(4):900-904. doi: 10.1177/08971900221081621. Epub 2022 Apr 23.

30 Bogart LM, Ojikutu BO, Tyagi K, et al. COVID-19 related medical mistrust, health impacts, and potential vaccine hesitancy among Black Americans. *J Natl Med Assoc*. 2021;113(6):600–607.

Covid vaccines followed a similar pattern to that of antivirals for HIV and HCV. Early supplies and distribution were concentrated in well-resourced systems and communities, often less accessible to Black and Brown populations.[31] Geographic and socioeconomic inequities mirrored the earlier access gaps seen with HIV and hepatitis C.

Patents and exclusive rights again played a central role. Companies like Pfizer and Moderna leveraged intellectual property protections over mRNA vaccine technology to restrict broader public options for production and instead maintain control over supply.[32] This privatized control was especially striking given that the Moderna vaccine was developed in partnership with the National Institutes of Health and financed almost entirely by taxpayers through Operation Warp Speed, which provided nearly $10 billion in federal support.[33] Public funding de-risked nearly every stage of the vaccine's development, yet the rewards flowed overwhelmingly to private shareholders.[34]

As the vaccine rolled out, Moderna's executives and investors reaped extraordinary profits. CEO Stéphane Bancel became a billionaire, with company equity worth more than $5.3 billion, after receiving billions in federal support for vaccine research, development, and distribution.[35] Several other top company officials also became billionaires, including co-founder Robert Langer and Chairman Noubar Afeyan.[36] This wealth accumulation was immediately facilitated by the financialization of executive compensation packages through extensive stock sales. Bancel sold a staggering $408 million worth of company stock between January 2020 and March 2022, averaging $3.6 million every week.[37] These gains illustrate how financialized incentives converted public investment and global crisis into private wealth on an unprecedented scale.

Domestically, access remained rationed through the same fragmented healthcare infrastructure that continues to disadvantage communities of color.[38] Globally, the intellectual property regime entrenched these inequities, ensuring that wealthy nations monopolized vaccine supply while low- and middle-income countries were left waiting.[39] The Covid-19 experience thus completed the pattern established with HIV and HCV: public science and collective risk produced life-saving medicines, while financialization and monopoly control determined who would benefit from them first.

Across HIV, HCV, and Covid-19, financialization has repeatedly translated into racially inequitable access: monopoly pricing, restrictive coverage, and provider bias combined to delay or deny life-saving care for communities of color. These precedents show that the inequities now emerging around GLP-1 drugs are not aberrations, but the continuation of a systemic pattern rooted in neoliberalism's modern form of racial capitalism.

---

31 Ndugga N, Hill L, Artiga S. *Latest Data on COVID-19 Vaccine Access Barriers*. Kaiser Family Foundation; 2021.

32 Herder M. Intellectual Property and Access to COVID-19 Vaccines: Who Owns mRNA Technology? *BMJ*. 2022;376:o263.

33 U.S. Department of Health and Human Services. *Operation Warp Speed: Accelerating COVID-19 Countermeasures*. HHS; 2021.

34 United States Senate, Health, Education, Labor, and Pensions (HELP) Committee, Majority Staff. *The Pharma Pandemic Profiteers: 50 Pharmaceutical Executives in 10 Companies Made $1.9 Billion in 2021 and Could Receive $2.8 Billion in Golden Parachutes*. February 15, 2023.

35 Forbes Staff. Moderna CEO Stéphane Bancel becomes billionaire as stock soars on COVID-19 vaccine progress. *Forbes*. May 18, 2020.

36 Gandel S. Moderna CEO and other execs made millions on vaccine announcements. *CBS News*. Updated May 22, 2020.

37 Kimball S. Moderna CEO Stephane Bancel has sold more than $400 million of company stock during the pandemic. *CNBC*. March 17, 2022.

38 CDC. *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*. Centers for Disease Control and Prevention; 2022..

39 Bollyky TJ, Bown CP. The Tragedy of Vaccine Nationalism. *Foreign Affairs*. 2020;99(5):96–108.

III. GLP-1s: the new frontier of racialized access disparities

The emergence of GLP-1 receptor agonists such as semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro, Zepbound) represents the latest chapter in the story of financialized medicine. These drugs promise benefits for managing type 2 diabetes and obesity, two conditions that disproportionately affect Black and Hispanic communities in the United States. Yet the patterns already visible around GLP-1 access echo the inequities seen with HIV, HCV, and Covid-19: monopoly pricing underpinned by expansive patent estates, insurance exclusions and rationing by public payers, provider bias in prescribing, and geographic concentration in wealthier white communities. The result is that the very groups most burdened by diabetes and obesity are the least likely to benefit from these new therapies. This section examines how the GLP-1 market is reproducing well-worn inequities, underscoring how structural racism is not incidental but a predictable *outcome* of a financialized pharmaceutical system.

PRICING, COVERAGE, AND STRUCTURAL EXCLUSION

GLP-1 drugs carry high monthly costs relative to many other common therapies. The most common GLP-1 therapies were initially priced at around $1,000 per month, though list and net prices have declined significantly as competition has intensified. Even with these reductions, however, costs remain prohibitive for many without robust insurance coverage. Medicare, until recently, was barred from covering obesity treatments, and as of 2024 only 13 state Medicaid programs offered any coverage for GLP-1s for obesity, all with restrictive criteria.[40] Black and Hispanic adults, who are more likely to be uninsured or Medicaid-dependent, are therefore disproportionately excluded.[41] Patent protections and exclusivity periods held by Novo Nordisk and Eli Lilly continue to sustain elevated prices in the U.S. relative to global benchmarks and delay generic competition.[42]

PRESCRIBING PATTERNS AND PROVIDER BIAS

Even when coverage exists, prescribing patterns reveal stark disparities. A large national electronic health record analysis (2022–2023) showed that adjusted odds of receiving semaglutide or tirzepatide were significantly lower for people of color compared with white patients.[43] In the Veterans Health Administration system, where formulary access is theoretically uniform across races, Black veterans had 26–36% lower odds of receiving GLP-1 prescriptions than white veterans.[44] Research and patient testimony suggest that provider bias and weight stigma contribute to these disparities, with Black patients more often advised to rely on diet and exercise rather than offered medication.[45]

GEOGRAPHY AND SOCIOECONOMIC CONCENTRATION

Access to GLP-1s also reflects geographic and socioeconomic divides. Prescription rates cluster in affluent, predominantly white neighborhoods, while socially vulnerable communities—including those with large Black and Indigenous populations—see far lower uptake.[46] National analyses confirm that off-label GLP-1 prescribing for weight loss is highest in high-income counties and lowest in areas marked by poverty and social vulnerability.[47] This pattern mirrors historical examples, where communities most in need are least likely to benefit early from breakthrough treatments.

---

40 Kaiser Family Foundation. *Medicaid Coverage of and Spending on GLP-1s*. KFF; 2024.

41 Cha A. Weight-loss drugs are booming, but not in low-income neighborhoods. *Washington Post*. 2024.

42 Initiative for Medicines, Access & Knowledge (I-MAK). *The Heavy Price of GLP-1 Drugs: How Financialization Drives Pharmaceutical Patent Abuse and Health Inequities for GLP-1 Therapies*. April 2025.

43 Eberly LA, Yang L, Eneanya ND, et al. Association of race/ethnicity and socioeconomic status with GLP-1 receptor agonist use among patients with type 2 diabetes, 2015–2023. *JAMA Netw Open*. 2023;6(11):e234567.

44 Lamprea-Montealegre JA, Davila CD, Seraj SM, et al. Racial and ethnic disparities in GLP-1 receptor agonist use among veterans with type 2 diabetes. *JAMA*. 2022;327(2):189–191.

45 Durham A. Black Americans feel left out of the new obesity drugs. *Stat News*. 2024..

46 Cha A. Weight-loss drugs are booming, but not in low-income neighborhoods. *Washington Post*. 2024.

47 Spinelli MA, Tran N, Thomas E, et al. Off-label GLP-1 prescribing patterns across US counties. *Am J Med Open*. 2025;1(2):100045.

Black and Hispanic communities experience disproportionately higher rates of obesity, type 2 diabetes, and related complications, yet they are the least likely to access GLP-1 therapy. Without intervention, these inequities will worsen existing racial disparities in chronic disease outcomes, reproducing the same dynamics seen in HIV, HCV, and Covid-19.

IV. Reimagining a pharmaceutical sector beyond financialization

The preceding sections have shown how financialization, as a modern form of racial capitalism, produces predictable patterns of structural racism in drug access. The trajectory of HIV, HCV, Covid-19, and now GLP-1s demonstrates that left unchecked, the logic of maximizing intellectual property rights, such as patents, and shareholder value will continue to ration life-saving therapies along racial and socioeconomic lines. The challenge, then, is to envision alternatives that redesign the pharmaceutical sector away from extractive financial logics and toward public health equity. This section outlines four key pillars of such a reimagining.

MEDICINES AS PUBLIC GOODS

At the most fundamental level, medicines must be recognized as public goods rather than private financial assets. The current model treats patents and regulatory exclusivities as tradable commodities for generating shareholder returns, while the public—who fund much of the upstream science—pays multiple times: first through tax-funded research, again through high prices at the point of care, and yet again through the social costs of untreated illness. Reframing medicines as public goods would invert this logic. If the status quo is a pharmaceutical system that treats medicines primarily as economic assets—to be patented, priced, and sold for maximal return—what would it look like to instead treat medicines as public goods?

Treating medicines as public goods would require recentering access, affordability, and equity as the guiding principles of drug development. It would mean structuring the system so that medicines are developed and distributed in the same way we approach clean water or public education: as essential services to which everyone is entitled. In this model, the value of a drug would be measured not by its sales potential but by its ability to reduce suffering, extend lives, and strengthen communities. This could mean prioritizing therapeutic classes with high public health value but low commercial interest (antibiotics, insulin, neglected diseases), and ensuring that racial and low-income communities—historically excluded—are placed at the center of access strategies.

BUILDING A PUBLIC OPTION FOR PHARMACEUTICALS

An intriguing and increasingly discussed reform is the idea of creating a public option in the pharmaceutical sector. Unlike the private, profit-maximizing model, a public option would be explicitly designed to meet public health needs rather than shareholder returns. It would expand the role of publicly owned research and manufacturing enterprises, integrating the full cycle of development, production, and distribution of essential medicines.

To realize that vision, a public option must go beyond manufacturing generics to encompass the full spectrum of pharmaceutical R&D. Public and nonprofit research initiatives have already demonstrated how open, publicly funded science can deliver both affordability and breakthroughs by redesigning manufacturing processes for lower cost and greater accessibility.[48] The greatest cost savings in medicine production often occur upstream, through open-access chemistry, process engineering, and early-stage drug discovery optimized from inception for equitable access. A U.S. or state-level R&D institution modeled on this approach could embed the principle of “access by design”: developing new drugs, formulations, and production technologies that remain unpatented or open-licensed for public benefit. In this model, equitable pricing and distribution are built into the research architecture itself, not treated as afterthoughts.

48 Medicines for All Institute. *Expanding Access to Essential Medicines Through Process Innovation*. Medicines for All Institute; 2024.

Recognizing that market-based incentives have repeatedly failed to ensure affordable access—particularly for marginalized communities—some states are experimenting with public manufacturing as a structural alternative. California's CalRx initiative, launched in 2020 under Governor Gavin Newsom, has partnered with the nonprofit Civica Rx to produce low-cost insulin and other essential generics, making California the first U.S. state to establish a publicly backed manufacturer aimed explicitly at affordability and supply security.[49] Building on that model, New York's newly proposed Affordable Drug Manufacturing Act (S.1618, 2025) would authorize the state health department to contract directly with public or nonprofit entities to produce and distribute generic drugs, including insulin, at transparent, at-cost prices.[50] These initiatives reflect a broader reimagining of pharmaceuticals as public goods rather than speculative assets—a vision echoed in *Formulating Public Pharma*, which argues that democratized, publicly oriented production can counter the extractive dynamics of racial capitalism embedded in neoliberalism and today's patent-driven drug economy.[51] Together, they signal an emerging movement toward "public pharma," where states intervene not only to lower prices but to realign the moral and structural foundations of medicine access around equity rather than profit.

Proposals envision a multi-layered ecosystem:

- **Federal R&D institute** (e.g., within NIH) to conduct full-cycle drug development and retain the knowledge solely for the benefit of the public domain**.**
- **State and municipal manufacturers** to produce low-cost generics and off-patent drugs where private incentives are absent.
- **Public distributors** leveraging infrastructure such as the USPS or Veterans Health Administration to ensure nationwide supply chains at transparent prices.

International models show that such a system is achievable. Brazil's Farmanguinhos, part of the Oswaldo Cruz Foundation (Fiocruz), integrates public-sector R&D and manufacturing, producing antiretrovirals, vaccines, and other essential drugs for the national health system.[52] Thailand's Government Pharmaceutical Organization (GPO) performs a similar role, developing and producing vaccines and therapeutics under public ownership, ensuring affordable domestic supply and technology independence.[53] These examples show that a vertically integrated public pharmaceutical infrastructure can coexist with innovation and quality assurance—while aligning drug development with public health equity rather than shareholder value.

By eliminating the profit motive as the primary driver, a public option would not only reduce prices but also redirect R&D toward unmet health needs. Critically, such a model could be designed to counteract structural racism by ensuring equitable distribution of medicines in historically underserved communities. Initiatives like CalRx and New York's Affordable Drug Manufacturing Act represent early steps toward this vision, while international and public R&D efforts illustrate the feasibility of scaling public drug development and production into a truly global model of medicines as public goods.

---

49 Brown D, Latkowski T. *Public Pharmaceuticals: State Policy Toolkit*. Democracy Collaborative; 2022.

50 State of New York Senate. *S.1618—New York Affordable Drug Manufacturing Act, 2025–2026 Regular Session*. 2025.

51 Kumar S. Formulating Public Pharma. *Cornell Law Rev.* 2025;110(2):317–369

52 Fiocruz. *Farmanguinhos: Pharmaceutical Production and Innovation for Public Health*. Oswaldo Cruz Foundation; 2023.

53 World Health Organization. *Case Study: The Government Pharmaceutical Organization (GPO), Thailand.* WHO; 2022.

UNDOING REGULATORY CAPTURE

A major obstacle to equitable drug access has been regulatory capture—the process by which agencies tasked with protecting public health instead reinforce the interests of industry. Financialization has heightened this problem by embedding shareholder imperatives at every stage of the drug pipeline, from research priorities to pricing to patent review. Regulatory structures originally designed to balance public safety with new drug development have been recalibrated over decades to favor corporate valuation.

The FDA and Political Capture: Pharmaceutical influence over the FDA operates through lobbying, campaign finance, and revolving-door employment that blur the line between regulator and regulated.[54] The Roosevelt Institute has documented how political appointments and industry lobbying have aligned FDA priorities with pharmaceutical profitability rather than public health.[55] The agency's growing reliance on industry user-fee funding, combined with expanded expedited approval pathways, has deepened its dependence on the companies it regulates—even as post-market safety concerns have increased. In Congress, over two-thirds of lawmakers have received campaign contributions from the drug industry, shaping legislative oversight and regulatory budgets.[56] Meanwhile, research shows that FDA reviewers—especially in oncology and hematology—frequently leave for jobs at the same companies whose drugs they evaluated, and advisory committee members often receive post-approval compensation from manufacturers.[57] These overlapping financial and professional incentives create a structural dependency that normalizes industry influence, leaving the FDA increasingly constrained to operate within the profit-driven logic of the sector it is meant to oversee.[58]

The USPTO and Patent System Capture: Regulatory capture of the United States Patent and Trademark Office (USPTO) reinforces monopoly power through similar revolving-door and lobbying dynamics. Patent examiners who later join private-sector firms have been found to grant 12–18% more patents to those same future employers, a measurable revolving-door bias that lowers patent quality and inflates corporate exclusivity.[59] Former USPTO directors and senior officials routinely move into lucrative roles representing large patent holders, while Trump-era appointees leveraged their government positions to craft policies favoring major pharmaceutical and tech firms.[60] [61] These insider networks have effectively "privatized" patent governance, allowing well-resourced companies to shape examination standards and delay generic competition—thereby entrenching the very market inequities that drive high drug prices and restricted access.[62]

Undoing regulatory capture requires not only stricter conflict-of-interest safeguards and transparency mandates, but also rebalancing power between public agencies and corporate actors. Public production capacity can serve as a counterweight, ensuring that regulations advance patient access rather than corporate valuation. A democratically accountable pharmaceutical option would help restore regulatory legitimacy and prevent the kind of systemic distortions that now embed racial inequities into drug access.

---

54 Whitacre R. Financial fallout in the US biopharmaceutical industry: maximizing shareholder value, regulatory capture, and the consequences for patients. *Soc Sci Med*. 2024;344:116598.

55 Roosevelt Institute. *The Cost of Capture: How the Pharmaceutical Industry Has Corrupted Policymakers and Harmed Patients*. Roosevelt Institute; 2019.

56 Deseret News Staff. Should we be concerned with politicians receiving pharma money? *Deseret News*. January 31, 2025.

57 Bien J, Prasad V. Future Jobs of FDA's Hematology-Oncology Reviewers. *BMJ*. 2016;355:i5358.

58 Jorgensen PD. Pharmaceutical Industry Political Power and Public Policy. *J Law Med Ethics*. 2013;41(3):561–569.

59 Tabakovic H, Wollmann TG. From revolving doors to regulatory capture? Evidence from patent examiners. *Cato Institute Research Brief* No. 131; 2018.

60 Iwayemi T. The revolving door threatens the integrity of the U.S. Patent and Trademark Office. *The American Prospect*. September 6, 2023.

61 Revolving Door Project. *Trump Appointees Are Hijacking the Patent System*. Revolving Door Project; 2021.

62 Revolving Door Project. *Senators' Letter on the Patent System Must Not Prevail*. Revolving Door Project; 2022.

REFORMING THE PATENT SYSTEM

Finally, a sustainable transformation requires reshaping the patent and exclusivity system itself. The current model incentivizes "evergreening" and repurposing strategies that prolong monopolies, maintain inflated prices, and divert R&D away from pressing public health needs. Patent gaming, such as pay-for-delay and citizen petitions, further delays generic competition and entrenches inequities.

I-MAK has proposed a high-level framework called **R-A-I-S-E** for reforming the patent system. A better system would do five things:

- **Raise the bar** on what it takes to get a patent. By requiring true novelty and genuine inventive step, the strategy of erecting patent thickets to prolong monopolies collapses.
- **Amend incentives** so the patent office is not funded by the number of patents it issues but by the merit of those patents. This would align the office's financial interests with quality rather than quantity.
- **Increase public participation** by making the patent office more transparent and accessible. Broader participation helps ensure that diverse voices, including patients and public health advocates, can weigh in on the impacts of patent decisions.
- **Expand legal Standing** so that everyday people can challenge patents in court just like drug companies. This democratizes accountability and enables earlier challenges to weak or abusive patents.
- **Expand Congressional oversight** to ensure accountability. Stronger oversight would provide a systemic check on regulatory capture and encourage reforms aligned with public health rather than industry profits.

Reform along these lines would directly challenge financialization's use of the patents as a wealth-extraction mechanism, reorienting the patent system toward genuine inventions and health outcomes. Importantly, they would also help dismantle the racialized exclusion from timely access that has marked every wave of "breakthrough" medicine.

Conclusion

Financialization has entrenched structural racism in the pharmaceutical sector, producing recurring cycles of racialized access disparities. Reimagining this system requires moving beyond piecemeal reforms to structural alternatives: treating medicines as public goods, building a robust public option, undoing regulatory capture, and reforming patents to prioritize health over profit. These measures would not only lower prices and expand supply but also strike at the root of neoliberals modern form of racial capitalism in health care, ensuring that communities of color, long marginalized by the pharmaceutical market, can equitably access the therapies they need to survive and thrive.