Article

The Crisis in U.S. Cancer Care: Law, Markets, and Privatization

Daniel G. Aaron†

Cancer is surging among youth and young adults in the United States, yet, instead of public regulation addressing its root causes, we have outsourced the management of cancer to the private sector. A suite of laws, embodying faith that corporations will cure cancer, has subsidized the cancer biomedical enterprise and transformed quasi-public institutions into marketized, profit-seeking entities. These changes, across patent law, healthcare law, innovation law, and Food and Drug Administration (FDA) law, have privatized cancer.

The market failures I describe in U.S. cancer care raise larger questions about who we entrust with managing critical social problems. This Article provides theoretical clarity on the

† M.D., J.D., Associate Professor of Law, S.J. Quinney College of Law, University of Utah. I am grateful to many, including Jamelia Morgan, Valarie Blake, Tammi Etheridge, Patti Zettler, Glenn Cohen, Chris Robertson, Craig Konnoth, Ronen Avraham, Becky Wolitz, Nathan Cortez, Gregg Bloche, Teneille Brown, Myrisha Lewis, Lewis Grossman, Laura Kessler, Lisa Larrimore Ouellette, Brigham Daniels, Katya Cronin, Ruhan Nagra, Lingxi Chenyang, Luis Inaraja Vera, Leslie Culver, Peter Barton Hutt, Holly Fernandez Lynch, Michael Sinha, Adam Muchmore, Sara Gerke, Rachel Sachs, Abbe Gluck, Renee Landers, Thomas Williams, Sarah Fox, Marie Boyd, Kim Fullerton, Jacki Lopez, Bradley Rebeiro, Brady Earley, and Anjali Deshmukh, as well as attendees at Harvard Law School's Health Law, Policy, Bioethics, and Biotechnology Workshop, the Law and Economics Workshop at the Washington and Lee University School of Law, the 2025 Seton Hall Health Law Works in Progress Retreat, the 2025 University of Utah Law and Biomedical Sciences Colloquium, the 2024 Health Law Professors Conference, the American Association of Law Schools 2024 conference, the American Law and Economics Association 2024 Annual Meeting, the Rocky Mountain Junior Scholars Forum at the BYU J. Reuben Clark Law School, and Regulation and Innovation in the Biosciences 2024 at the Northeastern University School of Law. My special thanks go to my research assistants Sonya Chechik and Avery Emery.

trans-substantive use of the term "privatization." I theorize that privatization underscores a shift from community-centered approaches to ones centered on individuals and firms. Further, in contrast with the traditional, economic understanding of privatization, I deconstruct privatization into five categorical forms: delegation, individualization, marketization, capture, and cultural privatization.

From climate change to reproductive justice to cancer, privatization has undermined public goals by warping systems in a way that promotes corporate interests and individualized framings over the common good. We must take seriously the harms to all Americans from unbridled privatization and push for a renewed promise of government intervention in the world we inhabit.

TABLE OF CONTENTS

"The molecularisation of cancer in terms of understanding it through molecular-level factors such as genes and hormone receptors rather than environmental or behavioral factors, has led not just to its pharmaceuticalisation but also to medicines gaining a dominant position in the social psyche of cancer care."

— Drs. Christopher M. Booth, Ajay Aggarwal, and Richard Sullivan, Oncology Researchers.[1]

"[T]here is no relationship between the value that [a] cancer drug provides and the cost of that drug in the United States . . . ."

— Dr. Vincent Rajkumar, Professor of Medicine, Mayo Clinic.[2]

INTRODUCTION

On June 16, 2023, thirty-six oncologists and cancer experts penned a stunning article[3] in *The Lancet Oncology*, a leading cancer journal. The authors warn that many new cancer therapies "do not help patients live longer or better."[4] The group critiques "[i]ndustry's control" over our cancer system and laments that "[c]ommercial interests, rather than patient interests, often drive cancer care and research . . . ."[5] The authors call for refocusing on "outcomes that matter to patients rather than the commercial bottom line."[6]

Far from a fringe opinion, this type of criticism is part of a tidal wave looming over the U.S. cancer biomedical arena. When assessed on the European Society for Medical Oncology Scale, a standardized measure for new oncology drugs, the vast majority of cancer therapies approved in the United States fail to deliver "substantial clinically meaningful benefit."[7] Critics have noted that much of cancer research is redundant, as pharmaceutical companies pursue copycat drugs to steal market share from

1. Christopher M. Booth et al., *Commercial Determinants of Cancer Medicines*, 28 EUROHEALTH, no. 2, 2022, at 18, 18 (footnote omitted).

2. Mayo Proceedings, *Why Are Cancer Drugs So Expensive in the US?*, YOUTUBE (Mar. 16, 2015), https://www.youtube.com/watch?v=MOHMgOPfv6I.

3. *See generally* Christopher M. Booth et al., *Common Sense Oncology: Outcomes That Matter*, 24 LANCET ONCOLOGY 833 (2023).

4. *Id.* at 833.

5. *Id.*

6. *Id.* at 834.

7. Frank Gannon, Opinion, *Clinical Trials and Tribulations*, 25 EMBO REPS. 1690, 1690 (2024).

competitors,[8] while truly transformative drugs are rare. Indeed, pharmaceutical companies have realized "that there is almost no limit to how much money dying patients will pay for cancer drugs"[9]—even, it seems, if they are minimally effective. The private research enterprise is, to be blunt, not saving us from cancer. Meanwhile, we have neglected the fact that most cancer cases in the United States are likely due to social causes—i.e., tobacco (20%), diet (up to 35%), and environmental exposures (12%)[10]—areas readily addressable through public law. This social emphasis on the private over the public exemplifies privatization.

The concept of privatization has a long pedigree dating from around the 1970s. Traditionally, as Part I explains, privatization refers to delegating control over government functions to corporations. This "economic" understanding of privatization might seem, initially, inapplicable to cancer, which is not a government function that can be delegated. But a burgeoning literature elucidates newer theories of privatization.[11] Melissa Murray has

8. *See infra* Part II.D.1 (discussing the rise of "me-too" drugs).

9. Teneille R. Brown, *Denying Death*, 57 ARIZ. L. REV. 977, 1023 (2015).

10. Daniel G. Aaron, *The Deregulation of Cancer*, TEX. A&M L. REV. (forthcoming 2026) (manuscript at 16–21), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4945884.

11. *See generally* Mary M. Shirley, *The What, Why, and How of Privatization: A World Bank Perspective,* 60 FORDHAM L. REV. S23 (1992); Michele Estrin Gilman, *Legal Accountability in an Era of Privatized Welfare*, 89 CALIF. L. REV. 569 (2001); Matthew Diller, *Form and Substance in the Privatization of Poverty Programs*, 49 UCLA L. REV. 1739 (2002); Michael J. Trebilcock & Edward M. Iacobucci, *Privatization and Accountability*, 116 HARV. L. REV. 1422 (2003); Jody Freeman, *Extending Public Law Norms Through Privatization*, 116 HARV. L. REV. 1285 (2003); Gillian E. Metzger, *Privatization as Delegation*, 103 COLUM. L. REV. 1367 (2003); Mark H. Moore, *Introduction*, 116 HARV. L. REV. 1212 (2003); Klint Alexander & Kern Alexander, *Vouchers and the Privatization of American Education: Justifying Racial Resegregation from* Brown *to* Zelman, 2004 U. ILL. L. REV. 1131 (2004); Martha Minow, *Outsourcing Power: How Privatizing Military Efforts Challenges Accountability, Professionalism, and Democracy*, 46 B.C. L. REV. 989 (2005); Alex E. Rogers, Note, *Clothing State Governmental Entities with Sovereign Immunity: Disarray in the Eleventh Amendment Arm-of-the-State Doctrine*, 92 COLUM. L. REV. 1243 (1992); Cynthia Estlund, *Rebuilding the Law of the Workplace in an Era of Self-Regulation*, 105 COLUM. L. REV. 319 (2005); Paul R. Verkuil, *Public Law Limitations on Privatization of Government Functions*, 84 N.C. L. REV. 397 (2006); Jon D. Michaels, *All the President's Spies: Private-Public Intelligence Partnerships in the War on Terror*, 96 CALIF. L. REV. 901 (2008); Alexander Volokh, *Privatization and the Law and Economics of Political Advocacy*, 60 STAN. L. REV. 1197 (2008); Jon D. Michaels, *Privatization's Pretensions*, 77 U. CHI. L. REV. 717

explained that "privatization has multiple meanings and interpretations";[12] Jody Freeman agrees that privatization describes "a host of arrangements."[13] Consider these examples:

Religious accommodations: Melissa Murray suggests that, when religious freedom claims exempt individuals from public laws, like non-discrimination statutes, they foment privatization through a "recharacterization of public space . . . into private space."[14]

Standing jurisprudence: Cass Sunstein has opined that, as a form of privatization, court decisions on Article III standing have diminished the public-law role of Congress in defining injuries; this has, in turn, empowered judges, through common law, to define the meaning of a judicially cognizable injury based on private rights.[15]

Climate change: Shelley Welton has described the risks of trying to solve climate change through private actors' "net-zero"

(2010); Julie A. Roin, *Privatization and the Sale of Tax Revenues*, 95 MINN. L. REV. 1965 (2011); Jon D. Michaels, *Privatization's Progeny*, 101 GEO. L.J. 1023 (2013); Alex Kozinski & Andrew Bentz, *Privatization and Its Discontents*, 63 EMORY L.J. 263 (2013); Joseph Blocher, *Selling State Borders*, 162 U. PA. L. REV. 241 (2014); Jon D. Michaels, *An Enduring, Evolving Separation of Powers*, 115 COLUM. L. REV. 515 (2015); JON D. MICHAELS, CONSTITUTIONAL COUP: PRIVATIZATION'S THREAT TO THE AMERICAN REPUBLIC (2017); K. Sabeel Rahman, *Reconstructing the Administrative State in an Era of Economic and Democratic Crisis*, 131 HARV. L. REV. 1671 (2018) (reviewing MICHAELS, *supra*); Asli Bâli & Aziz Rana, *Constitutionalism and the American Imperial Imagination*, 85 U. CHI. L. REV. 257 (2018); K. Sabeel Rahman, *Constructing Citizenship: Exclusion and Inclusion Through the Governance of Basic Necessities*, 118 COLUM. L. REV. 2447 (2018); Melissa Murray, *Consequential Sex: #MeToo,* Masterpiece Cakeshop*, and Private Sexual Regulation*, 113 NW. U. L. REV. 825 (2019); Micaela Gelman, Note, *Mismanaged Care: Exploring the Costs and Benefits of Private vs. Public Healthcare in Correctional Facilities*, 95 N.Y.U. L. REV. 1386 (2020); Craig Konnoth, *Privatization's Preemptive Effects*, 134 HARV. L. REV. 1937 (2021); Shelley Welton, *Rethinking Grid Governance for the Climate Change Era*, 109 CALIF. L. REV. 209 (2021).

12. Murray, *supra* note 11, at 837.

13. Freeman, *supra* note 11, at 1286–87.

14. Murray, *supra* note 11, at 878. Murray notes this would not fall into the "traditional model of privatization" because the state does not set the terms. *Id.* at 871. One might ask whether courts are playing this state role.

15. Cass R. Sunstein, *Standing and the Privatization of Public Law*, 88 COLUM. L. REV. 1432, 1480–81 (1988).

pledges (i.e., promises to bring one's carbon emissions to zero in a definite period of time).[16]

This Article forges new connections across the privatization literature, utilizing the case study of cancer. Specifically, I theorize that privatization speaks to a shift from community-centered approaches to ones centered on individuals and firms. Further, I deconstruct privatization into five forms: delegation, individualization, marketization, capture, and cultural privatization. This framework brings theoretical cohesion to the use of privatization in disparate literatures, including those on reproductive justice, law and economics, health law, and environmental law.

Part II applies this theory to a host of cancer-related statutory frameworks, including the Bayh-Dole Act, the Cancer Moonshot, the Affordable Care Act, and the Medicare Act, placing the growing literatures on privatization[17] and innovation law[18] in conversation with the medical and oncology literatures. This Article identifies a steep slant toward solving cancer through private markets with feeble public guardrails. As a result, our modern cancer apparatus cares far less about the public-law regulation of toxic chemicals in our food, water, and air[19] than

16. Shelley Welton, *Neutralizing the Atmosphere*, 132 YALE L.J. 171, 177 (2022). Welton emphasizes that "corporations should not be encouraged to develop . . . net-zero pledges." *Id.*

17. *See supra* note 11 (citing several examples of this literature).

18. *See generally* Amy Kapczynski & Talha Syed, *The Continuum of Excludability and the Limits of Patents*, 122 YALE L.J. 1900 (2013); Christopher Buccafusco & Samuel N. Weinstein, *Antisocial Innovation*, 58 GA. L. REV. 573 (2024); Mark A. Lemley et al., *The Medicare Innovation Subsidy*, 95 N.Y.U. L. REV. 75 (2020); Rebecca S. Eisenberg, *The Role of the FDA in Innovation Policy*, 13 MICH. TELECOMMS. & TECH. L. REV. 345 (2007); Daniel J. Hemel & Lisa Larrimore Ouellette, *Valuing Medical Innovation*, 75 STAN. L. REV. 517 (2023); W. Nicholson Price II & Arti K. Rai, *Manufacturing Barriers to Biologics Competition and Innovation*, 101 IOWA L. REV. 1023 (2016); Daniel J. Hemel & Lisa Larrimore Ouellette, *Innovation Policy Pluralism*, 128 YALE L.J. 544 (2019); Arti K. Rai et al., *Cryptic Patent Reform Through the Inflation Reduction Act*, 37 HARV. J.L. & TECH. 57 (2023); Wendy Netter Epstein & Laura G. Pedraza-Fariña, Polycentric Drug Innovation (Feb. 7, 2024) (unpublished manuscript), https://www.law.berkeley.edu/wp-content/uploads/2024/01/Epstein-Pedraza-Farina-Polycentric-Drug-Innovation.pdf [https://perma.cc/Z5RR-L3N3]; Mariana Mazzucato, *Rethinking Innovation in Drugs: A Pathway to Health for All*, 51 J.L. MED. & ETHICS (SPECIAL ISSUE) 16 (2023); Rachel E. Sachs, *Administering Health Innovation*, 39 CARDOZO L. REV. 1991 (2018).

19. *See generally* Aaron, *supra* note 10 ("The three main pillars of carcinogen regulation are the FDA, the EPA, and tort law. . . . I will argue that they have been deregulated.").

about developing lucrative vials of chemotherapy for individual patient administration—at immense cost and often with disappointing effectiveness.[20] New chemotherapies, sometimes sold at "4000 times the cost of gold,"[21] spare patients, on average, about two months of life.[22] That corporations fostered a stealth privatization of the world of cancer, and extracted billions in riches often for little public benefit, is an important recognition in and of itself.

Part III draws lessons about the risks of privatization and how we might address them. As I explain in Section III.A, unchecked privatization can impair biomedical innovation, drain public resources, undermine public goods, and damage equity—while entrenching the fall of the public sphere. Understanding the risks of privatization can guide lawmakers inclined to entrust social problems to private markets.

The remainder of Part III lays a roadmap for reversing each of the five forms of privatization, using cancer as a guide. Delegation, individualization, marketization, capture, and cultural privatization are addressed in turn. The solutions offered in Part III draw from critical lessons learned from the Environmental Justice Movement, including how social movements can fuel deprivatization.

To be clear, like Shelly Welton,[23] I do not argue that corporate entities must be absent from the management of social problems. Marketized interventions provided by firms have a role to play in cancer and other social matters.

But the integrity of the private sphere fundamentally depends on a public sphere that ensures drugs are safe and effective, that restricts pollution, that regulates firearms, and, ultimately, a government that keeps private power in check. Legal

---

20. *See* CHARLES SILVER & DAVID A. HYMAN, OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE 61–62 (2018) ("[T]heir cost is concerning. One reason is that many of these drugs confer few benefits on patients.").

21. Audrey Andrews, *Treating with Checkpoint Inhibitors—Figure $1 Million per Patient*, AM. HEALTH & DRUG BENEFITS, August 2015, at 9, 9.

22. *See infra* Part II.D.1.c (discussing the survival benefits, cost, and duplicative nature of new cancer drugs).

23. Welton, *supra* note 16, at 178, 240–41 (clarifying her article is "not an indictment of corporate action on climate change" but, rather, an argument for shifting away from private governance of carbon emission reduction and requiring corporations to fund public efforts).

scholars must take seriously the harms flowing from privatization, in order to revitalize government's role in protecting Americans from dire threats that elude individualized solutions.

I. PRIVATIZATION: A LEGAL FRAMEWORK

Nearly everyone has heard of privatization. But what meanings does it carry in legal scholarship, historically and now? Section A provides a historical overview of the concept of "privatization" in existing scholarship. Section B reconciles these meanings by elaborating five forms of privatization, which this Article will apply to cancer. Finally, Section C addresses the common refrain that society *is* and *should be* a mix of public and private. I argue this contention provides little guidance, either theoretically or practically, for law- and policymakers wrestling with who should control various social functions.

A. THE EVOLUTION OF PRIVATIZATION

Since its primetime debut around the 1970s, privatization has generally referred to when the "government formally or informally delegates a function previously carried out by the government to a private entity."[24] According to advocates of privatization, corporations and markets can achieve similar tasks as government but with greater efficiency, effectiveness, and wealth creation.[25] Proponents of privatization, therefore, believe that the public interest would benefit from greater delegation from the public to the private sphere.

Privatization has surged as "enthusiasm for greater reliance on market actors and market mechanisms . . . has grown in recent decades."[26] After the 1970s period of "stagflation" (inflation coupled with economic stagnation), which triggered a crisis of

24. Konnoth, *supra* note 11, at 1944; *see* Martha Minow, *Public and Private Partnerships: Accounting for the New Religion*, 116 HARV. L. REV. 1229, 1230 (2003) ("[A] useful definition [of privatization] encompasses the range of efforts by governments to move public functions into private hands and to use market-style competition.").

25. *See* Gelman, *supra* note 11, at 1395–96 ("[P]rivatization had another purported benefit: competition, which promised to drive down costs while promoting quality service."); DAVID HARVEY, A BRIEF HISTORY OF NEOLIBERALISM 65 (2005) ("Privatization and deregulation combined with competition, it is claimed, eliminate bureaucratic red tape, increase efficiency and productivity, improve quality, and reduce costs . . . .").

26. Freeman, *supra* note 11, at 1289.

rising prices coupled with unemployment,[27] economists and politicians pushed society "to the market and to policies of market liberalization as the solution to all manner of social ill."[28] Rather than being a partisan approach, privatization has, in some ways, become "routine" in government.[29] There has been a sustained push in the United States to privatize education,[30] health care,[31] prisons,[32] electricity governance,[33] transportation,[34] and much more.

Newer definitions of privatization have advanced broader understandings. Donald Cohen and Allen Mikaelian have defined privatization as the "transfer of power over our own destiny, as individuals and as a nation, to . . . corporations and their

---

27. NAOMI ORESKES & ERIK M. CONWAY, THE BIG MYTH: HOW AMERICAN BUSINESS TAUGHT US TO LOATHE GOVERNMENT AND LOVE THE FREE MARKET 310 (2023) ("In the 1970s, however, inflation and growth became decoupled . . . . Hence, stagflation: a stagnant economy with high inflation.").

28. Bâli & Rana, *supra* note 11, at 278.

29. E.S. Savas, Essay, *Privatization and the New Public Management*, 28 FORDHAM URB. L.J. 1731, 1731 (2001) ("[Privatization] is . . . a pragmatic and increasingly routine approach to governing and to managing public services.").

30. *See* Valerie Strauss, *Privatization of Public Education Gaining Ground, Report Says*, WASH. POST (Apr. 18, 2022), https://www.washingtonpost.com/education/2022/04/18/privatization-of-public-education-gaining-ground [https://perma.cc/PS9Y-XX8P] ("The movement to privatize public education is gaining ground in the United States . . . ."); Alexander & Alexander, *supra* note 11, at 1135 ("The result of this privatization has been the erosion of the public school ideal[ ] [and] the proliferation of private segregated academies . . . .").

31. *See* Larry Levitt, *Increasingly Privatized Public Health Insurance Programs in the US*, JAMA HEALTH F., Mar. 30, 2023, at 1, 1 ("[I]ncreasingly, our public insurance programs are looking very private."); Lindsay F. Wiley, *Medicaid for All? State Single-Payer Health Care*, 79 OHIO ST. L.J. 843, 851 (2018) ("The federal government and the states have privatized Medicaid through a combination of administrative waivers and legislative amendments.").

32. *See* Sharon Dolovich, *State Punishment and Private Prisons*, 55 DUKE L.J. 437, 439 (2005) ("Watching the cost of incarceration rise [during the 1980s and 1990s] . . . , state officials turned to the private sector for help."); Laura I. Appleman, *Cashing in on Convicts: Privatization, Punishment, and the People*, 2018 UTAH L. REV. 579, 580 (2018) ("The recent rise of privatizing punishment—spanning from for-profit incarceration to privatized probation . . . and parole—severs the essential link between the people and criminal punishment.").

33. *See* Welton, *supra* note 11, at 212–13 (discussing the embrace of privatization in electricity governance in the wake of the 1970s "deregulatory fever").

34. *See* Alexander & Alexander, *supra* note 11, at 1134 ("Since the 1980s, the free market ideology . . . [has] led the U.S. government down a slippery slope with respect to social policy, seeking to privatize and deregulate . . . transportation . . . .").

executives."[35] Reflecting a broad scope, Jody Freeman notes that privatization describes "a host of arrangements";[36] E.S Savas agrees that it "takes many forms."[37]

Rather than accept the premise that privatization is a heterogeneous concept, this Article aims to provide a cohesive theoretical framework for scholars' varying invocations of privatization.

B. FIVE FORMS OF PRIVATIZATION

There are arguably five dimensions on the scale from public to private. Ultimately, these dimensions speak to the contrast between community-centered approaches and those that center individuals and firms. Each dimension is associated with one form of privatization. The five dimensions are the following (Table 1): control (who manages the endeavor), the target population (whether the initiative targets the public or the individual), the method of access (government-provided vs. marketized), the beneficiary, and the cultural beliefs about the regime.

Table 1: This paper characterizes five forms of privatization. Privatization can occur in complex ways across one or more of these forms.

DIMENSION	"PUBLIC"		"PRIVATE"	TYPE OF PRIVATIZATION
CONTROL	Government	→	Corporation	Delegation
TARGET POPULATION	Communities	→	Individuals	Individualization
ACCESS	Provided to All	→	Market Transaction	Marketization; Commodification
BENEFICIARY	The Public Good	→	The Bottom Line	Capture
CULTURAL BELIEFS	Belief in Government	→	Superiority of Private Actors	Cultural Privatization

35. DONALD COHEN & ALLEN MIKAELIAN, THE PRIVATIZATION OF EVERYTHING 5 (2021); *see* Savas, *supra* note 29 (defining privatization as "greater reliance on the private institutions of society and less dependence on government to satisfy people's needs").

36. Freeman, *supra* note 11, at 1287.

37. Savas, *supra* note 29, at 1731.

Four clarifications are in order:

1. Not all five forms need to be present for privatization to occur. Most scholars use privatization to refer to only one sense of the term.

2. A single policy can be privatizing and publicizing on different dimensions. For example, the Medicare guarantee to insure patients with end-stage renal disease[38] offers public access but delegates public dollars largely to private healthcare entities.

3. Privatization is not necessarily ill-advised. Individualization can accentuate a person's voice or democratic participation. Marketization can be valuable; for example, compare our current marketized system for tobacco with one in which the government freely distributes cigarettes to the public. Imposing a cost can reduce the use of harmful products.

4. These forms of privatization derive from different literatures. This Article aims to connect distinct scholarly conversations about privatization.

Given that traditional privatization (i.e., delegation) is well characterized, I will cover the other four forms.

Individualization/Medicalization: Legal scholars have noted that privatization can focus on the individual's needs to the detriment of social policy. Much of the literature on the public-private distinction comes from family law, in which scholars contrast the home's private, sexual, and family space with the public arena of the state.[39] For example, Melissa Murray describes, effectively, the privatization of the public sphere when people assert religious objections to public accommodations or non-discrimination law by, for example, leveraging their private

38. Ctr. for Medicare & Medicaid Servs., *Medicare Coverage of Kidney Dialysis & Kidney Transplant Services*, U.S. DEP'T OF HEALTH & HUM. SERVS. 4 (2025), https://www.medicare.gov/publications/10128-medicare-coverage-esrd.pdf [https://perma.cc/N3WX-236A] (explaining that patients can receive Medicare if their kidneys do not work, they need dialysis or have received a kidney transplant, and one of three other criteria applies).

39. *See, e.g.*, Khiara M. Bridges, *Privacy Rights and Public Families*, 34 HARV. J.L. & GENDER 113, 116–17 (2011) (discussing state regulation of poor women's lives to examine the relationship between public and private in family law); Danaya C. Wright, *Theorizing History: Separate Spheres, the Public/Private Binary and a New Analytic for Family Law History*, 2012 AUSTL. & N.Z. L. & HIST. E-J. 44 ("I first explore lessons learned about the enduring nature of separate spheres and the power imbalance of the public/private binary . . . .").

religious beliefs to refuse to provide services to LGBTQ+ individuals in public markets.[40] Jana Singer has argued that privatization in family law amounts to a "transformation from public to private ordering of behavior" in areas like marriage, no-fault divorce, and adoption, as a means to support personal autonomy and the rejection of gender roles.[41] In the environmental law context, Shelly Welton criticizes corporations' net-zero climate pledges as an "atomized" approach that fails to meet the collective action needed to protect the planet.[42]

In the health context, individualization is often described as medicalization.[43] Medicalization is a "process by which personal, behavioral, and social issues are increasingly viewed through a biomedical lens and 'diagnosed and treated' as individual pathologies and problems by medical authorities."[44] By marshalling resources and attention toward individualized problems, medicalization can have a similar impact as the privatization in the contexts of family and environmental law in deemphasizing social policy or values.

Scholars, including Rachel Rebouché, Ruth Colker, and Maya Manian, have laid out feminist and reproductive-justice

---

40. Murray, *supra* note 11, *passim* ("[T]he private regulation seen in *Masterpiece Cakeshop* . . . evinces a new turn in the regulation of sex and sexuality. In the absence of appropriate state regulation of sex and sexuality, private actors . . . have claimed and recast parts of the public sphere as private space suitable for the imposition of their own norms and values.").

41. Jana B. Singer, *The Privatization of Family Law*, 1992 WIS. L. REV. 1443, 1444–46 (1992).

42. Welton, *supra* note 16, at 176, 217.

43. There is a voluminous literature on the subject. *See, e.g.*, Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165 (2020); Rabia Belt & Doron Dorfman, Response, *Reweighing Medical Civil Rights*, 72 STAN. L. REV. ONLINE 176 (2020), https://review.law.stanford.edu/wp-content/uploads/sites/3/2020/10/72-Stan.-L.-Rev.-Online-Belt-Dorfman.pdf [https://perma.cc/94MD-M5FH]; Allison K. Hoffman, Response, *How Medicalization of Civil Rights Could Disappoint*, 72 STAN. L. REV. ONLINE 165 (2020), https://review.law.stanford.edu/wp-content/uploads/sites/3/2020/10/72-Stan.-L.-Rev.-Online-Hoffman.pdf [https://perma.cc/788B-8ET4]; Craig Konnoth, Reply, *Medical Civil Rights as a Site of Activism: A Reply to Critics*, 73 STAN. L. REV. ONLINE 104 (2020), https://review.law.stanford.edu/wp-content/uploads/sites/3/2020/12/73-Stan.-L.-Rev.-Online-Konnoth.pdf [https://perma.cc/7E35-FBA4]; William M. Sage & Jennifer E. Laurin, *If You Would Not Criminalize Poverty, Do Not Medicalize It*, 46 J.L. MED. & ETHICS 573 (2018); Paula M. Lantz et al., *The Perils of Medicalization for Population Health and Health Equity*, 101 MILBANK Q. (SPECIAL CENTENNIAL ISSUE) 61 (2023); *see also infra* note 45.

44. Lantz et al., *supra* note 43, at 61–63.

critiques of the medicalized, individualized abortion framework enshrined in *Roe v. Wade*,[45] with Rebouché noting *Roe*'s individual framing "demands nothing from the state to support" reproductive freedom.[46] Melissa Murray notes that the *Roe* lawyers grounded their arguments not in sex equality or feminism, but in a "narrow logic of privacy"—on the privateness of reproduction.[47] This approach narrowed the understanding of abortion by stressing medical expertise and personal choice, while sidelining collective action and community solidarity.[48] Backlash to the privatized logic of *Roe* helped create the reproductive justice movement in the 1990s.[49]

Commentators have discussed the ways that medicalization zooms in on diagnosis and treatment in individuals over and above public approaches.[50] Allison Hoffman contends that medicalization can "limit how we think about justice" and "may draw us further away from thinking about structural solutions that address root causes."[51] William Sage and Jennifer Laurin contend that federal and state governments "neglect non-medical social services while massively indulging in overpriced, often ineffective medical care"—a "gross misallocation of social resources."[52]

---

45. Ruth Colker, *Overmedicalization?*, 46 HARV. J.L. & GENDER 205, 256–57 (2023) ("This overmedicalized framework may not have been the best way to justify abortion access, because it focuses on medical professionals, rather than the significance of abortion access for recognizing the full personhood of pregnant women."); Maya Manian, *A Health Justice Approach to Abortion*, 34 HEALTH MATRIX: J.L.-MED. 261, 280–84 (2024); Rachel Rebouché, Roe *Was Never Enough Anyway*, BOS. REV., https://www.bostonreview.net/articles/congress-could-legislate-roe-v-wade-and-still-fail-women [https://perma.cc/44UV-Z6LD]. Critiques of *Roe*'s medicalized approach are nuanced. For example, Maya Manian argues that medicalization in *Roe* helped insulate abortion from state regulation. Manian, *supra* note 45, at 282.

46. Rebouché, *supra* note 45.

47. Melissa Murray, *Race-ing* Roe*: Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade, 134 HARV. L. REV. 2025, 2049–51 (2021).

48. *Id.*

49. *Id.* at 2053.

50. *See, e.g.*, Lantz et al., *supra* note 43, at 62 ("*Medicine* is a distinctly different enterprise from population health science and public health practice, with a focus on the diagnosis and treatment of illness and injury in individuals.").

51. Hoffman, *supra* note 43, at 165–66.

52. Sage & Laurin, *supra* note 43, at 573.

When legal scholars invoke privatization to emphasize the role of individuals vis-à-vis the state, they are impliedly defining privatization as individualization.

Marketization: Privatization scholars have noted that governments can privatize by "mak[ing] a market in a particular commodity or service."[53] Through commodification or marketization, the access point becomes a market from which an individual purchases a good or service. For example, Tom Baker has noted that the Affordable Care Act expanded health care largely through empowering healthcare market exchanges, thereby exalting "private ownership, markets, choice, and individual responsibility."[54] Although the statute provides support for individuals to purchase insurance, access issues "abound" for a variety of reasons.[55] The marketized approach has "rel[ied] on private companies to make coverage determinations" instead of empowering government to allocate care based on public values.[56] The marketization of healthcare, and other goods, places individuals in the position of securing their own access, sometimes with a residual level of support from the state, and with corporations in the role of provider.

Capture: This is probably the newest, least established form of privatization. Essentially, where a regulatory system benefits private parties at the expense of the public, that is arguably a

53. Edward Rubin, *The Possibilities and Limitations of Privatization*, 123 HARV. L. REV. 890, 929 (2010) (reviewing JODY FREEMAN & MARTHA MINOW, GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY (2009)); Minow, *supra* note 24 (describing privatization through "market-style competition").

54. Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1579 (2011); *see* Lindsay F. Wiley et al., *Health Reform Reconstruction*, 55 UC DAVIS L. REV. 657, 671–72 (2021) (noting the reliance of the Affordable Health Care on private entities).

55. Lauren Clason et al., *Ten Years into Obamacare, Cost and Access Issues Abound*, ROLL CALL (Mar. 10, 2020), https://rollcall.com/2020/03/10/ten-years-into-obamacare-cost-and-access-issues-abound [https://perma.cc/BP7Y-JA8T]; *see* Wiley et al., *supra* note 54, at 672–73; Sara R. Collins, Lauren A. Haynes & Relebohile Masitha, *The State of U.S. Health Insurance in 2022*, COMMONWEALTH FUND (Sept. 29, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey [https://perma.cc/MH4A-AQ66] (noting that, despite the Affordable Care Act, "a large number of people in the United States remain uninsured or inadequately covered").

56. Erin C. Fuse Brown et al., *Social Solidary in Health Care, American-Style*, 48 J.L. MED. & ETHICS 411, 416 (2020).

form of privatization, embodied by the idea of capture. Concerns about capture's privatizing power have existed since the 1800s. In 1836, the *Boston Daily Herald* warned of private interests: "They are not for the public good – in design or end. . . . They are for the aggrandizement of the stockholders – for the promotion of the interest of the few. . . . We wish to have public good and private speculation more distinctly separated."[57]

The seminal text on capture, edited by Daniel Carpenter and David Moss, defines capture as the process through which regulation "is consistently or repeatedly directed away from the public interest and toward the interests of the regulated industry."[58] Where regulation is shifted in the direction of industry benefit, I will refer to that as a form of privatization.

Cultural Privatization: I use the term *cultural privatization* to refer to a shift in culture that reflects and reinforces privatized values. Movies, books, television, and radio can deliver messages that reinforce the superiority of corporations and markets and frame social problems as individualized. In the administrative law setting, James Kwak describes *cultural capture* as the shaping of "regulators' beliefs and actions" to achieve a similar result as traditional capture.[59] Corporate influence over popular culture has been described too. Jon Hanson and David Yosifon use the term *deep capture* to refer to the exertion of power over "features that purport to be, and that we experience as, independent, volitional, and benign"—like culture, beliefs, and faith.[60] They use the example of Galileo, who fought uphill against the church-supported view that Earth was the center of the universe.[61] In so doing, he advocated for people to challenge common sense notions—an idea immensely threatening to the Catholic Church, which forced him to recant his views under

57. William J. Novak, *A Revisionist History of Regulatory Capture*, *in* PREVENTING REGULATORY CAPTURE 25, 40–41 (Daniel Carpenter & David A. Moss eds., 2014).

58. Daniel Carpenter & David A. Moss, *Introduction* to PREVENTING REGULATORY CAPTURE, *supra* note 57, at 1, 13.

59. James Kwak, *Cultural Capture and the Financial Crisis*, *in* PREVENTING REGULATORY CAPTURE, *supra* note 57, at 71, 80.

60. Jon Hanson & David Yosifon, *The Situation: An Introduction to the Situational Character, Critical Realism, Power Economics, and Deep Capture*, 152 U. PA. L. REV. 129, 218 (2003).

61. *Id.* at 214–15.

threat of punishment in order to sustain false beliefs in the populace.[62]

Hanson and Yosifon extend this idea to suggest that many people's "faith in pro-market, anti-regulation" individualism is an example of deep capture.[63] This "person-centric view" benefits corporations,[64] and they spend "hundreds of billions of dollars" each year on advertising and public relations, in part to support their shared interest in sustaining faith in individual participation in markets.[65] Hanson and Yosifon's research[66] connects with the literature on neoliberalism,[67] a system that enshrines private "choice" over public values, like public health and consumer protection, and that became "mainstream" under President Bill Clinton.[68]

Bringing all five forms together, privatization is the shift across one or more of these dimensions in the direction of the private sphere.

Those familiar with the law-and-political-economy literature will immediately recognize that some forms of privatization, including marketization, individualization, and traditional privatization, are prominent features of neoliberalism.[69] While I

---

62. *Id.* at 215–17.

63. *Id.* at 235 ("Thus, the same evidence that, to many scholars, might constitute proof of the absence of shallow capture, strikes us as evidence of deep capture—the faith in pro-market, anti-regulation dispositionism.").

64. *Id.* at 303.

65. *Id.* at 226, 262.

66. Their other work on deep capture includes Ronald Chen & Jon Hanson, *The Illusion of Law: The Legitimating Schemas of Modern Policy and Corporate Law*, 103 MICH. L. REV. 1 (2004); Adam Benforado et al., *Broken Scales: Obesity and Justice in America*, 53 EMORY L.J. 1645 (2004); and Ronald Chen & Jon Hanson, *Categorically Biased: The Influence of Knowledge Structures on Law and Legal Theory*, 77 S. CAL. L. REV. 1103 (2004).

67. *See, e.g.*, ORESKES & CONWAY, *supra* note 27; NAOMI KLEIN, THE SHOCK DOCTRINE: THE RISE OF DISASTER CAPITALISM (2007); Jedediah Britton-Purdy et al., *Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis*, 129 YALE L.J. 1784 (2020); Kate Andrias & Benjamin I. Sachs, *Constructing Countervailing Power: Law and Organizing in an Era of Political Inequality*, 130 YALE L.J. 546 (2021); Tayyab Mahmud, *Debt and Discipline: Neoliberal Political Economy and the Working Classes*, 101 KY. L.J. 1 (2012–2013).

68. ORESKES & CONWAY, *supra* note 27, at 364.

69. *See* Daniel G. Aaron, *The Fall of FDA Review*, 22 YALE J. HEALTH POL'Y L. & ETHICS 95, 108, 145 (2023) (describing and illustrating these aspects of neoliberalism); Britton-Purdy et al., *supra* note 67, at 1789 n.21 (defining neoliberalism and its key objectives).

believe privatization is a better fit for the phenomena described in this Article, to a degree, this question is more philosophical than helpful; privatization and neoliberalism likely exist inside one another.[70] Legal scholars would likely contest the idea that privatization can neatly be subsumed by neoliberalism. Privatization also does not necessarily carry an ideological conviction.

Under the above theory, the epitome of a privatized approach would have private management, address the problem individual-by-individual, operate through markets, have benefits which redound principally to private industry, and be associated with a compelling cultural narrative favoring privatization. A public approach would be the opposite: It would be managed by government, target communities rather than individuals, de-marketize, provide predominantly public benefit, and have cultural narratives that do not unduly worship the private sphere. As the public and private spheres are not mutually exclusive, it is necessary to examine some theoretical considerations about the coexistence between them.

C. THE TUG-OF-WAR BETWEEN PUBLIC AND PRIVATE

There is an obvious answer to privatization: that the public and private spheres should coexist. We can have cancer prevention *and* cancer drugs; climate policy and electric vehicles; economic equity policies and personal financial responsibility.

This truism, however, neglects the larger battle between the public and private spheres. Today, the private sphere often defeats public policy—for example, through lobbying Congress and the President—thus muting the public sphere's impact in an array of areas.[71]

---

70. Other frameworks describing the dichotomy between individual and community approaches include dispositionism vs. situationism—whether policymakers should use the locus of individual actors or larger situations, *see* Hanson & Yosifon, *supra* note 60, at 157, 286–87 (explaining the difference between dispositionist and situationist outlooks and exploring their role in policymaking)—and "i-frames vs. s-frames"—mental schemas focusing on individuals or systems. Nick Chater & George Loewenstein, *The i-Frame and the s-Frame: How Focusing on Individual-Level Solutions Has Led Behavioral Public Policy Astray*, BEHAV. & BRAIN SCIS., Sept. 2022, at 1, 1.

71. *See, e.g.*, Melissa Murray & Katherine Shaw, Dobbs *and Democracy*, 137 HARV. L. REV. 728, 781–82 (2024) (arguing that *Citizens United v. FEC* opened the door to increased financial influence over the political process); Lee Drutman, *How Corporate Lobbyists Conquered American Democracy*,

Public policy accomplishes at least two objectives that some parts of industry would like to oppose. The first is fulfilling public services, like providing goods, utilities, and education to the public. The second is monitoring industry by regulating, enforcing the law, and holding industry actors responsible for misconduct. Both pose some threat to corporations: Government services reduce demand for marketized solutions, and checking private power can block some profitable avenues.

Stating that the spheres should co-exist does not solve the core problem of how they should co-exist or how we should guard the public sphere from the core incentive of some companies to render public policy inoperable. Some have suggested publicizing private functions, such as by bringing pharmaceutical development under state control,[72] creating a new national banking system (as opposed to private banking),[73] and the like. This idea could be called "publicization."[74]

Of course, this Article cannot, on its own, answer difficult questions about how to balance public and private power, which types of functions are better suited to public or private control, and optimal safeguards to protect the public sphere. But a clearer conceptual understanding of privatization can serve as a guiding light, in cancer and beyond. In the next Part, I will illustrate how the five forms of privatization apply in a rich, real-world context: cancer.

ATLANTIC (Apr. 20, 2015), https://www.theatlantic.com/business/archive/2015/04/how-corporate-lobbyists-conquered-american-democracy/390822 [https://perma.cc/H82Z-5JPE] (describing the scale and power of corporate lobbying in the United States); Aaron, *supra* note 69, at 184–86 (arguing that various forms of corporate influence have contributed to regulatory decline, particularly at the Food and Drug Administration (FDA)). According to Jody Freeman, private power's influence within "all aspects of governance" suggests that the idea of a separate public sphere may be an illusion. Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 543, 564 (2000).

72. *See* Shweta Kumar, *Formulating Public Pharma*, 110 CORNELL L. REV. (forthcoming 2026), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4993865.

73. *See generally* Lev Menand & Morgan Ricks, *Rebuilding Banking Law: Banks as Public Utilities*, 41 YALE J. ON REGUL. 591 (2024).

74. *C.f.* Freeman, *supra* note 11, at 1285 (describing mechanisms for advancing public aims by extending government control "into realms traditionally thought private"—and seeing privatization as publicizing).

II. THE PRIVATIZATION OF CANCER

Cancer is "a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body."[75] In U.S. culture, cancer is viewed as a terrifying disease. In one 2021 survey, the disease that U.S. adults most feared was cancer—beating heart disease and COVID-19.[76] According to data from 2007–2008, 61.6% of Americans perceive cancer as a death sentence.[77]

There are two contradictory stories of cancer's trajectory in the United States. The first is that we are gradually solving the cancer problem, exemplified by a 33% reduction in cancer mortality since 1991.[78] According to this story, we should double down on our "[e]normous progress" in cancer.[79]

The second story begins with the stubbornly high rate of cancer mortality.[80] It then points to a more recent trend: rising cancer incidence in the United States, particularly among our youth. Mainstream newspapers feature headlines like "Cancer Is Striking More Young People, and Doctors Are Alarmed and Baffled."[81] Every major media company seemingly has covered this problem.[82] We have also seen a shift toward younger people

---

75. *What Is Cancer?*, NAT'L CANCER INST. (Oct. 11, 2021), https://www.cancer.gov/about-cancer/understanding/what-is-cancer [https://perma.cc/BP3R-6W7T].

76. Megan Brenan, *Cancer, Heart Disease Worries Eclipse COVID-19*, GALLUP (Dec. 16, 2021), https://news.gallup.com/poll/358070/cancer-heart-disease-worries-eclipse-covid.aspx [https://perma.cc/7TX3-RD2E].

77. Richard P. Moser et al., *Perceptions of Cancer as a Death Sentence: Prevalence and Consequences*, 19 J. HEALTH PSYCH. 1518, 1518 (2014).

78. Rebecca L. Siegel et al., *Cancer Statistics, 2024*, 74 CA: CANCER J. FOR CLINICIANS 12, 44 (2024).

79. *See* Meredith S. Shiels et al., *Opportunities for Achieving the Cancer Moonshot Goal of a 50% Reduction in Cancer Mortality by 2047*, 13 CANCER DISCOVERY 1084, 1085 (2023) (discussing "the most promising and realistic opportunities to further reduce U.S. cancer death rates").

80. *See id.* (noting that cancer is still the second leading cause of death in the U.S., killing around 600,000 annually).

81. Brianna Abbott, *Cancer Is Striking More Young People, and Doctors Are Alarmed and Baffled*, WALL ST. J. (Jan. 11, 2024), https://www.wsj.com/health/healthcare/cancer-young-people-doctors-baffled-49c766ed [https://perma.cc/DMH4-YDXN].

82. *See, e.g.*, Trisha Pasricha, *More Young People Are Getting Cancer. Can I Lower My Risk?*, WASH. POST (Apr. 15, 2024), https://www.washingtonpost.com/wellness/2024/04/15/why-young-people-get-cancer [https://perma.cc/TC88-GGA5]; Knvul Sheikh, *More Young People Than Ever Will Get Colorectal Cancer This Year*, N.Y. TIMES (Mar. 27, 2024), https://www.nytimes

being diagnosed with cancer, apparently due to changing patterns in social exposure.[83] Therefore, although per-capita mortality is declining (*absolute* mortality is actually increasing),[84] the rising incidence of cancers in the young may be a harbinger of a future rise in mortality rates.

Amid this debate, the most searing critique of our cancer system came on June 16, 2023, when thirty-six oncologists and cancer experts, part of a new group called Common Sense Oncology, penned a stunning article assailing the multi-decade shift to industry control over cancer care and research.[85] The authors conclude the article by calling for refocusing on "outcomes that matter to patients rather than the commercial bottom line."[86] It is hard to understate the importance of this upstart group of oncology researchers in an age when oncologists depend on industry for prestigious clinical trial opportunities. These researchers risk angering the very group that holds the keys to career advancement.[87] Yet these researchers call out, essentially, the corporate capture of cancer.

The Common Sense Oncology Movement offers a useful starting point to begin discussion of privatization—the shift from "community" approaches to those centered on individuals and firms.[88] The privatization of cancer occurs via the overlapping actions of numerous institutions, actors, and policies that can be difficult to disentangle. Not only does the sprawling nature of privatized cancer treatment create a veil of complexity, but it contributes to the problem itself by making the shift in approach more difficult for the public to detect.

This Part will apply the theory of privatization to illustrate how power was transferred from public to private hands in the world of cancer and how the critical social function of addressing cancer became individualized and corporatized, ultimately to the detriment of patients and public health. I will analyze the

.com/2024/03/27/well/colon-cancer-symptoms-treatment.html [https://perma.cc/TDZ2-3MRJ].

83. Siegel et al., *supra* note 78, at 6.

84. *Id.* at 32–33.

85. Booth et al., *supra* note 3.

86. *Id.* at 834.

87. *See infra* Part II.C.2.

88. *See* Booth et al., *supra* note 3.

operation of delegation, individualization, marketization, capture, and cultural privatization.

A. DELEGATION

While many are aware that public control over firefighting,[89] prisons,[90] and utility management[91] has frequently been delegated to corporations, the delegation of cancer was more subtle. It generally occurred through *automatic coverage provisions*—legal requirements that public and private insurers pay for cancer drugs and screenings that pass evidentiary tests embedded in Food and Drug Administration (FDA) and healthcare law. Collectively, the hundreds of billions of dollars in state spending on cancer drugs and screenings represents an enormous delegation of wherewithal to manage cancer.[92] I will discuss automatic coverage provisions for drugs in the first Subsection, before turning to screenings in the second.

To be clear, spending on cancer drugs and screenings is not inherently ill-advised. Later, however, I argue that the vetting processes for cancer drugs and screenings have been partially captured.[93]

1. Automatic Coverage of Drugs

Under federal and state law, the bevy of cancer pharmaceuticals the FDA is approving[94] are usually guaranteed to be covered by insurers. Rachel Sachs's seminal article, *Delinking Reimbursement*, walks through the automatic coverage provisions connecting FDA approval with federal and state funds.[95]

89. *See* Lois Parshley, *The Firefighting Fire Sale*, LEVER (Feb. 27, 2025), https://www.levernews.com/the-firefighting-fire-sale [https://perma.cc/ZRJ6-DFYY] (describing increased delegation of U.S. Forest Service fire management to private companies).

90. *See* Dolovich, *supra* note 32.

91. *See* Welton, *supra* note 16, at 192.

92. Automatic coverage provisions also trigger spending of private healthcare resources—which could be conceived of as belonging to the public, as health insurers in the United States must generally spend at least 85% of premium revenue on healthcare benefits. Hayden Rooke-Ley et al., *Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All*, 391 NEW ENG. J. MED. 97, 98 (2024).

93. *See infra* Part II.D.

94. *Id.*

95. Rachel E. Sachs, *Delinking Reimbursement*, 102 MINN. L. REV. 2307, 2311–21 (2018).

Together, these legal provisions amount to a massive delegation of government power to private industry. While it may be logical to pay for drugs for patients whose lives are at risk,[96] one must, at minimum, observe that this delegation has occurred.

To unpack the law, the main players in insurance coverage are Medicare (Parts B and D), Medicaid, and private plans. Medicare Part B covers drugs that are not self-administered, are provided as part of a physician's care, and are "reasonable and necessary for the diagnosis or treatment of illness or injury."[97] Although the Center for Medicare and Medicaid Services (CMS) issues coverage determinations, in practice, coverage is quite broad,[98] and a chemotherapy agent would generally fall in the "reasonable and necessary" bucket, thus mandating coverage. Medicare Part D, intended for drugs outside of Medicare Part B, must cover nearly all anti-cancer drugs.[99] In Medicaid, all states have opted into covering drug costs, and so, by law, they are required to pay for nearly all FDA-approved drugs.[100] For private plans, forty-six states require private insurers to cover *all* FDA-approved cancer drugs.[101]

The result of these measures is a broad delegation of healthcare dollars to private industry.

---

96. Unfortunately, the average utility of these drugs is low. *See infra* Part II.D.1.

97. Sachs, *supra* note 95, at 2314–15 (quoting 42 U.S.C. § 1395y(a)(1)(A)).

98. *Id.* at 2315.

99. *Id.* at 2315–16; 42 U.S.C. § 1395w-104(b)(3)(G)(iv)(III). Where a cancer drug is used off-label, Medicare instead covers all drugs in at least one of five privately owned "drug compendia." Angela K. Green et al., *Time to Reassess the Cancer Compendia for Off-Label Drug Coverage in Oncology*, 316 JAMA 1541, 1541 (2016). These compendia can be financially conflicted. *See* Aaron P. Mitchell et al., *Financial Relationships with Industry Among National Comprehensive Cancer Network Guideline Authors*, 2 JAMA ONCOLOGY 1628, 1628 (2016) (finding that 86% of authors of one compendium had financial conflicts).

100. 42 U.S.C. § 1396r-8(k)(2); Sachs, *supra* note 95, at 2316–17.

101. LEWIS A. GROSSMAN, CHOOSE YOUR MEDICINE: FREEDOM OF THERAPEUTIC CHOICE IN AMERICA 277 (2021). For off-label use, drug compendia are influential. Edward R. Scheffer Cliff et al., *National Comprehensive Cancer Network Guideline Recommendations of Cancer Drugs with Accelerated Approval*, JAMA NETWORK OPEN, Nov. 2023, at 2, 7.

2. Automatic Coverage of Cancer Screenings

Cancer screening—testing asymptomatic patients at average risk for cancer[102]—seems like a no-brainer for cancer policy. For drugs, I will discuss the vetting process later,[103] but it suffices for now to show that a delegation of power—the first form of privatization—has occurred.

As a matter of law, most health insurers must cover cancer screenings. Ever since the Affordable Care Act (ACA),[104] individual and group health plans, as well as employer-sponsored plans, must generally cover all "evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force" (USPSTF).[105] Medicaid in expansion states must also cover cancer screenings rated "A" or "B" by the USPSTF.[106] The ACA did not require Medicare to cover these services, but it gave the Secretary of Health and Human Services the authority to modify coverage of "any preventive service" to be in line with USPSTF recommendations,[107] and cost-sharing is forbidden for preventive services it covers.[108] Medicare, as of 2025, covers all USPSTF-recommended cancer screenings.[109]

The USPSTF has rated the following cancer screenings "A" or "B":

- Breast cancer screening, ages 40–74;
- Cervical cancer screening, ages 21–65;
- Colorectal cancer screening, ages 45–75;

---

102. Crystal D. Taylor et al., *Redefining Cancer Screening Coverage—Screening to Diagnosis*, JAMA HEALTH F., Sept. 2024, at 1, 1.

103. *See infra* Part II.D.

104. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

105. 42 U.S.C. § 300gg-13(a)(1); Naomi Seiler et al., *Coverage of Clinical Preventive Services Under the Affordable Care Act: From Law to Access*, 129 PUB. HEALTH REPS. 526, 530 (2014).

106. Seiler et al., *supra* note 105, at 530.

107. Patient Protection and Affordable Care Act § 4105, 42 U.S.C. § 1395m(n).

108. *Id.* § 4104; Seiler et al., *supra* note 105, at 530.

109. *Medicare Coverage for Cancer Prevention and Early Detection*, AM. CANCER SOC'Y (last updated Feb. 13, 2025), https://www.cancer.org/content/dam/CRC/PDF/Public/301.00.pdf [https://perma.cc/SQT5-N4X2] (indicating Medicare coverage for USPSTF-recommended breast, cervical, colorectal, and lung cancer screenings).

• Lung cancer screening (with smoking history), ages 50–80.[110]

Health plans are mandated to shell out enormous sums of money for these cancer screenings. We spend $27.5 billion annually on colorectal cancer screening,[111] $8.8 billion each year on mammograms,[112] and $21 billion annually on cancer screenings for people for whom it is not even recommended[113]—placing our faith in private actors by funding their services, equipment, and personnel.

B. INDIVIDUALIZATION

While the law could take numerous approaches to combatting cancer, public-law approaches have given way to individualized and medicalized interventions. The individualization seen within cancer has a complex provenance, which includes automatic coverage provisions that subsidize the sale and marketing of individualized interventions,[114] as well as cultural reinforcement of the idea that cancer is a problem tackled through ex-post medical interventions.[115] Therefore, other aspects of privatization have contributed to the emphasis on individualized solutions. Generally, approaches that center private business are likely to be individualizing because businesses tend to produce products for purchase in markets.

This Section will unpack two individualizing changes in cancer law. First, I will summarize literature on the public-law world of cancer and reveal the dire position of federal regulatory agencies. The failures of cancer governance have hollowed out non-individualized approaches to cancer. Second, I will discuss the best-known cancer policy in the United States, the Cancer

110. *A & B Recommendations*, U.S. PREVENTIVE SERVS. TASK FORCE, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations [https://perma.cc/4879-PZCC].

111. Michael T. Halpern et al., *The Annual Cost of Cancer Screening in the United States*, 177 ANNALS INTERNAL MED. 1170, 1172 (2024).

112. *Id.* at 1173.

113. David Ropeik, *A 'More, More, More' Approach to Cancer Screening Is Misleading and Harmful*, STAT (Feb. 24, 2022), https://www.statnews.com/2022/02/24/more-more-more-approach-cancer-screening-harmful [https://perma.cc/VR48-8Y8W].

114. *See supra* Part II.A.

115. *See infra* Part II.E.

Moonshot, and discuss how it favors individualized approaches while distracting from regulatory dysfunction.

1. The Deregulation of Cancer

Deregulation is generally viewed among legal scholars as a form of privatization.[116] That is because deregulation of the public sphere increases the latitude and power of private corporations.[117] It also shifts the locus of action to a more local, individual level.

In *The Deregulation of Cancer*, I take a hard look at the exposures causing cancer in the United States (Table 2) and the regulatory regimes designed to address them.[118] Although data are limited, the top causes of cancer deaths are tobacco, diet, and environmental exposures.[119]

Table 2: Causes of cancer cases and deaths in the U.S.[120]

SYSTEMIC FACTOR	% OF ALL CANCER CASES	% OF ALL CANCER DEATHS
EXCESS BODY WEIGHT	4–20%	Up to 20%
TOBACCO	19%	30%
ALCOHOL	4.8–5.6%	3.5%
DIET	5–35%	35%
OCCUPATIONAL EXPOSURES	2–8%	4–10%

116. Savas, *supra* note 29, at 1731; Konnoth, *supra* note 11, at 1953.

117. *See* Konnoth, *supra* note 11, at 1953 (arguing that deregulation allows private entities to develop their own rules of conduct in a given industry).

118. *See generally* Aaron, *supra* note 10.

119. *Id.* (manuscript at 17–18). Excess body weight is associated with various cancers. Daniel G. Aaron & Fatima Cody Stanford, *Is Obesity a Manifestation of Systemic Racism? A Ten-Point Strategy for Study and Intervention*, 290 J. INTERNAL MED. 416, 418 (2021). It is not listed in the text nor added to the table totals because it overlaps significantly with diet.

120. Aaron, *supra* note 10 (manuscript at 17–18). While I total these percentages, this is no substitute for rigorous evaluation of how multiple carcinogens and other causes of cancer (e.g., genetics) intersect. References and other caveats are provided in *The Deregulation of Cancer*. *See id.* The table is intended to illustrate that cancer is substantially an environmental disease caused by exposures. (And the table neglects many other exposures, including ones that have not been adequately studied.).

ULTRAVIOLET RADIATION	4–6%	~2%
RADON	1.7%	3.5%
SUM (EXCLUDING EXCESS BODY WEIGHT)	**37–76%**	**78–84%**

Together, these data, which reveal that much or most cancer mortality is socially caused, highlight the need to regulate carcinogens in our environment.

However, U.S. cancer regulatory regimes are often splintered and dysfunctional.[121] The FDA, the major U.S. regulator of food and tobacco, has been embroiled in major controversies over its tobacco and food regulatory centers.[122] Statutory defects, insufficient funding and personnel, and judicial decisions have nearly nullified the FDA's regulation of carcinogens.[123] Serious

121. Deregulation is of course not unique to cancer. *See, e.g.*, Daniel G. Aaron, *Contesting Deregulation and Medicalization to Revitalize Public Health*, 114 AM. J. PUB. HEALTH 968 (2024) (examining deregulation generally but focusing on food); Micah L. Berman, *The Faltering Promise of FDA Tobacco Regulation*, 12 ST. LOUIS U. J. HEALTH L. & POL'Y 145 (2018) (tobacco); Daniel G. Aaron, Connor R. Wallace & Michael S. Sinha, *Including E-Cigarettes in the FDA Rule Limiting Nicotine*, 330 JAMA 1129 (2023) (tobacco); Daniel G. Aaron, I. Glenn Cohen & Eli Y. Adashi, *The FDA Struggle to Withdraw Makena: Problems with the Accelerated Approval Process*, 328 JAMA 2394 (2022) (pharmaceuticals); Matthew Herder, *Aducanumab, Accelerated Approvals & the Agency: Why the FDA Needs Structural Reform*, 51 J.L. MED. & ETHICS 900 (2023) (pharmaceuticals); Rachel Rothschild, *Unreasonable Risk: The Failure to Ban Asbestos and the Future of Toxic Substances Regulation*, 47 HARV. ENV'T L. REV. 529 (2023) (toxic substances); Jennifer L. Pomeranz et al., *Regulation of Added Substances in the Food Supply by the Food and Drug Administration Human Foods Program*, 114 AM. J. PUB. HEALTH 1061 (2024) (food additives).

122. *See, e.g.*, Berman, *supra* note 121, at 145 ("[T]he FDA is now scrambling to address a youth e-cigarette epidemic that caught it off guard."); Aaron, Wallace, & Sinha, *supra* note 121, at 1129 (describing the FDA's failure to limit nicotine in combustible tobacco); Pomeranz et al., *supra* note 121, at 1061 (highlighting concerns and potential shortcomings with FDA regulation of food additives); Helena Bottemiller Evich, *The FDA's Food Failure*, POLITICO (Apr. 8, 2022), https://www.politico.com/interactives/2022/fda-fails-regulate-food-health-safety-hazards [https://perma.cc/535N-E6UQ].

123. *See, e.g.*, Aaron, *supra* note 10 (describing the deregulation of carcinogens); Pomeranz et al., *supra* note 121, at 1065 (explaining the barriers to effective FDA review of cancer-linked food additives).

flaws likewise exist with regulation of air, water, and toxic substances by the Environmental Protection Agency (EPA).[124]

Moreover, although tort law has known regulatory functions, doctrinal developments have rendered it inadequate, largely negating the public impact of toxic tort lawsuits.[125] Courts have imposed an unusually high causation burden for toxic tort plaintiffs, capped punitive damages and the powerful incentives thereof, weakened aggregation mechanisms like the class action that encourage private-attorney-general suits, and narrowed strict liability in favor of fault-based liability—despite fault being difficult to prove for long-term or old carcinogen exposures.[126]

The media have not appropriately covered these regulatory defeats, instead reinforcing the notion that cancer is an individualized problem. Cultural privatization, operating through media, is discussed later.[127] Individualization and cultural privatization can be mutually reinforcing, in the same way that the media (1) emphasizes medical drama over public health activity and (2) delights in true-crime legal investigations more than crime prevention through ameliorating poverty, public housing, and public health.[128]

---

124. *See, e.g.*, Rothschild, *supra* note 121, at 533–44 (describing the Environmental Protection Agency's (EPA) struggle to successfully regulate asbestos); Ann E. Carlson, *The Clean Air Act's Blind Spot: Microclimates and Hotspot Pollution*, 65 UCLA L. REV. 1036, 1036 (2018) (describing the failure of the Clean Air Act to manage air pollution hotspots); City of San Francisco v. EPA, 145 S. Ct. 704, 707 (2025) (curbing the EPA's ability to impose certain types of water pollution limitations under the Clean Water Act).

125. *See* Aaron, *supra* note 10 (manuscript at 44–51) (citing scholars about the regulatory impact of tort law and describing relevant doctrinal developments in toxic torts).

126. *Id.*

127. *See infra* Part II.E.

128. *How Media Copaganda Hides the Truth About the US Punishment Bureaucracy,* CURRENT AFFS. (Sept. 15, 2022), https://www.currentaffairs.org/news/2022/09/how-media-copaganda-hides-the-truth-about-the-us-punishment-bureaucracy [https://perma.cc/2NNH-9SFB]; *cf.* Benjamin Levin, *De-Naturalizing Criminal Law: Of Public Perceptions and Procedural Protections*, 76 ALB. L. REV. 1777, 1786 (2013) (arguing that dominant cultural narratives about crime focus on extreme individual cases, diverting attention from systemic questions). *See generally* ALEC KARAKATSANIS, COPAGANDA: HOW POLICE AND THE MEDIA MANIPULATE OUR NEWS (2025).

2. The Cancer Moonshot

As the best-known U.S. cancer policy, the Beau Biden Cancer Moonshot aims to "use the power of data to generate real solutions for treating cancer."[129] Inspired by Joe Biden's experience with his son's brain cancer, the "moonshot" harkens to humans' goal of reaching the moon, which, though it seemed impossible, we accomplished in 1969.[130] Curing cancer evokes similar feelings—a grand feat, the promise of new technology. It appears to have been such a political winner that President Biden renewed the program in 2022, announcing a "Cancer Cabinet" and driving public awareness, although with no additional funding.[131]

The Moonshot is contained in the 21st Century Cures Act,[132] and the statutory policy is decidedly simple: It creates an "NIH Innovation Account" containing about $4.8 billion dollars, split nearly three ways among precision medicine, neurotechnology, and cancer.[133] The $1.8 billion for the moonshot is "[t]o support cancer research, such as the development of cancer vaccines, the development of more sensitive diagnostic tests for cancer, immunotherapy and the development of combination therapies, and research that has the potential to transform the scientific field, that has inherently higher risk, and that seeks to address major challenges related to cancer."[134] These uses of funds are decidedly medicalized, i.e., individualized.[135]

---

129. Jacob S. Sherkow, *Cancer's IP*, 96 N.C. L. REV. 297, 299–300 (2018) (emphasis omitted) (quoting Greg Simon, *The Cancer Moonshot: Achieving Lift Off*, MEDIUM (May 24, 2016), https://medium.com/cancer-moonshot/the-cancer-moonshot-achieving-lift-off-aa22a1b37c43 [https://perma.cc/6D9U-M3KG]).

130. Greg Simon, *The Cancer Moonshot: Achieving Lift Off*, MEDIUM (May 24, 2016), https://medium.com/cancer-moonshot/the-cancer-moonshot-achieving-lift-off-aa22a1b37c43 [https://perma.cc/6D9U-M3KG].

131. Donald Judd & Kate Sullivan, *Biden Relaunches 'Cancer Moonshot' Initiative Aimed at Halving Rate of Cancer Deaths by 2047*, CNN (Feb. 2, 2022), https://www.cnn.com/2022/02/02/politics/cancer-moonshot-initiative-white-house-biden/index.html [https://perma.cc/Y64V-RSP9].

132. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

133. *Id.* §§ 1001(b)(1), (b)(4)(A)–(C).

134. *Id.* § 1001(b)(4)(C).

135. The Biden Administration attempted to connect the Cancer Moonshot with efforts at regulatory agencies to address carcinogens. *See Cancer Moonshot*, WHITE HOUSE, https://bidenwhitehouse.archives.gov/cancermoonshot [https://perma.cc/U7Q5-UN9X]. These are not the focus of the moonshot, however, either in the authorizing statute or in most public communications

Though technically public policy, the Cancer Moonshot funds have generated a "series of public-private partnerships" amounting to a large capital investment into private development of cancer therapeutics.[136] The Moonshot largely omits cancer prevention in favor of individualized cancer interventions.

Jacob Sherkow has argued the Cancer Moonshot also produces the public good of "scientific information."[137] But with privatization being on a spectrum, information about one-by-one treatment neglects social patterns and underlying causes of disease and remains fairly individualized.[138]

Moreover, despite the Cancer Moonshot's big name, its monetary contribution to cancer research is small. Viewed in context, the Cancer Moonshot looks like an unimpressive small bump in the budget of the National Cancer Institute (NCI). The NCI's annual budget is $7.3 billion, as of 2023.[139] So, the $216 million from the Moonshot in 2023[140] amounted to 3% of NCI's 2023 budget. Granted, $1.8 billion over seven years is not nothing. But, for context, the NCI's annual budget increase in 2023 exceeded its entire 2023 funding from the Cancer Moonshot by almost twofold.[141] As Ezekiel Emanuel has pointed out, cancer research was already flush with money.[142]

---

materials, including the main website. *See Cancer Moonshot*, NAT'L CANCER INST., https://web.archive.org/web/20230915045339/www.cancer.gov/research/key
-initiatives/moonshot-cancer-initiative [https://perma.cc/TQV5-RLYS] (naming the goals as "to accelerate scientific discovery in cancer, foster greater collaboration, and improve the sharing of cancer data").

136. Sherkow, *supra* note 129, at 300, 353.

137. *Id.* at 300.

138. However, information about the public causes and possible public and regulatory approaches to cancer would be less individualized.

139. *NCI Budget and Appropriations*, NAT'L CANCER INST. (last updated Sept. 6, 2023), https://web.archive.org/web/20231001052401/https://www.cancer.gov/about-nci/budget#what-is-ncis-current-fiscal-year-2023-fy23-budget [https://perma.cc/3KZ2-D58P].

140. 21st Century Cures Act, Pub. L. No. 114-255, § 1001(b)(4)(C)(vii), 130 Stat. 1033, 1041 (2016).

141. *See Research Gets Funding Boost for FY 2023*, 13 CANCER DISCOVERY 520, 520 (2023) (noting NCI's funding increased by $407.6 million in 2023).

142. Erin Schumaker & Ruth Reader, *Biden's Moonshot Examined: Researchers Say Cancer Cure Is a Long Ways Off*, POLITICO (Feb. 10, 2023), https://www.politico.com/news/2023/02/10/scientists-say-cancer-moonshot-is-largesse-00082345 [https://perma.cc/5QEJ-KGSJ]. Although it is hard to argue we are truly "overinvested" in solving a disease that kills over a half-million

For the public hype it receives, and its stated goal of finding "real solutions" to cancer,[143] the Moonshot program should be addressing root problems that cause the vast majority of cancer deaths. Instead, amounting to about three pennies on the dollar of NCI funding, the "moonshot" appears to be largely pomp, designed to secure public support for medicalized solutions (and the politicians pushing them).

The individualized approach of modern cancer policy leaves an opening for markets to become the de facto solution to cancer.

C. MARKETIZATION

Marketization is "the process by which the delivery and content of a social service is transformed by market logics."[144] Along with its cousin neoliberalism, marketization favors the "imperatives of profit," the freedom to spend one's capital, and minimalist governance.[145]

To illustrate how marketization illuminates the privatization of cancer, I will demonstrate, first, how legal reforms allowed universities and cancer centers to profit from cancer research and medical care. Second, I will lay out the legal incentives that imbued these institutions with a thirst for profit. As law restructured the legal permission and incentives, various entities joined the for-profit cancer enterprise. Legal scholars have described the financialization and corporatization of medicine more broadly,[146] although the incentives in cancer differ by law, to a degree.

---

people each year, we arguably are overinvested in individualized technological solutions to cancer, as this Article argues.

143. Sherkow, *supra* note 129, at 300.

144. Elenore Wade, *The Undeserving Poor and the Marketization of Medicaid*, 72 BUFF. L. REV. 875, 880 (2024). Scholars like David Grewal and Jedediah Purdy have expounded on the "contest between the imperatives of market economics and nonmarket values." David Singh Grewal & Jedediah Purdy, *Introduction: Law and Neoliberalism*, 77 LAW & CONTEMP. PROBS., no. 4, 2014, at 1, 2.

145. *See* Britton-Purdy et al., *supra* note 67, at 1826, 1828.

146. *See, e.g.*, Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527 (2024); Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 UC DAVIS L. REV. 2149 (2021); Metzger, *supra* note 11; Dan Weiss, Comment, *Privatization and Its Discontents: The Troubling Record of Privatized Prison Health Care*, 86 U. COLO. L. REV. 725 (2015); Joseph Dov Bruch et al., *The Financialization of Health in the United States*, 390 NEW ENG. J. MED.

These changes also help answer a critical question: Why did quasi-public-interest institutions, like hospitals, oncology practices, and universities, not oppose the privatization of cancer? These institutions, I argue, were folded into cancer markets.

1. Legal Changes Allowing Market Participation

The legal changes fostering marketization operated differently for research universities and oncology healthcare facilities.

a. Research Universities: Bayh-Dole and Legal Permission to Privatize

A tremendous amount of ink has been spilled about the promise and peril of the Bayh-Dole Act.[147] Traditionally, patents

178 (2024); Clark C. Havighurst, *Starr on the Corporatization and Commodification of Health Care: The Sequel*, 29 J. HEALTH POL., POL'Y & L. 947 (2004); J. WARREN SALMON & STEPHEN L. THOMPSON, THE CORPORATIZATION OF AMERICAN HEALTH CARE (2021); Benjamin Goodair & Aaron Reeves, *The Effect of Health-Care Privatisation on the Quality of Care*, 9 LANCET PUB. HEALTH e199 (2024); Gelman, *supra* note 11; Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES (last updated July 14, 2023), https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html [https://perma.cc/E4N6-RKNA] ("The corporatization of health care has changed the practice of medicine, causing many physicians to feel alienated from their work."); ROBERT W. DERLET, CORPORATIZING AMERICAN HEALTH CARE: HOW WE LOST OUR HEALTH CARE SYSTEM (2021); MIKE MAGEE, CODE BLUE: INSIDE AMERICA'S MEDICAL INDUSTRIAL COMPLEX (2019); Jane M. Zhu et al., *A Doctrine in Name Only — Strengthening Prohibitions Against the Corporate Practice of Medicine*, 389 NEW ENG. J. MED. 965 (2023); Maureen Tkacik, *The AMA Debates a Federal Ban on Corporate Medicine*, AM. PROSPECT (Nov. 13, 2023), https://prospect.org/health/2023-11-13-ama-debates-federal-ban-corporate-medicine [https://perma.cc/RZN3-NSST].

147. *See, e.g.*, Lisa Larrimore Ouellette & Rebecca Weires, *University Patenting: Is Private Law Serving Public Values?*, 2019 MICH. ST. L. REV. 1329; Rebecca S. Eisenberg, *Public Research and Private Development: Patents and Technology Transfer in Government-Sponsored Research*, 82 VA. L. REV. 1663 (1996); Rebecca S. Eisenberg & Robert Cook-Deegan, *Universities: The Fallen Angels of Bayh-Dole?*, DAEDALUS, Fall 2018, at 76; Mark A. Lemley, *Are Universities Patent Trolls?*, 18 FORDHAM INTELL. PROP., MEDIA & ENT. L.J. 611 (2008); Jacob H. Rooksby, *Innovation and Litigation: Tensions Between Universities and Patents and How to Fix Them*, 15 YALE J.L. & TECH. 312 (2013); Christopher J. Ryan, Jr. & Brian L. Frye, *An Empirical Study of University Patent Activity*, 7 N.Y.U. J. INTELL. PROP. & ENT. L. 51 (2017); Michael S. Mireles, *An Examination of Patents, Licensing, Research Tools, and the Tragedy of the Anticommons in Biotechnology Innovation*, 38 U. MICH. J.L. REFORM 141 (2004); Lorelei Ritchie de Larena, *The Price of Progress: Are Universities Adding to the Cost?*, 43 HOUS. L. REV. 1373 (2007); Margo A. Bagley, *Academic Discourse and Proprietary Rights: Putting Patents in Their Proper Place*, 47 B.C.

stemming from federally funded inventions were retained by the federal government.[148] The Bayh-Dole Act, passed in 1980, allows universities that receive federal grants to patent and license (to third-party corporations) any resulting inventions,[149] thereby enlisting universities in a for-profit, intellectual-property-driven innovation system.[150] This system is widely acknowledged as a scheme for "privatization of publicly funded university research."[151]

Criticism of Bayh-Dole has grown over time,[152] largely because it increases the cost of purchasing inventions, such as pharmaceuticals, protected by a university's patent monopoly as a result of Bayh-Dole.[153] The incentive to keep discoveries secret to protect their profitability may also clash with universities' traditional function of higher learning and expanding public knowledge.[154] Ximena Benavides calls universities' shift of focus from the public interest to shareholder profit the "financialization of medical research."[155] On the other hand, it has been justified as subsidizing the cost of commercialization of inventions,

---

L. REV. 217 (2006); Gary Pulsinelli, *Share and Share Alike: Increasing Access to Government-Funded Inventions Under the Bayh-Dole Act*, 7 MINN. J.L. SCI. & TECH. 393 (2006); Arti K. Rai & Rebecca S. Eisenberg, *Bayh-Dole Reform and the Progress of Biomedicine*, LAW & CONTEMP. PROBS., Winter/Spring 2003, at 28; Tohru Takebe et al., *The Current Status of Drug Discovery and Development as Originated in United States Academia: The Influence of Industrial and Academic Collaboration on Drug Discovery and Development*, 11 CLINICAL & TRANSLATION SCI. 597 (2018); Emily Michiko Morris, *The Many Faces of Bayh-Dole*, 54 DUQ. L. REV. 81 (2016).

148. Mary Eberle, *March-In Rights Under the Bayh-Dole Act: Public Access to Federally Funded Research*, 3 MARQ. INTELL. PROP. L.J. 155, 155 (1999).

149. Ouellette & Weires, *supra* note 147, at 1330.

150. Kapczynski & Syed, *supra* note 18, at 1953 n.170. Some universities were involved in patenting before Bayh-Dole, but Bayh-Dole accelerated privatization. *See* David C. Mowery et al., *The Growth of Patenting and Licensing by U.S. Universities: An Assessment of the Effects of the Bayh–Dole Act of 1980*, 30 RSCH. POL'Y 99, 116 (2001) (noting that universities' patenting and licensing activities are frequently attributed to Bayh-Dole).

151. Ouellette & Weires, *supra* note 147, at 1330.

152. *Id.*

153. Eisenberg & Cook-Deegan, *supra* note 147, at 78.

154. Morris, *supra* note 147, at 83.

155. Ximena Benavides, Beyond Patents: Resetting Medical Progress with Relational Grants (Mar. 15, 2025) (unpublished manuscript) (on file with the Minnesota Law Review).

thus encouraging universities to carry through their biomedical research to the patient bedside.[156]

Regardless of this debate, privatizing incentives have, in some ways, shaped the conduct and priorities of research universities such that they are increasingly behaving like private actors.

For one, universities, often intent on "maximizing the university's licensing revenue," are behaving like "patent trolls."[157] Patent trolls are entities that acquire large numbers of patents and then engage in sometimes "abusive" lawsuits[158] to obtain a financial share of someone else's product.[159] Despite the intent of Bayh-Dole to foster the commercialization of inventions, universities' "anticipatory poaching"[160] of inventions can sometimes stymie such commercialization,[161] and biomedical research more generally, by forcing manufacturers to navigate new patents incentivized by Bayh-Dole.[162]

---

156. *See* Ouellette & Weires, *supra* note 147, at 1331 (concluding that "the benefits of university patenting may justify costs where licensees need exclusivity to undertake the cost of commercialization"); Mowery et al., *supra* note 150, at 116 (finding that the "data . . . suggest that, for universities already active in patenting and licensing, Bayh-Dole resulted in expanded efforts to market academic inventions"); Goshen David Miteu, *Patenting: The Bayh–Dole Act and Its Transformative Impact on Science Innovation and Commercialization*, 86 ANNALS MED. & SURGERY 3192, 3194 (2024) ("The Act undoubtedly accelerated the pace of technological advancements. Innovations, once confined to academic journals, now found their way into the public domain at an unprecedented speed, enriching lives, especially with novel or improved therapeutic development in life sciences.").

157. Lemley, *supra* note 147, at 611.

158. Max Baucus, *It's Time for the U.S. to Tackle Patent Trolls*, HARV. BUS. REV. (Sept. 16, 2022), https://hbr.org/2022/09/its-time-for-the-u-s-to-tackle-patent-trolls [https://perma.cc/62W2-GLCC]; *see* Bhaven N. Sampat, *Lessons from Bayh-Dole*, 468 NATURE 755, 756 (2010) (arguing Bayh-Dole encouraged excessive patenting).

159. Lemley, *supra* note 147, at 614–16; Eisenberg & Cook-Deegan, *supra* note 147, at 79.

160. Eisenberg & Cook-Deegan, *supra* note 147, at 81.

161. *Id.* at 86.

162. *See* Lemley, *supra* note 147, at 613 (identifying the problem of "patent hold-up" where "product developer[s] . . . that must aggregate thousands of different inventions . . . [are] vulnerable to hold-up by any one of the thousands of inventors"); Rai & Eisenberg, *supra* note 147, at 291 ("This frenzy of proprietary claiming . . . may hinder rather than accelerate biomedical research."); *id.* at 302 (noting that often "upstream patents issued to academic institutions serve as a tax on innovation"); Ariad Pharms., Inc. v. Eli Lilly & Co., 598 F.3d 1336, 1353 (Fed. Cir. 2010) (en banc) (involving Harvard's and MIT's attempts to patent, essentially, a basic science research finding).

Second, despite a long tradition of scientists presenting and publishing their conclusions at various stages of their research, universities are now incentivized to guard research findings in order to later seek patent protection, which must be done within twelve months after a patent is shared with the public.[163] New information, if released, could facilitate inventions by others and reduce duplicative work—although Bayh-Dole's impact on innovative research is debated.[164]

Third, because Bayh-Dole rewards research that leads to patented inventions, universities are incentivized to prioritize research toward biomedical inventions, like pharmaceuticals, rather than, say, research on regulation and public health (e.g., banning certain tobacco products or other carcinogens).[165] As Jacob Rooksby has argued,

> Most likely the traditional . . . conception of universities as socially detached and disinterested bastions of general and specialized knowledge increasingly will be supplemented or even wholly supplanted with a conception of the American research university as firmly market-situated by design. Many signs indicate that such reconstruction of the modern research university is well underway. No longer indifferent to the concerns of society's markets, the socially embedded modern university is very much a part of them.[166]

While the privatized university is not inherently malicious, the Bayh-Dole Act legally empowered universities to prioritize financial self-interest, on the grounds that privatized university

163. *See* Bagley, *supra* note 147, at 220; *see also* Eisenberg, *Public Research*, *supra* note 147, at 1666–67 (noting that the incentives risk "impoverish[ing] the public domain of research science"); Eisenberg & Cook-Deegan, *supra* note 147, at 84 (describing a "decline of academic sharing norms").

164. *See* Sampat, *supra* note 158, at 755–56 (noting that "Bayh-Dole has been widely celebrated" but also that it "replaced one set of frictions with another," namely replacing underpatenting with overpatenting); Daniel J. Hemel & Lisa Larrimore Ouellette, *Bayh-Dole Beyond Borders*, 4 J.L. & BIOSCIENCES 282, 282–84 (2017) (describing debate over the social benefits and cost and access concerns stemming from Bayh-Dole). The major U.S. pharmaceutical lobbying group PhRMA has released a "fact sheet" calling the Bayh-Dole Act "landmark legislation" that "ensures that innovative ideas are protected and brought to market." *The Bayh-Dole Act: Spurring American Biopharmaceutical Innovation*, PHRMA (Oct. 20, 2022), https://phrma.org/resources/the-bayh-dole-act-spurring-american-biopharmaceutical-innovation [https://perma.cc/3RFP-JDWV].

165. *See* Mowery et al., *supra* note 150, at 117 ("[T]he content of U.S. universities' research has shifted toward biomedical research . . . .").

166. Rooksby, *supra* note 147, at 356.

practices will benefit the public by accelerating innovation.[167] While fully parsing the benefits and harms of these privatization incentives on universities would require a book, I will argue later that many of the research developments in cancer are minimally benefitting the public interest.[168]

Part of the problem is that solving the pressing problems causing cancer—tobacco and food—is not associated with potential profit. Amy Kapzynski and Talha Syed have powerfully argued that patent-based systems "fail to create goods whose value is difficult to appropriate in consumer markets."[169] Few of the "million or more" chemicals that humans are exposed to throughout their life course are routinely monitored, and many are considered research "dark matter."[170] It is not clear who would profit from this research in a marketized system. Some of the most valuable research takes "highly abstract, intangible forms" that are "ill suited to be generated by markets and patents."[171]

b. Cancer Care Advertising

The legal incentives for the privatization of the university operated in parallel with changes in health care. Initially, the marketization of health care was prohibited by the Principles of Medical Ethics of the American Medical Association (AMA).[172] While the Principles were not binding in and of themselves, the

167. *See* Sampat, *supra* note 158, at 755 (highlighting that since the passage of Bayh-Dole, "the number of patents that universities have been granted has climbed from fewer than 300 a year to more than 3,000," and "US universities now earn almost US$2 billion annually"). Some might counterargue that technology transfer offices are unprofitable, and their revenue is small (about 4% on average) within a university's budget. *Technology Transfer in U.S. Research Universities: Dispelling Common Myths*, COGR 4 (2022), https://web.archive.org/web/20220810013826/https://www.cogr.edu/sites/default/files/Myths_Final%2008-01-22.pdf [https://perma.cc/D5NL-6KAM]. But this limited profit does not mean there is no incentive; the same report describes why universities are "so active in partnering with industries." *Id.* at 1. And the small average disguises the high revenue at a small number of universities (9 universities accounted for 51% of licensing revenue as of 2020, according to COGR). *Id.* at 4. Universities may understandably wish to become one of the top earners.

168. *See infra* Part II.D.

169. Kapczynski & Syed, *supra* note 18, at 1900.

170. Xin Hu et al., *A Scalable Workflow to Characterize the Human Exposome*, NATURE COMMS., Sept. 22, 2021, at 1, 2.

171. Kapczynski & Syed, *supra* note 18, at 1951.

172. Brown & Hall, *supra* note 146, at 563.

AMA lobbied state legislatures to enshrine them into law.[173] The AMA also required its organizational members to adopt them.[174] The Principles "play[ed] a central role in delineating the ethical standards for physicians in this country"[175] and sought to safeguard physicians as "independent decision-makers who cared for nothing but the scientific treatment of patients."[176]

A key Principle was discouraging the advertising of medical services as inconsistent with physician integrity.[177] Arguably, the AMA was forestalling the marketization of medical care. The Federal Trade Commission (FTC) sued, arguing that the Principles were a restraint of competition in health care.[178] When the case reached the Supreme Court, the court split 4-4, leaving a Second Circuit ruling against the AMA intact.[179] The FTC's cease-and-desist order resulting from the case is incredibly broad, prohibiting (1) any restriction on providing information about medical services, (2) any interference with physicians' arrangements and the consideration paid therefor, and (3) advising on the ethical propriety of these arrangements.[180]

Although it is true the FTC may have increased healthcare competition by allowing the advertising of prices,[181] its order opened the door to medical marketing of all stripes, fostering the corporatization of cancer care. Only 5% of cancer-center, direct-

---

173. *Id.*; Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX: J.L.-MED. 243, 243 (2004).

174. *In re* Am. Med. Ass'n, 94 F.T.C. 701, 996–97 (1979), *aff'd in part sub nom.*, Am. Med. Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam*, 455 U.S. 676 (1982).

175. *Id.* at 997.

176. Huberfeld, *supra* note 173, at 248.

177. Fay J. Hlubocky et al., *Direct-to-Consumer Advertising for Cancer Centers and Institutes: Ethical Dilemmas and Practical Implications*, 40 AM. SOC'Y CLINICAL ONCOLOGY EDUC. BOOK e207, e208 (2020).

178. *Id.*

179. Am. Med. Ass'n v. FTC, 455 U.S. 676 (1982) (per curiam); Ernest G. Barnes, *The Federal Trade Commission's* American Medical Association *Case and Other Health-Related Activities*, 37 FOOD DRUG COSM. L.J. 237, 237–38 (1982).

180. Barnes, *supra* note 179, at 239.

181. Kelly Signs, *FTC Milestone: A New Age Dawns for the FTC's Competition Work*, FED. TRADE COMM'N (Feb. 20, 2015), https://www.ftc.gov/enforcement/competition-matters/2015/02/ftc-milestone-new-age-dawns-ftcs-competition-work [https://perma.cc/C65J-CXAS].

to-consumer advertisements present cost information.[182] Only 2% discuss risks.[183] More commonly, they promote treatments (88%), use emotional appeals (85%), evoke hope (61%), suggest cancer is a fight (41%), and include patient testimonials (50%).[184] These appeals arguably raise "ethical dilemmas" when they seem designed to draw in patients with a false promise,[185] and they reveal the "underbelly of marketplace health care" in cancer.[186]

In lifting the ethics infrastructure on physician promotion, the courts legally allowed privatization by marketization.

c. Deregulation of Financial Arrangements

A final legal change enabling the marketization of cancer care was the deregulation of physician financial arrangements. The AMA litigation above already had neutered ethical constraints on these arrangements, but another step was the erosion of corporate practice of medicine (CPOM) laws. CPOM laws prohibited non-physicians from "owning or controlling medical practices" and often included fee-splitting laws that prevented private interests from profiting from medical care.[187]

These rules came under attack from the legal academy for obstructing marketization. Sympathetic to a market logic (at that time), Nicole Huberfeld argued that, given concern about "effectuating a health care system that is closer to the market-driven model of other systems in this country, the time has come to rid ourselves of this archaic doctrine."[188] Mark Hall criticized the concern of marketization as "the most ill-considered" reason for prohibiting the corporate practice of medicine, lamented the insistence on "fiscal purity" of clinical practice, and quoted a state attorney general stating that "market forces may redound to the benefit of consumers."[189]

---

182. Hlubocky et al., *supra* note 177, at e209 (citing a 2012 study).

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.* at e215.

187. Brown & Hall, *supra* note 146, at 562; Huberfeld, *supra* note 173, at 244.

188. Huberfeld, *supra* note 173, at 291.

189. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 516 & n.307 (1988).

Growing faith in private markets, as well as the "managed care revolution"—an effort to control healthcare costs in the 1970s and 1980s—led to the degradation of state CPOM laws.[190] Legal tactics, such as clever ownership structures and contracting arrangements,[191] have rendered CPOM laws "ineffectual."[192] These changes have facilitated private ownership of and influence over oncology practices. Between 2003 and 2022, 724 U.S. oncology clinics (affiliated with a total of least 2,060 oncologists) became enmeshed with private equity.[193] More broadly, marketization fostered private actors' influence over and profiting from oncology practice.

2. Legal Incentives Encouraging Market Participation

The legal permission for marketization, embedded in the Bayh-Dole Act and the deregulation of physicians' financial arrangements and ethical guardrails, helped enable the marketization of cancer.[194] To a degree, once an institution can partake in profit-seeking activities, there is an inherent financial incentive to behave in a profit-driven manner to obtain additional funds.

Marketization, however, was intensified by incentives that drew cancer medical care further into the market logic.[195] Today, cancer centers can financially benefit from prescribing cancer treatment and pass part of the resulting wealth to their physicians as salary and benefits.

The legal machinations of these incentives operate through arcane drug-pricing provisions that apply a lucrative incentive for the prescription of expensive chemotherapies. Under the Medicare Modernization Act of 2003, reimbursement for cancer drugs is set at 106% of the average sales price, which essentially

190. Brown & Hall, *supra* note 146, at 564–65; Rooke-Ley et al., *supra* note 92, at 99.

191. Hayden Rooke-Ley & Erin C. Fuse Brown, *Lessons from Oregon's Attempt to Strengthen the 'Corporate Practice of Medicine' Ban*, HEALTH AFF. FOREFRONT (May 2, 2024), https://www.healthaffairs.org/content/forefront/lessons-oregon-s-attempt-strengthen-corporate-practice-medicine-ban [https://perma.cc/8HHM-W2GR].

192. Rooke-Ley et al., *supra* note 92, at 99.

193. Kevin Tyan et al., *Private Equity Acquisition of Oncology Clinics in the US from 2003 to 2022*, 183 JAMA INTERNAL MED. 621, 621–22 (2023).

194. *See supra* text accompanying notes 149–51, 181.

195. *See infra* text accompanying notes 356–60.

provides a 6% average margin for most prescribed chemotherapies.[196] This inducement incentivizes both increased prescribing and the prescribing of more expensive drugs, which redounds to the benefit of both oncology practices and pharmaceutical companies.[197] Research following the Medicare Modernization Act confirmed that these incentives indeed increased prescribing generally and raised prescribing of expensive drugs.[198] In one example, after the FDA approved levoleucovorin in 2008, a drug considered interchangeable with its predecessor leucovorin (available since 1952),[199] the new drug captured the market despite being fifty-eight times as expensive.[200] And while certain legal rules combat such private exploitation, like "blended reimbursement" and the "least costly alternative" system, chemotherapy is exempt from these legal frameworks.[201] When the financing of oncology practices has received public scrutiny, "[c]ancer specialists have successfully resisted most government efforts."[202]

These incentives, furthermore, interact with high drug prices in the United States and legal constraints on public and private payers. Earlier, I discussed automatic coverage provisions, which limit the discretion of insurers to decline coverage

196. 42 U.S.C. § 1395w-3a(b)(1); Brown, *supra* note 9, at 1026. The 6% bonus applies to medications administered in a physician's office and are, therefore, reimbursed under Part B, i.e., many oncologic and immunologic drugs. Rachel E. Sachs, *A New Framework for Drug Pricing Law and Policy*, IND. L.J. (forthcoming 2026) (manuscript at 26) (on file with the Minnesota Law Review).

197. *See* Brown, *supra* note 9, at 1027–28; *see also Skyrocketing: How Big Pharma Exploits Launch Prices to Cash In on Cancer*, OFF. OF REP. KATIE PORTER 9 (2022), https://web.archive.org/web/20240528060157/https://porter.house.gov/uploadedfiles/skyrocketing_-_how_big_pharma_exploits_launch_prices_to_cash_in_on_cancer.pdf [https://perma.cc/W7QY-3YYJ] (chronicling the rise in launch prices of cancer drugs); Sachs, *supra* note 196, at 26 (noting expert views that the 6% bonus can incentivize clinicians to prescribe higher-priced products).

198. Brown, *supra* note 9, at 1027.

199. Victor Tuan Giam Chuang & Manabu Suno, *Levoleucovorin as Replacement for Leucovorin in Cancer Treatment*, 46 ANNALS PHARMACOTHERAPY 1349, 1349 (2012); Brown, *supra* note 9, at 1028.

200. Brown, *supra* note 9, at 1028.

201. *Id.* at 1029.

202. Reed Abelson, *Drug Sales Bring Huge Profits, and Scrutiny, to Cancer Doctors*, N.Y. TIMES (Jan. 26, 2003), https://www.nytimes.com/2003/01/26/us/drug-sales-bring-huge-profits-and-scrutiny-to-cancer-doctors.html [https://perma.cc/CE96-AWY5].

of cancer medicines.[203] The resulting increase in prices amplifies the incentive to research and prescribe chemotherapy. Drug-pricing laws—which, in theory, could blunt the incentives to overprescribe pharmaceuticals—have faced legal and political challenges.[204] By sharing in the revenue for new cancer drugs (with an average launch price of $283,000),[205] cancer centers are incentivized to become market actors.

As a result of these incentives, oncology centers, on average, make between 66 to 77% of their income from the sale of drugs.[206] In 2022, the MD Anderson Cancer Center made a whopping $5.7 billion in revenue.[207] That same year, Memorial Sloan Kettering Cancer Center took in $6.6 billion in revenue.[208] For comparison, the FDA's budget request in 2022, across all regulatory centers, was $6.5 billion.[209] About 58% of cancer centers recognized by the NCI advertised in 2014.[210] Cancer centers more than tripled their advertising spending between 2005 and

203. *See supra* Part II.A.

204. *See, e.g.*, Michelle M. Mello & Rebecca E. Wolitz, *Legal Strategies for Reining in "Unconscionable" Prices for Prescription Drugs*, 114 NW. U. L. REV. 859, 862 (2020) (highlighting a successful challenge to Maryland's attempt to combat price gouging for generic drugs); Isaac D. Buck, *The Drug (Pricing) Wars: States, Preemption, and Unsustainable Prices*, 99 N.C. L. REV. 167, 167–68 (2020); Daniel G. Aaron et al., *Lawsuits over the Price of Insulin—State Efforts for Insulin Access*, 184 JAMA INTERNAL MED. 9, 9 (2024).

205. OFF. OF REP. KATIE PORTER, *supra* note 197, at 4 (citing a 2021 statistic).

206. Jonas A. de Souza & Gilberto de Lima Lopes Jr., *Medicare Reimbursement Changes and the Practice of Oncology: Understanding of the Past Is a Key to the Future*, 7 J. ONCOLOGY PRAC. 306, 307 (2011).

207. Laura Nathan-Garner et al., *Making a Statement: Annual Report FY2022*, MD ANDERSON CANCER CTR. 82 (2022), https://web.archive.org/web/20230402155108/https://www.mdanderson.org/documents/publications/annual-report/MDAnderson_Annual_Report_FY22.pdf [https://perma.cc/5MNT-BS9X].

208. Nick Thomas, *Memorial Sloan Kettering Reports $483M Slide in Operating Income*, BECKER'S HOSP. REV. (Apr. 14, 2023), https://www.beckershospitalreview.com/finance/memorial-sloan-kettering-reports-483m-slide-in-operating-income.html [https://perma.cc/8QKJ-69AH].

209. *FY 2022 Budget Request*, U.S. FOOD & DRUG ADMIN. 1 (2022), https://www.fda.gov/media/149613/download?attachment [https://perma.cc/K64L-WMB5].

210. Laura B. Vater et al., *Trends in Cancer-Center Spending on Advertising in the United States, 2005 to 2014*, 176 JAMA INTERNAL MED. 1214, 1215 (2016).

2014.[211] In 2016, hospitals spent $200 million in advertising cancer services.[212] These advertisements are "unavoidable"—they appear on billboards, during prime-time television, and on podcasts.[213] Figure 1 depicts the rising revenue of several prominent cancer centers compared with a hypothetical hospital whose revenue grows at the rate of inflation.[214]

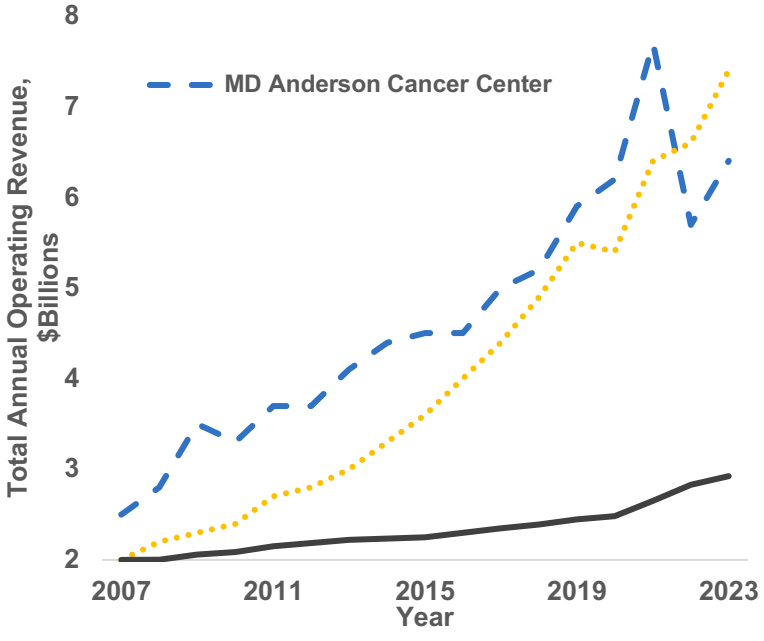
211. Kathryn Doyle, *Cancer Hospital Advertising Triples Since 2005*, REUTERS (July 11, 2016), https://www.reuters.com/article/us-health-cancer-ads-idUSKCN0ZR2D6 [https://perma.cc/MK6D-LCAQ].

212. Allison Lipitz-Snyderman et al., *Cancer Hospital Advertising and Outcomes: Trust the Messenger?*, 20 LANCET ONCOLOGY 760, 760 (2019).

213. *Id.*

214. *Best Hospitals for Cancer*, U.S. NEWS & WORLD REP., https://health.usnews.com/best-hospitals/rankings/cancer [https://perma.cc/7XZZ-AZ87]; *Fact Book 2012*, MD ANDERSON CANCER CTR. A-20 (2012); *Fact Book 2015*, MD ANDERSON CANCER CTR. A-21 (2015); *Fact Book 2020*, MD ANDERSON CANCER CTR. A-17 (2020); *Fact Book 2022*, MD ANDERSON CANCER CTR. A-17 (2022); *Operating Budget: Fiscal Year Ending August 31, 2024*, MD ANDERSON CANCER CTR. B.4 (2023), https://www.utsystem.edu/sites/default/files/documents/report-state/2023/annual-operating-budget-ut-m-d-anderson-cancer-center/fy-2024-budget-university-of-texas-m-d-anderson-cancer-center.pdf [https://perma.cc/LWJ8-XGTC]; *2008 Annual Report*, MEM'L SLOAN-KETTERING CANCER CTR. 52 (2009), https://www.mskcc.org/sites/default/files/node/17255/documents/mskcc08ar.pdf [https://perma.cc/LWG4-HD8J]; *Transformations: 2013 Annual Report*, MEM'L SLOAN-KETTERING CANCER CTR. 63 (2014), https://www.mskcc.org/sites/default/files/node/33873/document/annual-report-2013_0.pdf [https://perma.cc/BQ2F-XUMP]; *Why I Choose MSK: 2018 Annual Report*, MEM'L SLOAN-KETTERING CANCER CTR. 45 (2019), https://www.mskcc.org/sites/default/files/node/158749/document/msk_2018_ar.pdf [https://perma.cc/E4MP-2KGV]; *Ending Cancer for Life: 2023 Annual Report*, MEM'L SLOAN-KETTERING CANCER CTR. 67 (2024), https://www.mskcc.org/sites/default/files/node/299836/documents/msk_ar2023_final.pdf [https://perma.cc/YVS4-AH4H]. The MD Anderson Fact Books are no longer available online but are on file with the *Minnesota Law Review* and may be requested.

Figure 1: Total annual operating revenue of the top two U.S. News 2023–2024 cancer hospitals, compared with a hypothetical cancer hospital with a 2007 revenue of $2 billion that grows at the rate of inflation.[215]



These data matches prior data, showing accelerating increases in total medical revenue per full-time equivalent physician across U.S. cancer centers from 1991 to 2010.[216]

Given the legal rules and resulting incentives, it is not surprising that we have seen a surge in cancer center advertising, including direct-to-consumer advertising.[217] Cancer center advertising is designed, at least in part, to "gain market share,"[218] reflecting the importance of attracting lucrative cancer patients.

215. *Current US Inflation Rates: 2000–2025*, US INFLATION CALCULATOR, https://www.usinflationcalculator.com/inflation/current-inflation-rates [https://perma.cc/M2WF-ABUF].

216. Thomas R. Barr & Elaine L. Towle, *National Oncology Practice Benchmark: An Annual Assessment of Financial and Operational Parameters—2010 Report on 2009 Data*, 7 J. ONCOLOGY PRAC. (SPECIAL ISSUE) 2s, 2s–3s (2011).

217. Hlubocky et al., *supra* note 177, at e207.

218. *Id.*

The intertwining of cancer centers with private industry is discussed later.[219]

All told, the law has legalized and incentivized marketization. In doing so, it has contributed to the privatization of cancer.

D. CAPTURE

If our cancer system served the public interest—in spite of the above forms of privatization—then these legal developments would not be so troubling. Up to this point, it is possible that the profit-seeking actors in our cancer system are producing commensurate public benefits. In that sense, privatization is not inherently problematic.

But there is another critical aspect of privatization in the cancer space: capture. I use the term capture to refer to the cooptation of systems for private, as opposed to public, benefits. There are strong indications that our cancer system is not serving us—that the public fisc is being looted for private wealth, as opposed to maximizing benefits for patients and public health.

It is possible that capture is independent of the other forms of privatization, such that full-blown privatization can occur in the absence of capture. Instead, and more likely, I will argue that capture is predictably associated with the other forms of privatization. Particularly in the absence of public checks on private power, private entities are likely to favor their own self-interest as they accumulate market power. Hoping for spontaneous alignment of self-interest with the public good—without public calibration or oversight—is wishful thinking.

To give a brief overview, capture begins with (1) the FDA approval of new cancer therapies. Due to (i) the statutory program of accelerated approval and (ii) the FDA's failure to exercise its legal discretion to deny cancer drugs with weak evidence of benefit,[220] the bevy of cancer drugs coming to market are increasingly aligned with private, not public, interests.[221] Similarly, (2) health policymakers have embedded unsupported cancer screenings into clinical care.[222] I substantiate these claims

219. *See infra* Part II.D.3.

220. *See infra* text accompanying note 232.

221. Booth et al., *supra* note 3, at 833 ("Often the goal of improving and lengthening the lives of patients and that of making a profit for commercial organisations are not concordant.").

222. *See infra* text accompanying note 232.

with the latest data and case examples.[223] In another vein, (3) the pharmaceutical industry has sought to capture oncology practice itself.[224] Recall that cancer centers and oncologists have been marketized through legal shifts.[225] This has allowed the formation of a conflicted financial relationship, in which cancer centers and oncologists arguably depend on industry. Industry also holds the keys to career advancement for oncologists.[226] Together, these legal developments align the actors in our cancer system with private interests.

1. Capture at the FDA: Cancer Drugs

The FDA, under influence of regulated industry,[227] has approved new cancer therapies at a breakneck pace[228]—despite poor evidence of efficacy for many drugs and an immense cost to the U.S. health care system and patients themselves.[229] Today, cancer is the number one area of drug development,[230] likely due to ease of approval, automatic coverage provisions, and exemptions from drug price limits that produce a uniquely profitable investment.[231]

a. Accelerated Approval

The first problem with cancer drug development is that, due to a statutory program called accelerated approval, companies are not required to demonstrate that their drugs provide a clinical benefit.[232] I have reviewed the problems with this program

223. *See infra* Part II.D.1.c.

224. *See infra* text accompanying notes 358–62.

225. *See infra* Part II.C.

226. *See infra* text accompanying notes 366–67.

227. Aaron, *supra* note 69, at 140–41.

228. *See infra* text accompanying note 249.

229. *See infra* text accompanying note 252.

230. Asher Mullard, *2024 FDA Approvals*, 24 NATURE REVS. DRUG DISCOVERY 75, 75 (2025) (noting that in 2024, cancer remains "the dominant focus of drug developers," accounting for 30% of novel approvals, compared with 12% for both dermatology and non-malignant hematology, which were tied for second).

231. See *supra* Parts II.A, II.C and the discussion below about ease of approval.

232. Bishal Gyawali et al., *Fulfilling the Mandate of the US Food and Drug Administration's Accelerated Approval Pathway: The Need for Reforms*, 181 JAMA INTERNAL MED. 1275, 1275 (2021) ("[C]linical benefits have not been demonstrated for drugs that receive accelerated approval . . . .").

in prior work,[233] as have many commentators.[234] For cancer specifically, a large number of articles have surfaced that criticize the use of accelerated approval for cancer therapeutics.[235] Perhaps due to the severity of and fear surrounding cancer, the FDA has thrust open the door of accelerated approval in this area.[236]

Accelerated approval, launched in 1992, is a pathway that allows the FDA to follow a more liberal standard for drug approvals.[237] To use accelerated approval, the FDA looks for an

233. Aaron, *supra* note 69.

234. *See, e.g.*, Herder, *supra* note 121; Alexandra Maulden, Note, *Ignoring the Experts: Implications of the FDA's Aduhelm Approval*, 48 AM. J.L. & MED. 108 (2022); Gyawali et al., *supra* note 232; Ezekiel J. Emanuel, *A Middle Ground for Accelerated Drug Approval—Lessons From Aducanumab*, 326 JAMA 1367 (2021); Aaron, Cohen & Adashi, *supra* note 121; U.S. DEP'T OF HEALTH & HUM. SERVS., OEI-01-21-00401, DELAYS IN CONFIRMATORY TRIALS FOR DRUG APPLICATIONS GRANTED FDA'S ACCELERATED APPROVAL RAISE CONCERNS (2022); Stephanie Diu, Note, *Slowing Down Accelerated Approval: Examining the Role of Industry Influence, Patient Advocacy Organizations, and Political Pressure on FDA Drug Approval*, 90 FORDHAM L. REV. 2303 (2022); Holly Fernandez Lynch et al., *Extending the US Food and Drug Administration's Postmarket Authorities*, JAMA HEALTH F., June 2023, at 1; Anjali D. Deshmukh et al., *Timing of Confirmatory Trials for Drugs Granted Accelerated Approval Based on Surrogate Measures from 2012 to 2021*, JAMA HEALTH F., Mar. 2023, at 1.

235. *See, e.g.*, Sarah S. P. DiMagno et al., *Accelerated Approval of Cancer Drugs—Righting the Ship of the US Food and Drug Administration*, 179 JAMA INTERNAL MED. 922 (2019); Vinay Prasad et al., *The Strength of Association Between Surrogate End Points and Survival in Oncology: A Systematic Review of Trial-Level Meta-Analyses*, 175 JAMA INTERNAL MED. 1389 (2015); Ian T. T. Liu et al., *Clinical Benefit and Regulatory Outcomes of Cancer Drugs Receiving Accelerated Approval*, 331 JAMA 1471 (2024); Ravi B. Parikh et al., *Exposure to US Cancer Drugs with Lack of Confirmed Benefit After US Food and Drug Administration Accelerated Approval*, 9 JAMA ONCOLOGY 567 (2023); Bishal Gyawali et al., *The Accelerated Approval Program for Cancer Drugs — Finding the Right Balance*, 389 NEW ENG. J. MED. 968 (2023) [hereinafter Gyawali et al., *Finding the Right Balance*]; Bishal Gyawali et al., *Assessment of the Clinical Benefit of Cancer Drugs Receiving Accelerated Approval*, 179 JAMA INTERNAL MED. 906 (2019) [hereinafter Gyawali et al., *Assessment of the Clinical Benefit*].

236. Aaron, *supra* note 69, at 127–32.

237. *See id.* at 128 (explaining that the accelerated approval pathway permits the FDA to consider "the severity and prevalence of the disease and the need for the drug" when making approval decisions).

"unmet medical need[]."[238] But for cancer, the FDA views "nearly any cancer condition" as an unmet medical need.[239]

Accelerated approvals are based not on clinical benefit, but substitute metrics called "surrogate markers" or "surrogate endpoint[s]," which frequently have a tenuous link to clinical benefits.[240] The FDA approves two-thirds of new cancer drugs based on surrogate markers[241]—often response rate or progression-free survival.

A full 87% of cancer drugs passing through accelerated approval between 1992 and 2017 used the surrogate marker of "response rate"—defined as shrinkage of a tumor by at least 30%.[242] Progression-free survival, also common,[243] refers to the patient surviving without a new tumor or growth beyond 20% of its smallest size.[244] As many have noted, while these measures sound appealing, the cutoffs are arbitrary, and drugs that shrink a tumor may not actually help patients live longer or better.[245] Cancer drugs often cause severe toxicities—including immunosuppression and death—so metrics that only measure drugs' impact on cancer while disregarding effects on other parts of the body can be misleading.[246] In addition, under accelerated

238. 21 U.S.C. § 356(b)(1). The Food, Drug, and Cosmetic Act allows the FDA to consider the "availability or lack of alternative treatments" and does not require an unmet medical need per se. *Id.* § 356(c)(1)(A). But the FDA often examines whether a proposed drug fills an unmet medical need. *See, e.g.*, *Accelerated Approval Program*, U.S. FOOD & DRUG ADMIN. (last updated Aug. 21, 2025), https://www.fda.gov/drugs/nda-and-bla-approvals/accelerated-approval-program [https://perma.cc/7TYY-4Z56].

239. VINAYAK K. PRASAD, MALIGNANT: HOW BAD POLICY AND BAD EVIDENCE HARM PEOPLE WITH CANCER 184 (2020).

240. *See id.* at 37–39 (explaining a study showing that "many surrogates are based on little more than a gut feeling").

241. *See* Gyawali et al., *Finding the Right Balance*, *supra* note 235, at 968.

242. DiMagno et al., *supra* note 235, at 922.

243. *See* PRASAD, *supra* note 239, at 27.

244. *See id.* at 27 (explaining that progression-free survival is the time until a patient dies, develops a new tumor, or an existing tumor grows more than 20% from its smallest size).

245. *See* DiMagno, *supra* note 235, at 922 (calling the selection of surrogate end points "highly controversial"); PRASAD, *supra* note 239, at 3, 26–27.

246. *See* Aaron, *supra* note 69, at 131 ("Surrogate markers such as blood pressure are easier to target with a drug, yet, without measuring clinical outcomes (e.g., deaths), they can be misleading because they may fail to capture overall impact on health."); PRASAD, *supra* note 239, at 143 ("[A]ctive anticancer drugs might keep tumors from growing past arbitrary thresholds, but does that result in a longer or happier life?").

approval, the FDA can consider malleable factors, such as the need for new therapies and the severity and prevalence of the disease—which go far beyond a drug's safety and effectiveness.[247]

Therefore, the approvals of cancer drugs through this pathway reflect a substantial deviation from the standards the FDA normally follows for drug approvals.[248] And the pace of these approvals is only increasing. Between 1992 and July 2010 (approximately eighteen years), the FDA granted accelerated approval to forty-seven cancer indications (i.e., clinical uses), but, from July 2010 to 2017 (seven-and-a-half years), it granted

247. *See* 21 U.S.C. §§ 357(e)(9)(B), 356(c)(1)(A); Aaron, *supra* note 69, at 128.

248. Accelerated approvals are technically conditional: Drugmakers are theoretically required to conduct confirmatory trials to demonstrate the clinical benefits of their drugs. But confirmatory trials for all 93 cancer indications approved, using surrogates between 1992 and 2019, showed a survival benefit for a meager 19 of 93. Gyawali et al., *Assessment of the Clinical Benefit*, *supra* note 235, at 906. For the other 39 of 93 indications that purportedly had a confirmed benefit, 19 of them were based on the same surrogate marker as the preapproval trial, and 20 were based on a different surrogate marker. *Id.* at 906. When the FDA has used a surrogate for a cancer accelerated approval, that surrogate marker was novel for that type of cancer about one third of the time. *Id.* at 909. The continuing use of surrogate markers means that many cancer drugs have uncertain—sometimes no—clinical benefit after approval.

The evidence that the FDA accepts under accelerated approval of cancer drugs is inferior in other ways, beyond surrogate markers. The gold standard of clinical evidence is the randomized controlled trial, yet such trials are rare for cancer accelerated approvals. *See* Table 3. Blinding is important to reduce the effect of the patient's or clinician's treatment expectations on the clinical course. And more participants generate a more reliable result and a better understanding of the drug's clinical properties.

Table 3: Properties of trials supporting cancer drug approvals, 2000–2017. Aviv Ladanie et al., *Clinical Trial Evidence Supporting US Food and Drug Administration Approval of Novel Cancer Therapies Between 2000 and 2016*, JAMA NETWORK OPEN, Nov. 10, 2020, at 1, 4–5.

STUDY FEATURE	TRIALS SUPPORTING ONCOLOGY REGULAR APPROVALS	TRIALS SUPPORTING ONCOLOGY ACCELERATED APPROVALS
Randomized	82%	18%
Double-Blinded	41%	5%
Number of Participants	374	136

accelerated approval to another forty-six indications.[249] Accelerated approval appears to have opened the floodgates for new cancer drugs.

Seemingly in response to the significant criticism of its approach, the FDA released draft guidance in March 2023 encouraging drugmakers to provide stronger evidence when aiming for accelerated approval and complained about excess uncertainty that can result from inadequate evidence.[250] Of course, the FDA could simply deny approval to drugs with poor-quality data, thereby refusing to accept excess uncertainty.

Accelerated approval generates a problem of unknowns. Whereas the FDA is generally expected to verify that new drugs are safe and have "substantial evidence" of effectiveness,[251] accelerated approval is being used to circumvent these requirements and approve drugs of unknown utility. Researchers who reviewed results from studies completed *after* accelerated approval have found that 43% of cancer drug indications—less than half—demonstrate a clinical benefit.[252]

This low bar for approval has helped draw investment from the pharmaceutical industry, turning cancer into the number one area of drug development.[253] Although drug development can certainly benefit the public good, the perverse incentive provided by accelerated approval has helped privatize industry itself, greatly reducing its potential public impact by incentivizing the development of low-quality drugs.[254]

Not only is the FDA approving drugs irresponsibly under accelerated approval, it also has tolerated companies conducting poor-quality trials using small sample sizes and no control group—options they readily take advantage of.[255]

---

249. *See* Gyawali et al., *Assessment of the Clinical Benefit*, *supra* note 235, at 906 (stating that the FDA granted accelerated approval of ninety-three cancer indications between 1992 and 2017); John R. Johnson et al., *Accelerated Approval of Oncology Products: The Food and Drug Administration Experience*, 103 J. NAT'L CANCER INST. 636, 643 (2011) (stating that from 1992 to 2010, the FDA granted accelerated approval for forty-seven cancer indications).

250. *See* Gyawali et al., *Finding the Right Balance*, *supra* note 235, at 969.

251. 21 U.S.C. § 355(d)(5) (effectiveness); 21 U.S.C. §§ 355(d)(2), (4) (safety).

252. *See* Liu et al., *supra* note 235, at 1471.

253. *See infra* Part II.C.1.

254. *See infra* Part II.D.1.c.

255. *See infra* Part II.D.1.b.

b. FDA Tolerance of Clinical Trial Tactics

Pharmaceutical companies have discovered other cancer drug development tricks that obscure safety and effectiveness but are tolerated by the FDA. Whereas new drugs are generally compared to the medical "standard of care," some companies use a *suboptimal control arm*, or an inferior treatment for the comparison group that is easier to surpass.[256] Because treating patients with substandard therapies is unethical, many companies conduct these trials abroad.[257] Otherwise, physicians would likely refuse to give control patients an inferior therapy beneath the standard of care.[258]

Alternatively, companies can run non-inferiority trials, which show that a new drug is "not much worse" than available drugs; these trials can lead to approval of substandard drugs that are often heavily promoted.[259] Of course, therapies can still be valuable even if they are inferior to others, but the point is that pharmaceutical companies can intentionally set low bars for their drugs, and after approval, they can fuel sales through the generation of hype.[260] One study found that 59% of negative breast cancer trials (i.e., failed trials) were spun to reach a positive conclusion for the journal audience.[261] Companies also sometimes conduct very large studies looking for a microscopic benefit—which is only detectable across huge numbers of patients.[262] This strategy led to the approval of erlotinib for

256. *See* Talal Hilal et al., *Analysis of Control Arm Quality in Randomized Clinical Trials Leading to Anticancer Drug Approval by the US Food and Drug Administration*, 5 JAMA ONCOLOGY 887, 887 (2019); *see also* Alessandro Rossi et al., *Analysis of the Adequacy of Control Arms in Oncology Randomised Clinical Trials Published Between 2017 and 2021: A Meta-Research Study*, EUR. J. CANCER, May 15, 2023, at 1, 2, 4.

257. *See* PRASAD, *supra* note 239, at 166–75 (explaining that some trials seeking approval in the United States are conducted globally and "problematically have used control arms that are beneath the US standard").

258. *See id.* at 175 (noting that a randomized chemotherapy trial was likely run outside of the United States because "[n]o self-respecting physicians in the United States would allow their patients" to participate in such a trial).

259. *See id.* at 161–63 (explaining and giving examples of non-inferiority trials).

260. *See id.* at 67–69 (noting that cancer drugs are "drowning in hype" as society seeks to generate excitement about every new treatment option).

261. *See id.* at 73–74 (explaining the study).

262. *See id.* at 183 (explaining that companies may conduct large studies to "squeeze out" a p-value of less than 0.05, which shows a "statistically significant improvement in survival").

pancreatic cancer, with a ten-day median survival benefit[263]—thus arguably offering minimal patient benefit for large costs.

The FDA, of course, has significant discretion to shape its evidentiary standards for new drugs by interpreting statutory provisions like "adequate and well-controlled investigations"; such investigations are required for new drugs.[264] The FDA could simply deny approval to cancer drugs with shaky evidence as part of its adjudications of new drug applications. The FDA itself has complained about the quality of submitted evidence for many new cancer drugs, exemplified by its 2023 guidance on evidentiary problems in accelerated approval applications.[265] There, the FDA encouraged industry to conduct more randomized controlled trials when aiming for accelerated approval,[266] noting that poor-quality trials without control groups can "add uncertainty to the assessment of the safety and/or effectiveness of a drug."[267] While this sort of guidance can be valuable, the FDA speaks louder through its actions when it approves cancer drugs despite serious evidentiary flaws.

c. Impacts of the FDA's Generous Drug Approvals in Cancer

The FDA is approving cancer drugs rapidly, despite fairly poor average effectiveness. Between 2000 and 2016, the FDA approved 92 new cancer drugs, with a median survival gain of 2.4 months.[268] Another study found a median gain of 0.56 years of life from cancer drugs approved between 1995 and 2017.[269] Yet another study found a median of 2.1 months gained for solid-

263. *Id.*

264. 21 U.S.C. § 355(d)(7); *see* Mason Marks, *Automating FDA Regulation*, 71 DUKE L.J. 1207, 1209 (2022) (noting that the FDCA was amended in 1962 to empower the FDA to "require proof of drug efficacy"); Aaron, *supra* note 69, at 132 (explaining that the FDA has discretion to accept evidence in place of a second clinical trial that was previously required).

265. *See* U.S. FOOD & DRUG ADMIN., CLINICAL TRIAL CONSIDERATIONS TO SUPPORT ACCELERATED APPROVAL OF ONCOLOGY THERAPEUTICS: GUIDANCE FOR INDUSTRY 2–3 (2023), https://www.fda.gov/media/166431/download [https://perma.cc/92LQ-AYDD] (critiquing the use of single-arm trials to support cancer accelerated approvals and encouraging manufacturers to conduct randomized controlled trials).

266. *See* Gyawali et al., *Finding the Right Balance*, *supra* note 235, at 969.

267. U.S. FOOD & DRUG ADMIN., *supra* note 265, at 2.

268. *See* Ladanie et al., *supra* note 248, at 1.

269. *See* Alice J. Chen et al., *Trends in the Price per Median and Mean Life-Year Gained Among Newly Approved Cancer Therapies 1995 to 2017*, 22 VALUE HEALTH 1387, 1391 (2019).

tumor drugs approved between 2002 and 2014.[270] And another study found a median survival benefit of 2.55 months for new cancer drugs approved between 2000 and 2020.[271] These findings are remarkably consistent over the past 2 decades.

While having several additional months of life is undeniably valuable, surveys reveal that patients would accept the toxicity of chemotherapy for a benefit of 4.5 months for mild toxicity or 9 months for severe toxicity[272]—which exceeds the gains from most drugs. This raises questions of informed consent beyond the scope of this Article.

In addition, the tradeoffs to secure a 2- or 3-month benefit are enormous. Between 2017 and 2021, launch prices for new cancer drugs grew 53% to $283,000 per year, on average.[273] Unfortunately, "multiple studies confirm that cancer drug prices do not correlate with value or clinical benefit."[274] Instead, costs in the United States appear to be higher, on average, for oncology drugs with less effectiveness.[275] Cancer drug prices are also not explainable by research and development costs but rather, according to one oncology researcher, may be the result of a "dysfunctional market" that arguably does not prioritize patient

270. *See* Tito Fojo et al., *Unintended Consequences of Expensive Cancer Therapeutics—The Pursuit of Marginal Indications and a Me-Too Mentality that Stifles Innovation and Creativity: The John Conley Lecture*, 140 JAMA OTOLARYNGOLOGY-HEAD & NECK SURGERY 1225, 1227 (2014).

271. Viktoria Gloy et al., *The Evidence Base of US Food and Drug Administration Approvals of Novel Cancer Therapies from 2000 to 2020*, 152 INT'L J. CANCER 2474, 2475 (2023).

272. Gerard Silvestri et al., *Preferences for Chemotherapy in Patients with Advanced Non-Small Cell Lung Cancer: Descriptive Study Based on Scripted Interviews*, 317 BMJ 771, 773 (1998).

273. *See* OFF. OF REP. KATIE PORTER, *supra* note 197.

274. Natasha B. Leighl et al., *An Arm and a Leg: The Rising Cost of Cancer Drugs and Impact on Access*, 41 AM. SOC'Y CLINICAL ONCOLOGY EDUC. BOOK e1, e4 (2021).

275. Joseph C. Del Paggio et al., *Delivery of Meaningful Cancer Care: A Retrospective Cohort Study Assessing Cost and Benefit with the ASCO and ESMO Frameworks*, 18 LANCET ONCOLOGY 887, 891 (2017); *see* Bryant Furlow, *US Cancer Drug Prices Do Not Reflect Benefits to Patients*, 23 LANCET ONCOLOGY e532, e532 (2022) (referencing a study that found cancer drug prices "do not reflect evidence of clinical benefits"); Miloš D. Miljkovi et al., *Association Between US Drug Price and Measures of Efficacy for Oncology Drugs Approved by the US Food and Drug Administration From 2015 to 2020*, 182 JAMA INTERNAL MED. 1319, 1319–20 (2022) (finding that drugs relying on a lower-quality form of evidence have higher average costs).

well-being.[276] One prominent oncologist has noted that some modern cancer drugs are worth "4000 times the cost of gold."[277] About 64% of oncology drugs reviewed by the U.S. Institute for Clinical and Economic Review (ICER), which assesses the cost-effectiveness of treatments, are *not* cost-effective.[278]

In addition to direct drug costs routinely in the hundreds of thousands of dollars annually, oncology drugs' toxicity can require expensive monitoring through bone scans, cardiac ultrasounds, and the like.[279] Financial costs frequently drive cancer patients to bankruptcy, which paradoxically damages their health.[280] They also amount to a substantial drain on the healthcare system, with spending on cancer drugs projected to rise from $99 billion in 2023 to $180 billion by 2028.[281] Cancer drugs are not risk-free either; their toxicity can deteriorate a dying patient's quality of life in their final moments and sometimes cut it short.[282] Consider whether living an additional 0.25 years from pancreatic cancer is worth the pain, nausea, and isolation (as a result of immunosuppression from chemotherapy), as well as thousands of dollars per month in patient costs.

This status quo for oncology drugs, arguably reflecting capture at the FDA, provides a compelling set of legal incentives to the pharmaceutical industry. Rather than vet a new anti-cancer mechanism, industry is incentivized to pursue low-risk pathways to approval and guaranteed reimbursement.[283] These

276. PRASAD, *supra* note 239, at 236.

277. Andrews, *supra* note 21, at 9.

278. Avi Cherla et al., *Cost-Effectiveness of Cancer Drugs: Comparative Analysis of the United States and England*, ECLINICALMEDICINE, Dec. 2020, at 1, 23 (finding that seven out of eleven "commonly assessed cancer drugs" were not cost-effective).

279. *See* Stephen M. Schleicher et al., *Medication Overuse in Oncology: Current Trends and Future Implications for Patients and Society*, 19 LANCET ONCOLOGY e200, e204 (2018) (providing examples to show that cancer patients' financial costs go beyond just the cancer drugs).

280. *See id.* (noting that personal bankruptcy is linked to "increased mortality").

281. *See* Denise Myshko, *Global Spending on Cancer Drugs to Increase to $409 Billion*, MANAGED HEALTHCARE EXEC. (May 28, 2024), https://www.managedhealthcareexecutive.com/view/global-spending-on-cancer-drugs-to-increase-to-409-billion [https://perma.cc/4BJ6-EWBV].

282. *See* Schleicher et al., *supra* note 279, at e204–05 (explaining that cancer drugs can have acute and chronic effects that decrease quality of life and cause long-term complications).

283. *See infra* Part II.C.2.

incentives have colored pharmaceutical development in the United States. According to Robin Feldman, "[s]ince the turn of the millennium, the pharmaceutical industry in the United States has shifted decidedly toward cancer therapeutics" to the detriment of other pharmaceutical areas, like antibiotics and birth control.[284] While U.S. drug sales in 2018 were $58.4 billion for cancer, they were $11.4 billion for all vaccines and $5.7 billion for antibiotics.[285] Between 2010 and 2019, total annual oncology drug revenue for the top ten pharmaceutical companies increased 70%, whereas non-oncology drug revenue fell 18%.[286] From 2016 to 2020, the number of cancer drugs in late-stage trials increased more than 60%.[287] U.S. consumer spending on cancer drugs doubled from 2013 to 2018 to reach $56 billion and hit $75 billion in 2021.[288] As a comparator, $75 billion is greater than the combined annual budgets of the Federal Communications Commission, Consumer Financial Protection Bureau, Securities and Exchange Commission, Nuclear Regulatory Commission, Government Accountability Office, FDA, Centers for Disease Control and Prevention, and Federal Trade Commission.[289]

Rather than generate truly innovative products, many companies are now pursuing "me-too" drugs, or copycat drugs, with a similar function to an existing drug.[290] This is most evident from the class of drugs called PD-1/PD-L1 inhibitors, which

284. Robin Feldman, *The Cancer Curse: Regulatory Failure by Success*, 21 COLUM. SCI. & TECH. L. REV. 82, 87 (2019).

285. *Id.* at 90.

286. *See* Daniel E. Meyers et al., *Trends in Drug Revenue Among Major Pharmaceutical Companies: A 2010-2019 Cohort Study*, 128 CANCER 311, 312 (2022).

287. *See* Feldman, *supra* note 284, at 87.

288. *Id.*; Murray Aitken et al., *Global Oncology Trends 2022*, IQVIA INST. FOR HUM. DATA SCI. 51 (2022), https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/global-oncology-trends-2022 [https://perma.cc/N3J5-ACNL].

289. *See Agency Profiles*, USASPENDING.GOV (2025), https://www.usaspending.gov/agency [https://perma.cc/CK7U-EPNP] (providing budgetary information for federal government agencies).

290. *See* Deena Beasley, *Too Many 'Me-Too' Cancer Drugs? FDA Official Asks*, NBC (June 10, 2016), https://www.nbcnews.com/health/cancer/too-many-me-too-cancer-drugs-fda-official-asks-n589601 [https://perma.cc/7EHS-JPF5] (questioning whether it makes sense to create so many similar cancer drugs rather than investing in "unproven approaches").

activate the immune system against cancer.[291] As of December 2021, there were 5,683 trials ongoing for PD-1/PD-L1 inhibitors,[292] an enormous investment. As of November 2023, the FDA has approved 9 drugs targeting this receptor system.[293] These agents have been described as a "me-too drug tsunami" and a "frenzy."[294] In 2016, an FDA official warned about this PD-1 redundancy: "People should ask themselves . . . would we be better off spending those resources into looking at more novel drugs?"[295]

While me-too drugs can offer benefits, including reducing prices through competition and offering alternatives for people who develop drug allergies, me-tooism has led to redundant cancer research that is arguably not benefitting patients.

In cancer, we accept these costs and do not question why we bear them or whether there is another way. Or, perhaps, we are unaware of the true extent of the cost upon us. Taking a bird's-eye view, are the serious risks and uncertain benefits of oncology drugs worth the massive social investment we make in them, relative to universal public health measures?[296]

---

291. Elliot A. Philips et al., *Transmembrane Domain–Driven PD-1 Dimers Mediate T Cell Inhibition*, SCI. IMMUNOLOGY, Mar. 2024, at 1, 1 ("Programmed cell death-1 (PD-1) is a potent immune checkpoint receptor on T lymphocytes. Upon engagement by its ligands, PD-L1 or PD-L2, PD-1 inhibits T cell activation and can promote immune tolerance. Antagonism of PD-1 signaling has proven effective in cancer immunotherapy . . . .").

292. *See PD-1 / PD-L1 Landscape*, CANCER RSCH. INST. (Feb. 10, 2022), https://www.cancerresearch.org/pd-1-pd-l1-landscape [https://perma.cc/2V8L-NKCL].

293. *See* Jacob Plieth, *Loqtorzi Becomes Ninth US Anti-PD-(L)1 Drug*, ONCOLOGYPIPELINE: APEXONCO (Oct. 30, 2023), https://www.oncologypipeline.com/apexonco/loqtorzi-becomes-ninth-us-anti-pd-l1-drug [https://perma.cc/CXW7-K2AP].

294. Roberto Ferrara et al., *The Anti-Programmed Cell Death Protein-1/Programmed Death-Ligand 1 Me-Too Drugs Tsunami: Hard to Be Millennials Among Baby Boomers*, 18 J. THORACIC ONCOLOGY 17, 17 (2023); Jeff Hodge, *Checkpoint Frenzy*, IQVIA BLOG (Apr. 11, 2022), https://web.archive.org/web/20230806155551/https://www.iqvia.com/blogs/2022/04/checkpoint-frenzy [https://perma.cc/KC8N-E2TA].

295. Beasley, *supra* note 290.

296. *See infra* Part III.A (describing harsh tradeoffs of oncology drugs); John-John B. Schnog et al., *An Urgent Call to Raise the Bar in Oncology*, 125 BRIT. J. CANCER 1477, 1477 (2021) (arguing recent reduction in cancer mortality is due to prevention and early detection, whereas therapeutics have carried little benefits for high costs); Cole Wayant et al., *Financial Conflicts of Interest Among Oncologist Authors of Reports of Clinical Drug Trials*, 4 JAMA

Although cancer drugs are often framed as lifesaving, this Article contends the 2 to 3 months gained are marginal and that much of this money would be better spent elsewhere.[297] It is true that several cancer drugs have been miracles, such as imatinib (Gleevec), which can nearly cure chronic myeloid leukemia.[298] But miraculous chemotherapies are rare, and the few wonder drugs touted in public debate are singletons.

The FDA's legal framework for approval of cancer drugs redounds to the benefit of private industry, reflecting privatization by capture.

2. Capture at the USPSTF: Cancer Screenings

Cancer screening refers to cancer testing performed on asymptomatic, normal-risk patients. Where a patient has a genetic mutation that predisposes them to cancer (e.g., BRCA1/2) or relevant symptoms, medical testing is not screening, and the critiques in this Subsection do not apply. This Subsection will examine how cancer screenings, and their oversight by the USPSTF, have been deflected toward the benefits of industry as opposed to patients—i.e., captured.[299]

Cancer screening is explicitly advocated as a means to increase longevity.[300] Cancer screenings carry immense hope for patients, who would like to avoid the ill fortune of a cancer diagnosis. Women have been long advised of the wisdom behind breast cancer screening through annual or biannual mammograms, starting at age forty or fifty.[301] Colonoscopies are seen as a rite of passage as one grows older.

ONCOLOGY 1426, 1427 (2018) ("[O]ncology drugs are often associated with marginal improvement in survival but exorbitant costs.").

297. *See infra* Part III.A.2 (describing impoverished public health programs).

298. *See* PRASAD, *supra* note 239, at 49, 68 (explaining that imatinib has a "98% complete response rate" and is a "game changer").

299. *See* Carpenter & Moss, *supra* note 58, at 13 (defining regulatory capture).

300. Michael Bretthauer et al., *Estimated Lifetime Gained with Cancer Screening Tests: A Meta-Analysis of Randomized Clinical Trials*, 183 JAMA INTERNAL MED. 1196, 1197 (2023) ("Cancer screening is advocated to save lives and increase longevity.").

301. *See, e.g.*, *American Cancer Society Recommendations for the Early Detection of Breast Cancer*, AM. CANCER SOC'Y (Dec. 19, 2023), https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html [https://perma.cc/B39V-RSX4].

While screening to catch cancers early sounds wise, oncologists are increasingly questioning the merits of screening to a degree that the public seems unaware of.[302] According to a 2023 landmark meta-analysis of six cancer screenings, "evidence does not substantiate the claim that common cancer screening tests save lives by extending lifetime, except possibly for colorectal cancer screening with sigmoidoscopy" (a less invasive version of colonoscopy).[303] Large meta-analyses have failed to find statistically significant mortality benefits for cancer screening in the lungs,[304] breast,[305] and colon/rectum[306]—top killers for which cancer screening is often touted as an important solution.

Screening advocates often cite attractive numbers, but, usually, these are for disease-specific survival (e.g., dying from breast cancer).[307] For example, the CDC explains that biannual breast cancer screening from ages fifty to seventy-four can "**REDUCE** deaths"; it then elaborates that screening reduces "breast cancer deaths" by 26%.[308] Such figures fail to capture whether a screening improves or lengthens the lives of patients. That is because screening causes harms that are not included in

---

302. *See, e.g.*, *id.* at 1197 (providing an example of a study that questions the merits of cancer screening).

303. *Id.* at 1196; *see* Nazmus Saquib et al., *Does Screening for Disease Save Lives in Asymptomatic Adults? Systematic Review of Meta-Analyses and Randomized Trials*, 44 INT'L J. EPIDEMIOLOGY 264, 264 (2015) (finding that none of the cancer screenings examined had confirmed all-cause-mortality benefits).

304. *See* Francesco Passiglia et al., *Benefits and Harms of Lung Cancer Screening by Chest Computed Tomography: A Systematic Review and Meta-Analysis*, 39 J. CLINICAL ONCOLOGY 2574, 2576 (2021) (finding a "nonsignificant reduction" in all-cause-mortality as a result of lung cancer screening).

305. *See* Heidi D. Nelson et al., *Effectiveness of Breast Cancer Screening: Systematic Review and Meta-Analysis to Update the 2009 U.S. Preventive Services Task Force Recommendation*, 164 ANNALS INTERNAL MED. 244, 244 (2016) (finding that "[a]ll-cause mortality was not reduced with screening" for breast cancer).

306. *See* Henriette C Jodal et al., *Colorectal Cancer Screening with Faecal Testing, Sigmoidoscopy or Colonoscopy: A Systematic Review and Network Meta-Analysis*, BMJ OPEN, Oct. 2, 2019, at 1, 16 (finding that "none" of the colorectal cancer screenings "show effect on all-cause mortality").

307. *See, e.g.*, Bretthauer, *supra* note 300, at 1197 ("Others claim that effects on cause-specific death of the target cancer are enough to promote screening.").

308. *Health and Economic Benefits of Breast Cancer Interventions*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 14, 2025), https://www.cdc.gov/nccdphp/priorities/breast-cancer.html [https://perma.cc/4PDA-CR6G].

disease-specific survival.[309] For example, colonoscopes can rupture the intestines or cause bleeding, and interventions triggered by screening—biopsies, surgery, radiation, and chemotherapy—can actually increase overall mortality, even if disease-specific mortality is lowered.[310]

In addition, many cancers would be better left undiscovered. When found, they can lead to unnecessary costs through so-called overdiagnosis and unnecessary treatment.[311] The "barnyard" analogy in cancer explains this well.[312] The goal of screening is to prevent cancer deaths, analogized as keeping animals from escaping the barnyard.[313] A turtle—a slowly growing cancer—is going nowhere, and a patient will likely die from other things.[314] A bird is a fast-growing cancer that will fly over the fence.[315] But rabbits, which can be trapped in the barnyard, are the only cancers really worth detecting.[316] Consider the story of a cancer patient who died of pneumonia, after which an autopsy revealed that his kidney cancer was a turtle.[317] Yet he had received more than twenty abdominal CT scans and suffered ten years of anxiety.[318]

Third, screening can yield false positives: non-cancers that expend healthcare resources, cause anxiety, and necessitate follow-up procedures with real risks. A third of women say that

309. The informal balancing of benefits and harms is discussed shortly. However, USPSTF recommendations generally review the harms in a half-hearted manner, despite the fact that they are "critically important." Aruna Kamineni et al., *Evaluation of Harms Reporting in U.S. Cancer Screening Guidelines*, 175 ANNALS INTERNAL MED. 1582, 1585, 1588 (2022) (identifying inconsistencies and inadequacies in harm reporting and noting, "[U]nderstanding the balance of benefits and harms for various risk groups and screening regimens is critically important for the decision of whom, how, and when to screen.").

310. *See, e.g.*, *id.* at 1582, 1587 (showing that disease-specific screening tests can lead to particular harms).

311. H. Gilbert Welch & Elliott S. Fisher, *Income and Cancer Overdiagnosis — When Too Much Care Is Harmful*, 376 NEW ENG. J. MED. 2208, 2208 (2017) (explaining that overuse of cancer screening can lead to overdiagnosis and "potentially unnecessary treatment").

312. *See* Dave A Chokshi, *Finding the Sweet Spot in Medicine*, 385 LANCET 2037, 2037 (2015) (explaining the "barnyard" analogy from *Less Medicine, More Health*, a book by H. Gilbert Welch).

313. *Id.*

314. *Id.*

315. *Id.*

316. *Id.*

317. *Id.*

318. *Id.*

experiencing a false positive from breast cancer screening is "very scary" or "the scariest time of my life."[319]

It may be surprising that U.S. cancer policy does not always rely on measures of net benefit—like overall survival—that take into account various types of harms from screening.[320] Given that screening is frequently marketed to patients as lifesaving,[321] it is particularly noteworthy that we do not rely on a measurement of net benefit to broadly recommend screening to the U.S. public. In one landmark article, called "Why Cancer Screening Has Never Been Shown to 'Save Lives'—And What We Can Do About It," several experts explain that overall mortality, and not disease-specific mortality, should be the right benchmark to evaluate screening.[322]

There is one principal argument to defend the common use of disease-specific mortality: It is theoretically possible that the benefits of cancer screening are quantitatively small, such that a large sample size is needed to reach statistical significance.[323] That cancer screening could be a lifesaver (as it is often portrayed) simply because it offers a theoretical, small, and difficult-to-measure benefit is dubious. Under this scenario, are the gains truly worth the substantial costs we expend on cancer screening?

To be fair to those in favor of screening, at least one modeling study argues that, even assuming that screening offers a significant reduction in cancer-specific mortality, such as 20%, both a large sample size (40,000 to 600,000) and a lengthy follow-up

319. Steven Woloshin et al., *The New USPSTF Mammography Recommendations — A Dissenting View*, 389 NEW ENG. J. MED. 1061, 1062 (2023).

320. Some readers may quibble that scientific bodies do find a net benefit; for example, as discussed in the example just below, the USPSTF does conclude that breast cancer screening has a net benefit. But it concludes so not based on a *measure* of net benefit, but by informally weighing risks and benefits. A conclusion of net benefit differs from a measure of net benefit.

321. Vinay Prasad et al., *Why Cancer Screening Has Never Been Shown to "Save Lives"—And What We Can Do About It*, BMJ, Jan. 6, 2016, at 1, 1 (noting that cancer screening advocates "still claim that it 'saves lives'").

322. *Id.*

323. *Id.*

(11 to 20 years[324]) are needed to decipher overall survival.[325] This study, however, largely excluded the risks of overdiagnosis and deaths from treatment,[326] and, at the core, it is a modeling study, and therefore subject to assumptions taken by the authors.[327] If the benefits to longevity are so marginal even without including all of the risks of screening (let alone its financial costs), then it is possible many recommended cancer screenings are not worthwhile. To emphasize an earlier point, the harms of screening are nothing to sneeze at. For example, men who receive a diagnosis of prostate cancer are more likely to commit suicide or suffer a heart attack.[328]

Deciphering how to measure net benefit, other than overall survival, is a challenge. Other methods of doing so are to informally balance benefits (e.g., disease-specific mortality) with known costs (e.g., known mortality numbers or rates of adverse events) or to use modeling studies to estimate net benefit. However, informal balancing fails to calculate a net benefit with which to advise patients or a reimbursement policy. And modeling studies are reliant on underlying assumptions and fail to confirm, in real humans, that screening offers a net benefit.[329]

Despite these problems, the regulatory apparatus has generally blessed screenings. Cancer screenings are embedded into a legal framework involving the USPSTF.[330] Insurance coverage for cancer screening is largely gated by the USPSTF, whose recommendations trigger automatic coverage provisions.[331] Showing resemblance to the FDA, the USPSTF appears to be demonstrating significant solicitude to cancer screenings, perhaps in a

---

324. Effectiveness studies for breast cancer mammography that were used in the USPSTF's 2016 evidence review have a range of follow-up times from 11.2 to 21.9 years and, therefore, are long enough to meet the study's suggestions. U.S. PREVENTIVE SERVS. TASK FORCE, 23-05303-EF-1, SCREENING FOR BREAST CANCER: A COMPARATIVE EFFECTIVENESS REVIEW 9 (2024), https://www.ncbi.nlm.nih.gov/books/NBK603789 [https://perma.cc/4GYS-X8AR].

325. Eveline A. M. Heijnsdijk et al., *All-Cause Mortality Versus Cancer-Specific Mortality as Outcome in Cancer Screening Trials: A Review and Modeling Study*, 8 CANCER MED. 6127, 6132 (2019).

326. *Id.* at 6136.

327. Woloshin et al., *supra* note 319, at 1061–62.

328. Prasad et al., *supra* note 321, at 1.

329. Woloshin et al., *supra* note 319.

330. *See supra* Part II.A.2.

331. *See supra* Part II.A.

well-intended effort to ensure that cancer screening is robustly covered by insurance. Ironically, this solicitude contributes to capture by triggering huge financial investments in under-vetted medical screenings.[332] The result is that a mainstay of cancer control in the United States—cancer screening—is significantly aligned with private interests, rather than public health.

I will now explore how these debates over cancer screening played out in breast cancer. Whether mammography screening offers a net benefit is, to this date, unclear.

Breast cancer is one of the most serious forms of cancer the USPSTF interfaces with. Breast cancer was forecasted to afflict about 319,750 Americans in 2025 and kill about 42,170, with 99% of cases and deaths in women.[333] The USPSTF gives a "B" rating to biennial mammography for cisgender women 40 to 74.[334] Finding that the benefits from breast-cancer-specific mortality are "moderate" and the harms "small," it concludes with "moderate certainty" that such screening has a "moderate net benefit."[335] Numerically, USPSTF found, based on modeling studies, that, in a hypothetical cohort of 1,000 women aged 40 through 74, biennial mammography would avert 8 breast cancer deaths, yield 1,376 false-positive results (the most common harm), save 165 years of life from breast cancer, and lead to 14 episodes of overdiagnosis (i.e., finding cancers that would never have impacted a patient's well-being).[336]

Before diving further into USPSTF's rationale, it is worth noting that, based on these data, biennial mammography produces more than one false positive per woman screened;[337] therefore, women should fully expect to have at least one—if not more—false positive should they follow USPSTF recommendations. A third of women say that experiencing a false positive is "very scary" or "the scariest time of my life."[338]

---

332. As noted, the USPSTF's "A" and "B" recommendations bind insurers by requiring coverage. *See supra* Part II.A.2.

333. Rebecca L. Siegel et al., *Cancer Statistics, 2025*, 75 CA: CANCER J. FOR CLINICIANS 10, 13 (2025).

334. *Breast Cancer: Screening*, U.S. PREVENTIVE SERVS. TASK FORCE (Apr. 30, 2024), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening [https://perma.cc/DA67-P78G].

335. *Id.*

336. *Id.*

337. *Id.*

338. Woloshin et al., *supra* note 319, at 1061, 1062 (2023).

The evidence undergirding USPSTF's finding of net benefit largely amounts to 9 randomized controlled trials comparing mammography with non-screening.[339] As the USPSTF final evidence review from 2023 admits, "[a]ll-cause mortality was not reduced with screening for any age group."[340] This was the case despite the fact that the number of total patients (more than 600,000) and the duration of follow up (11.2 to 21.9 years) should be sufficient to infer at least a signal for overall survival, according to the modeling study discussed above.[341] Breast cancer screening recommendations, therefore, are and have been based on *breast cancer mortality*.[342]

While the evidence review acknowledges the harms of screening, it appears to discount them, noting, "[a]lthough overdiagnosis, anxiety, pain, and radiation exposure may cause harm, their effects on individual women are difficult to estimate and vary widely."[343] It is far from clear the USPSTF has adequately assessed these harms, and I could not find a numerical calculation of net benefit.[344] Most likely, then, USPSTF used an

339. U.S. PREVENTIVE SERVS. TASK FORCE, *supra* note 324, at 9.

340. *Id.*

341. *See supra* note 324 and accompanying text (discussing a modeling study, finding that a sample size of 40,000 to 600,000 and a duration of 11 to 20 years could be needed to measure an overall survival benefit).

342. *Id.* at 6, 60, 64 ("Previous reviews of breast cancer screening for the USPSTF, and the basis for its current screening recommendations, were grounded in evidence from effectiveness trials that showed decreased breast cancer mortality with mammography screening for women ages 50 to 69."); *id.* at 42 (explaining that "few longitudinal trials of screening have been conducted since the original effectiveness trials were completed" and that six trials have been added, largely to compare various forms of breast cancer screening as opposed to comparing screening with non-screening).

343. *Id.* at 9.

344. USPSTF finds that biennial screening ages 40 to 74 for 1000 women would save 119 quality-adjusted life-years, essentially meaning each woman would live about 0.1 additional years in good health. U.S. PREVENTIVE SERVS. TASK FORCE, 23-05303-EF-2, BREAST CANCER SCREENING WITH MAMMOGRAPHY: AN UPDATED DECISION ANALYSIS FOR THE U.S. PREVENTIVE SERVICES TASK FORCE 33 (2024). However, the study in question appears to quantify screenings' harms based on their frequency, rather than their impact on longevity, and seems not to include these mortality impacts into its quality-adjusted-life-year estimates. *See id.* at iv. The study further notes that harm-benefit tradeoffs were assessed by comparing predicted breast-cancer morality reductions for various screening strategies against the number of mammograms. *See id.* at iv, 66. However, ultimately, this approach is likely geared toward comparing strategies, rather than identifying a true net benefit.

informal balancing approach to conclude the existence of a net benefit.

Further, the study appears to find a breast cancer mortality reduction of around 25% for biennial screening,[345] which significantly exceeds what the trials show (around 16%, potentially suggesting model bias).[346]

For all the fanfare around mammography (and cancer screening generally), it is surprising that measuring and evaluating net benefit have not been a priority. One reason for this may be that the USPSTF acts as a gatekeeper of insurance coverage, and, therefore, its members may feel a level of pressure to expand access through overly broad recommendations.

In addition, the USPSTF has seemed interested in improving health equity through earlier access to mammography for Black women, given their worse breast cancer outcomes.[347] The task force noted that "[e]nsuring Black women start screening at forty is an important first step, yet it is not enough to improve [racial] inequities."[348] When USPSTF, in 2023, lowered the initiation age for screening mammography from fifty to forty, commentators warned that its "models are insufficient to support a new public health imperative, given the limited benefits and such common and important harms to healthy women."[349] Some evidence suggested that Black women could benefit from screening starting at age forty, and, therefore, a "one-size-fits-all" approach starting at age fifty would be inequitable.[350] Yet under the Equal Protection Clause, governments generally cannot make policies that draw lines based on race.[351] Therefore, it may have seemed preferable to grant access to everyone—i.e., be overinclusive—and allow doctors to tailor screening recommendations by patient. While understandable, it appears the

345. *Id.* at 33.

346. Woloshin et al., *supra* note 319, at 1062.

347. *Breast Cancer: Screening*, *supra* note 334.

348. *Id.*

349. Woloshin et al., *supra* note 319, at 1063.

350. Tianhui Chen et al., *Race and Ethnicity–Adjusted Age Recommendation for Initiating Breast Cancer Screening*, JAMA NETWORK OPEN, Apr. 19, 2023, at 1, 2.

351. *See* Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll., 143 S. Ct. 2141, 2166 (2023) (deciding that two admissions programs, which offered an educational benefit in part based on race, were invalid under the Equal Protection Clause).

USPSTF has been recommending screenings that have not definitively been shown to benefit patients. A patient-centered system should prioritize obtaining and disseminating information about the magnitude of benefit, rather than opening the door to the use of potentially unhelpful medical procedures.

Partly due to the automatic coverage provisions triggered by the USPSTF, in 2010, the United States spent $8 billion on mammography screening,[352] and, in 2011–2013, it spent $4 billion annually on follow-up tests and treatments for inaccurate mammograms.[353] These large sums infuse riches onto healthcare facilities and device manufacturers alike, often in exchange for minimal or uncertain patient benefits.

That USPSTF broadly endorses mammography suggests that USPSTF recommendations may have been deflected in the interests of regulated industry rather than patients—thereby meeting a common definition of capture. While I cannot, in this space, cover all cancer screenings recommended by USPSTF,[354] the regulatory outcome with breast cancer screening suggests either that we should change the overoptimistic way cancer screenings are marketed (i.e., avoid marketing them as proven to save lives) or that a larger reckoning with the evidence base is needed to ensure these screenings are benefiting the public, given a tendency to over-recommend unproven screenings.

352. Cristina O'Donoghue et al., *Aggregate Cost of Mammography Screening in the United States*, 160 ANNALS INTERNAL MED. 145, 145 (2014).

353. Patti Neighmond, *The Hidden Cost of Mammograms: More Testing and Overtreatment*, NPR (Apr. 13, 2015), https://www.npr.org/sections/health-shots/2015/04/13/398818949/the-hidden-cost-of-mammograms-more-testing-and-overtreatment [https://perma.cc/E693-GM8D]. As noted, where a patient has a BRCA1/2 mutation, testing that patient is not considered a screening.

354. It is worth noting that, after the USPSTF issued recommendations in 2012 failing to recommend prostate cancer screening with a grade A or B, it received some criticism from screening advocates. Michael S. Leapman et al., *Changes in Prostate-Specific Antigen Testing Relative to the Revised US Preventive Services Task Force Recommendation on Prostate Cancer Screening*, 8 JAMA ONCOLOGY 41, 45 (2022); *Our Priority: Ensure Patient Access to PSA Testing & Reform the U.S. Preventative Services Task Force (USPSTF) Recommendation Process*, AM. UROLOGICAL ASS'N, https://www.auanet.org/advocacy/federal-advocacy/psa-testing [https://perma.cc/TPE2-G8XA]. Therefore, the USPSTF has not unanimously recommended all available cancer screenings.

3. Capture of Oncologic Medicine

If the capture of regulatory bodies gauging the evidence behind cancer drugs and screenings were not enough, the capture of oncology raises the alarm even further.

Again, cancer medicine has been at least partly marketized by legal changes and incentives.[355] One could imagine physicians operating independently of industry by gatekeeping cancer drugs, educating the public about evidentiary deficits, and treating patients in full accordance with evidence-based practice. Unfortunately, medicine often falls short of these ideals. This is in part because of marketization, which arguably contributes to capture by allowing and incentivizing oncology practice to ally with, rather than serve as a check on, private industry.

As noted, oncology centers, on average, make between 66 to 77% of their income from the sale of drugs.[356] Some of this sum is from the 6% bonus they can take off the top of some oncology drug sales.[357] Given their thirst to host clinical trials, for reasons described earlier,[358] these centers often cater to the interests of private industry.[359] Today, 89% of cancer clinical trials are industry-funded, which means that most drug development partners are private, not public.[360] Industry involvement "influences all stages" of trials, "including design, data collection, analysis, and manuscript drafting."[361] Numerous presidents and executives of cancer centers hold conflicting positions on the boards of pharmaceutical companies that develop cancer drugs.[362] Cancer centers have a symbiotic relationship with pharmaceutical

355. *See supra* Part II.C.

356. *See supra* Part II.C.2.

357. *See supra* Part II.C.2.

358. *See supra* Part II.C.2.

359. *See* S. Gail Eckhardt & Leonidas C. Platanias, *Effects of the Oncology Industrial Complex on Academic Cancer Centers*, 10 JAMA ONCOLOGY 1615 (2024) (describing an "oncology industrial complex" at cancer centers as part of a larger phenomenon of corporatization of the U.S. healthcare system, with cancer centers' dependence on chemotherapy revenue driving harmful changes in oncology practice).

360. Joseph C. Del Paggio et al., *Evolution of the Randomized Clinical Trial in the Era of Precision Oncology*, 7 JAMA ONCOLOGY 728, 728 (2021).

361. *Id.* at 733.

362. Katie Thomas & Charles Ornstein, *When Doctors Serve on Company Boards*, N.Y. TIMES (Dec. 31, 2018), https://www.nytimes.com/2018/12/31/health/cancer-centers-board-memberships-graphic.html [https://perma.cc/Q8SF-TC3V].

companies as joint investors in the cancer therapeutic space. Taken together, this intertwinement raises the possibility of capture.

Beyond cancer centers, it is worth looking more closely at the real-world relationship, as elaborated in oncology scholarship, between practitioners and industry. One might expect oncologists to be in open revolt over the corporatized, profit-driven state of much of oncology practice. Some are—exemplified by the Common Sense Oncology Movement.[363] But oncologists are driven by similar incentives to cancer centers. Payments from the pharmaceutical industry to oncologists are increasing, relative to those made to general medicine doctors.[364] And these payments are associated with increased prescription of expensive, low-value drugs.[365] A 2022 study found that oncologists who receive more than $100,000 in industry payments related to cancer drugs "hold major leadership roles within oncology."[366] Of U.S. authors of oncology clinical trials, 77% have received at least one industry payment, yet these payments frequently go undisclosed.[367] Industry-influenced oncologists may also be the most vocal on social media. A 2017 study of the Twitter oncology community found that, of 632 U.S.-based oncologists on Twitter, 80% had at least one financial conflict of interest.[368]

Pharmaceutical companies also may hold some of the keys to professional advancement. They decide which oncology experts will receive lucrative opportunities to present to the FDA advisory committee, regarding proposed new drugs,[369] and

363. *See supra* Part II.

364. Mohammed W. Rahman et al., *Increasing Financial Payments from Industry to Medical Oncologists in the United States, 2014–2017*, J. NAT'L COMPREHENSIVE CANCER NETWORK, Dec. 2022, at 1, 4.

365. Aaron P Mitchell et al., *Pharmaceutical Industry Payments and Delivery of Non-Recommended and Low Value Cancer Drugs: Population Based Cohort Study*, BMJ, Oct. 25, 2023, at 1, 8.

366. Kristin Wright et al., *Industry Relationships with Medical Oncologists: Who Are the High-Payment Physicians?*, 18 J. CLINICAL ONCOLOGY PRAC. 511, 511 (2022).

367. Wayant et al., *supra* note 296, at 1427.

368. Derrick L. Tao et al., *Financial Conflicts of Interest Among Hematologist-Oncologists on Twitter*, 177 JAMA INTERNAL MED. 425, 426 (2017).

369. Austin Lammers et al., *Financial Conflict of Interest and Academic Influence Among Experts Speaking on Behalf of the Pharmaceutical Industry at the US Food and Drug Administration's Oncologic Drugs Advisory Committee Meetings*, 92 MAYO CLINIC PROC. 1164, 1165–66 (2017). This study found that

which oncologists will participate in "more important and influential research" managed by industry.[370] For these oncologists, words or actions that undercut industry would amount to biting the hand that feeds them and threaten opportunities to advance their career.[371]

All together, the research on cancer centers and oncologists suggests many of their incentives align with those of industry. Not only do they benefit financially from a medicalized, pharmaceuticalized approach to cancer,[372] but their worlds have greatly intermeshed, to the point that oncologists themselves have become dependent on industry for advancement of their research careers.[373] This phenomenon resembles capture, but for physicians. Oncology practice itself has become a pillar undergirding privatized biomedicine.

I would posit that this sort of capture, for oncology practice as well as for the FDA and cancer screenings, is a natural outgrowth of other forms of privatization. Indeed, there is substantial evidence that industry has fought public checks on its own power, such as FDA evidentiary standards for new drugs,[374] so it is not surprising that industry appears to have deliberately attempted to further capture over U.S. institutions and medical practitioners. Delegation, individualization, and marketization contributed to this outcome, while reducing the availability of alternatives (e.g., regulation) for Americans who would like to avoid affliction with cancer.

E. CULTURAL PRIVATIZATION

The law, of course, is only a part of modern society. Legal scholars have emphasized the importance of culture to the development of the law.[375] As I argue here, the culture

expert physicians had higher metrics of academic success when they received more industry funding. *Id.* at 1165. However, all the experts appear successful, with a median of 275 published articles.

370. *See* Beverly Moy et al., *The Impact of Industry on Oncology Research and Practice*, 2015 AM. SOC'Y CLINICAL ONCOLOGY EDUC. BOOK 130, 131 (2015).

371. *Id.*

372. Aggarwal et al., *supra* note 11, at 18.

373. *See supra* note 371 and accompanying text.

374. Aaron, *supra* note 69.

375. *See, e.g.*, Tamar Frankel & Tomasz Braun, *Law and Culture*, 101 B.U. L. REV. ONLINE 157 (2021), https://www.bu.edu/bulawreview/files/2021/12/Law-and-Culture.pdf [https://perma.cc/XF4M-9FLL]; Menachem Mautner, Essay, *Three Approaches to Law and Culture*, 96 CORNELL L. REV. 839 (2011).

surrounding cancer in the United States is highly privatized. Generally, the stories we are told about cancer portray individuals learning of their diagnosis and experiencing a personal struggle through treatment. The role of carcinogens in the environment and in consumer products features minimally. These cultural beliefs, then, reinforce our flawed, privatized approach to cancer.

The most important cultural text to understand modern cancer policy is President Biden's book about his son's cancer[376]—the Number One New York Times bestseller on its release.[377] Biden's struggle, and his son's death from brain cancer in 2015, fueled his 2016 launch of the Cancer Moonshot program.[378] Biden describes his son's cancer as sudden and shocking. Beau "awakened one morning . . . unable to speak and paralyzed on the right side of his body."[379] He recovered but then came down with other neurological symptoms a few years later. A scan revealed a mass in his brain. Biden remarks:

> It was hard to fathom, looking at Beau—tan and handsome and fit . . . that there could be anything seriously wrong with him. He looked to me to be as healthy and vibrant as he always had, from the time he was a little boy. He could have gone out and run ten miles that day, and he seemed to be firing on all cylinders.[380]

Biden's surprise reflects privateness—a lack of awareness of the systemic causes of cancer and why Beau might be sick—and an implied understanding that Beau's cancer is exceedingly random and unfair.[381] Biden reflects that, as Vice President, he "was likely to be able to convince almost any doctor or medical researcher in the country to take his call."[382] Therefore, Biden could use his private privileges on behalf of his son, to secure

376. JOSEPH R. BIDEN, PROMISE ME, DAD: A YEAR OF HOPE, HARDSHIP, AND PURPOSE (2017).

377. *Joe Biden's 'Promise Me, Dad' Tops U.S. Bestsellers List*, REUTERS (Nov. 22, 2017), https://www.reuters.com/article/lifestyle/joe-bidens-promise-me-dad-tops-us-bestsellers-list-idUSKBN1DM2K0 [https://perma.cc/5G4F-X6Z4].

378. Sarah Beth Hensley, *Biden made fighting cancer his life's mission with his 'moonshot' initiative*, NBC NEWS (May 19, 2025), https://abcnews.go.com/Politics/biden-made-fighting-cancer-lifes-mission-moonshot-initiative/story?id=121960099 [https://perma.cc/C97T-CALV].

379. BIDEN, *supra* note 376, at 24.

380. *Id.* at 26.

381. While Biden has speculated that burn pits in Iraq may have contributed to Beau's brain cancer, he did not discuss this in his book.

382. BIDEN, *supra* note 376, at 31–32.

him "extraordinary advances being made" in Beau's type of cancer.[383]

Biden describes the doctor recommending an aggressive treatment plan, adding, "[y]ou're going to be in for a tough fight, Beau. You have a long battle in front of you."[384] The war metaphor reflects the courage and fortitude Beau would need in his personal battle with cancer, as opposed to a community approach.

Beau's physicians threw drugs at him. They tripled the dose of the standard drug used for Beau's cancer, while also providing him an experimental drug as part of a trial.[385] Several months later, they added an "unapproved but promising new drug" supported by no human studies—only animal studies.[386] And they provided Beau another drug requiring "special permission from the pharmaceutical company."[387] Although his symptoms periodically recurred, the family "believed, like [Beau] did, that if he could just hang on long enough, science might outrun his disease. . . . There might be a breakthrough treatment, we told ourselves, or even a cure."[388] Meanwhile, Biden explains, he plunged himself into his work with sixteen-hour days to distract himself from the pain.[389] The story of the Biden family is one of private suffering and loss, desperate treatments, and the belief that salvation from cancer should be found from pharmaceutical development and early access to minimally tested therapeutics, in defiance of the FDA's longstanding public guarantee of safe and effective drugs.

Biden's private tale of cancer is, by and large, the dominant cultural narrative of cancer. As we lose celebrities to cancer each year—Chadwick Boseman, 43; Nat King Cole, 45; Bob Ross, 52; Bob Marley, 36; Steve Jobs, 56—we rarely consider what caused their cancer, even when they tell us.[390] Walt Disney, a renowned

383. *Id.* at 31.
384. *Id.*
385. *Id.* at 80.
386. *Id.* at 81.
387. *Id.*
388. *Id.* at 82.
389. *Id.* at 85.
390. *Official Obituary of Chadwick Boseman*, MARCUS D. BROWN FUNERAL HOME, https://www.marcusdbrownfuneralhome.com/obituary/Chadwick-Boseman [https://perma.cc/TVD5-KYT6]; Paul Weeks, *From the Archives: Nat*

Fortune 500 founder, died from lung cancer.[391] But he, per a popular urban legend, is commonly believed to have preserved himself in a cryogenic chamber to be later revived.[392] His "hacking, dry cough" and his long-existing emphysema were forgotten,[393] replaced with a delicious story painting Disney as taking his own life, rather than a victim of tobacco. Nor do many know that Disney's daughter, Diane Disney Miller, begged the public to support FDA's tobacco regulatory push in the mid-1990s.[394] She wrote:

> Smoking has killed 10 million people in the United States since the first surgeon general's report on the dangers of nicotine and smoking in 1964. It will continue to kill smokers and susceptible nonsmokers. This is senseless and deplorable. . . . More than 90% of lung cancer, one of the cancers most resistant to treatment, is caused by smoking. Before the birth of the American cigarette industry, lung cancer was almost unheard of.[395]

Movies press similar stories—cancer begins at diagnosis and ends at treatment or death; there is generally no larger community narrative. *The Fault in Our Stars*, perhaps the most famous cancer film, follows two teenagers with cancer, wrestling with their love for each other while contemplating "oblivion."[396] The characters do not ponder the causes of their cancers and perceive no injustice. *The Bucket List*, starring Morgan Freeman and Jack Nicholson, starts with both men's diagnoses and ends

---

'King' Cole dies of cancer at 45, L.A. TIMES (Feb. 16, 1965), https://www.latimes.com/local/obituaries/archives/la-me-nat-king-cole-19650216-story.html [https://perma.cc/L344-2GGE]; *Bob Ross, 52, Dies; Was Painter on TV*, N.Y. TIMES (July 13, 1995), https://www.nytimes.com/1995/07/13/obituaries/bob-ross-52-dies-was-painter-on-tv.html [https://perma.cc/5GGQ-NWK2]; Jo Thomas, *With Pride and Music, Jamaicans Bury Bob Marley*, N.Y. TIMES (May 22, 1981), https://www.nytimes.com/1981/05/22/world/with-pride-and-music-jamaicans-bury-bob-marley.html [https://perma.cc/M8SF-2R4C]; Jack Schofield, *Steve Jobs Obituary*, GUARDIAN (Oct. 5, 2011), https://www.theguardian.com/technology/2011/oct/06/steve-jobs-obituary [https://perma.cc/JT3Z-LCX3].

391. Diane Disney Miller, *A Plea to Eradicate a 'Pediatric' Disease*, L.A. TIMES (Aug. 9, 1995), https://www.latimes.com/archives/la-xpm-1995-08-09-me-33097-story.html [https://perma.cc/D9UH-SHC6].

392. Howard Markel, *How a Strange Rumor of Walt Disney's Death Became Legend*, PUB. BROAD. SERV. (Dec. 17, 2018), https://www.pbs.org/newshour/health/how-a-strange-rumor-of-walt-disneys-death-became-legend [https://perma.cc/YW5Z-ZYQ2].

393. Miller, *supra* note 391.

394. *Id.*

395. *Id.*

396. THE FAULT IN OUR STARS (Fox 2000 Pictures 2014).

with their death—after many bucket-list adventures, of course.[397] *Funny People* portrays Adam Sandler diagnosed with leukemia, placed on an experimental medication, and miraculously cured.[398] *Tig* discusses comedian Tig Notaro's personal struggle with breast cancer.[399] While there are exceptions, like *Erin Brockovich*,[400] the stories that are told about cancer are ex post and privatized—generally failing to reckon with systemic causes of cancer. The media reinforces the notion that cancer is a random occurrence to be managed through chemotherapy. By telling us that our cancer regimes have the proper focus, cultural privatization diffuses tension and pulls the American people on board a private project.

To be clear, factors beyond culture likely entrench privatization. For example, Neel Sukhatme and Gregg Bloche have argued that "[w]e're hard-wired to come to the aid of people we know are in distress," and this rescue impulse entrenches ex post medicalized interventions for people on death's door.[401] Erin Fuse Brown and Mark Hall point to regulatory gaps and barriers to enforcement, ultimately noting that "so long as the United States treats health care as a market commodity, profit-seeking will persist."[402] Brown and Hall seem to describe deregulation and marketized approaches as self-reinforcing. These accounts overlap with the idea of cultural privatization: the common belief that individualized, marketized solutions are acceptable, even desirable.

F. MULTI-MODAL PRIVATIZATION

In this Part, I offered a sprawling discussion of the laws around cancer and argue that cancer has been privatized across five dimensions. Unlike the traditional understanding of privatization (delegation), the privatization of cancer was multi-modal.

This more subtle, multi-modal privatization placed corporations in charge and largely accrued to their benefit. Corporations sell the products that cause most cancers; they receive the funds

397. THE BUCKET LIST (Warner Bros. 2008).

398. FUNNY PEOPLE (Universal Pictures 2009).

399. TIG (Beachside Films 2015).

400. ERIN BROCKOVICH (Universal Pictures 2000).

401. Neel U. Sukhatme & M. Gregg Bloche, *Health Care Costs and the Arc of Innovation*, 104 MINN. L. REV. 955, 967 (2019).

402. Brown & Hall, *supra* note 146, at 547–49, 578–79.

to fix it; they pursue solutions that enrich themselves; they paint themselves as the savior; and our culture buys into this tale. Often it is the same company doing all of these things.[403] Meanwhile, the root causes of cancer go unaddressed,[404] and cancer has remained the second-leading cause of death for more than a century.[405]

III. DE-PRIVATIZATION

This Part leverages cancer law to elucidate the under-recognized risks of privatization, then uses the five-part theory of privatization to propose publicizing (i.e., de-privatizing) reforms.

A. RECOGNIZING THE RISKS OF PRIVATIZATION

The extreme privatization of cancer has brought into stark relief four categories of risks—both for cancer and for social policy writ large. They are innovation failures, draining the public fisc, impairing social policy, and inequity.

1. Innovation Failures

Legal scholars have discussed at length the role of U.S. "innovation institutions," largely centering on patent law and agencies including the FDA, the National Institutes of Health, and the Center for Medicare and Medicaid Services.[406] The argument for fostering innovation to meet various social needs is a powerful one. Without doubt, the FDA's solicitude toward new cancer drugs is driven largely by the faith in innovation to mitigate a deadly disease. At the same time, this "innovation" fixation in healthcare entrenches corporatized pharmaceutical policy. According to former HHS Secretary Alex Azar, whenever

403. For example, Bayer, which sells the carcinogenic pesticide Roundup (after purchasing Monsanto), has been gobbling up small pharmaceutical companies to increase its oncology-drug sales. Zoey Becker, *Bayer's Oncology Business Looks to Collect $10B in Sales by 2030, Exec Says*, FIERCE PHARMA (Jan. 24, 2023), https://www.fiercepharma.com/pharma/jpm-23-bayers-and-coming-oncology-business-looks-collect-10-billion-sales-2030 [https://perma.cc/NGS2-4A4H]; *IARC Monograph on Glyphosate*, WORLD HEALTH ORG.: INT'L AGENCY FOR RSCH. ON CANCER (July 19, 2018), https://www.iarc.who.int/featured-news/media-centre-iarc-news-glyphosate [https://perma.cc/VW27-W4WD] (finding that Roundup, also known as glyphosate, is "probably carcinogenic to humans").

404. Aaron, *supra* note 10 (manuscript at 16).

405. *Id.* at 9.

406. *See supra* note 18 (providing examples of this discussion).

changes to pharmaceutical policy are proposed that do not benefit industry, industry complains that "American innovation will grind to a halt."[407] Cynthia Ho and Liza Vertinsky have coined "innovation bullying" as the use of unsubstantiated claims about protecting innovation to push private interests.[408]

Legal scholars have also characterized ways that innovation policy can seriously go awry.[409] For example, Daniel Hemel and Lisa Ouellette describe how "innovation policy failures" helped produce the opioid crisis.[410] They note that intellectual property incentives spurred early opioid manufacturers to "invest in demand creation" to foster sales of addicting opioids.[411] More broadly, Christopher Buccafusco and Samuel N. Weinstein have identified the concept of "antisocial innovation" to push back against a "sunny vision of innovation."[412] That is, innovation has a "dark side" that can "make people's lives worse."[413] Inventions, like cigarette additives, firearm bump stocks, and artificial intelligence, can range from bad to "potentially catastrophic."[414]

Where do cancer drugs lie on the spectrum of innovation? Part II argued that the FDA is generally approving minimally effective, often inadequately tested, cancer drugs. These drugs are automatically covered, under law, by third-party payers.[415] In other words, we channel untold resources to arguably mediocre innovations. Our incentives for cancer drug development are so large that, as Robin Feldman has noted, cancer is overtaking

407. Michael A. Carrier & Genevieve Tung, *The Industry that Cries Wolf: Pharma and Innovation*, STAT (Sept. 26, 2019), https://www.statnews.com/2019/09/26/innovation-boy-cried-wolf-pharma-industry [https://perma.cc/R74B-KA6K].

408. Cynthia Ho & Liza Vertinsky, *"Innovation Bullying" in Drug Policy*, HEALTH AFFS. FOREFRONT (Sept. 11, 2023), https://www.healthaffairs.org/content/forefront/innovation-bullying-drug-policy [https://perma.cc/96DB-PH86].

409. *See, e.g.*, Buccafusco & Weinstein, *supra* note 18; Daniel J. Hemel & Lisa Larrimore Ouellette, *Innovation Institutions and the Opioid Crisis*, J.L. & BIOSCIENCES, June 2020, at 1; Lemley et al., *supra* note 18; Mazzucato, *supra* note 18.

410. Hemel & Ouellette, *supra* note 409, at 2.

411. *Id.* at 15–22.

412. Buccafusco & Weinstein, *supra* note 18, at 573.

413. *Id.* at 599.

414. *Id.* at 573.

415. *See supra* Part II.A.1.

the drug development space.[416] In other words, overclocked incentives may be tamping down innovation.

The innovation failure within cancer pharmaceuticals pushes against the ideas of some innovation scholars. For example, Mark Lemley, Lisa Ouellette, and Rachel Sachs have explained that Medicare coverage of pharmaceuticals amounts to an "innovation subsidy" and that price reduction efforts should be pursued in ways that preserve the incentive to innovate new drugs.[417] But, in my view, it is not at all clear that larger incentives to develop drugs will lead to better drugs. Instead, the cancer industry appears to be responding to lucrative incentives by designing mediocre drugs.

Cancer drugs undermine the idea that lowering the approval standard and offering generous financial incentives will support innovation.[418] Instead, this approach has prioritized low-value, high-cost innovations, which then, in turn, compete with true innovations.[419] This outcome represents an innovation failure.

2. Draining the Public Fisc

While failing to drive innovation, cancer privatization also expends a significant fraction of U.S. healthcare dollars. Cancer drugs account for the largest spending compared with any specialty's drugs and are, by some calculations, the largest expenditure within cancer care.[420] In part, this is due to a "unique" set of legal rules, including automatic coverage provisions, cancer drugs' exemptions from healthcare cost controls, and incentives for heavy use.[421]

The hundreds of billions of dollars we spend on medicalized solutions to cancer generate an artificial scarcity of funds for

416. Feldman, *supra* note 284, at 82.

417. Lemley et al., *supra* note 18, at 123–25.

418. Aaron, *supra* note 69, at 10.

419. *Id.* at 103.

420. *See* Nicholas G. Zaorsky et al., *Medical Service Use and Charges for Cancer Care in 2018 for Privately Insured Patients Younger than 65 Years in the US*, JAMA NETWORK OPEN, Oct. 6, 2021, at 1, 7–8; Keith Loria, *Up, Up and Not Going Away: Cancer Drug Prices*, MANAGED HEALTHCARE EXEC. (Oct. 14, 2022), https://www.managedhealthcareexecutive.com/view/up-up-and-not-going-away-cancer-drug-prices [https://perma.cc/6H2L-73WS] (stating cancer drugs "represent[ ] between 50% and 60% of the total cancer spend").

421. *See supra* Part II.A, II.C.3.

more preventive and public approaches to managing cancer (Table 4). Public-health commentators have described "decades of underfunding" that "have made it challenging to protect the public's health."[422] But with cancer specifically, these trends are particularly salient because the spending on a single cancer screening (e.g., colonoscopy) can exceed the total spending on public health in the United States.[423] The deregulation of the leading causes of cancer, discussed at length in prior work,[424] is driven, first and foremost, by underfunding of agencies.[425]

422. Matt McKillop & Dara Alpert Lieberman, *The Impact of Chronic Underfunding on America's Public Health System*, TR. FOR AM.'S HEALTH 4 (2023), https://www.tfah.org/wp-content/uploads/2023/06/TFAH-2023-PublicHealth FundingFINALc.pdf [https://perma.cc/U42V-3SRX]; Lauren Weber et al., *Hollowed-Out Public Health System Faces More Cuts Amid Virus*, KFF HEALTH NEWS (last updated Aug. 24, 2020), https://kffhealthnews.org/news/us-public-health-system-underfunded-under-threat-faces-more-cuts-amid-covid -pandemic [https://perma.cc/9S5G-34NG].

423. *See* Table 4.

424. *See generally* Aaron, *supra* note 10.

425. *See, e.g.*, *id.* (manuscript at 59) ("Deficient appropriations impacted every cancer regime, albeit to varying degrees.").

Table 4: Comparison of spending on private vs. public approaches to cancer in billions (b). Public spending uses the fiscal year.

PRIVATE SPENDING		PUBLIC SPENDING	
U.S. sales for Merck's Keytruda (pembrolizumab), 2024	$5.6 b[426]	U.S. budget request for FDA tobacco regulation, 2023	$0.78 b[427]
U.S. spending on Celgene's Revlimid (levalidomide), 2018	$6.47 b[428]	EPA's budget to improve air quality, 2018	$0.768 b[429]
U.S. spending on AbbVie/Janssen's Imbruvica (ibrutinib), 2020	$4.3 b[430]	Requested appropriations for EPA's toxics review and reduction program, 2020	$0.066 b[431]

426. Joseph Walker, *Why Drug Prices for Some Big Medicines Will Remain High for a Longer Time*, WALL ST. J. (Aug. 3, 2025), https://www.wsj.com/health/pharma/trump-tax-spending-bill-drug-prices-medicare-5465f4e2 [https://perma.cc/56TQ-ZZHE].

427. *Fiscal Year 2024: Justifications of Estimates for Appropriations Committees*, U.S. FOOD & DRUG ADMIN. 17 (2024), https://www.fda.gov/media/166182/download [https://perma.cc/U8XM-B3JQ]. This comes from the tobacco industry as user fees, so these are, in a way, private dollars.

428. *Drug Pricing Investigation: Celgene and Bristol Myers Squib*—Revlimid, U.S. H.R. COMM. ON OVERSIGHT & REFORM 3 (2020), https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/Celgene%20BMS%20Staff%20Report%2009-30-2020.pdf [https://perma.cc/H6BN-CPD2].

429. U.S. ENV'T PROT. AGENCY, EPA-190-R-002, FISCAL YEAR 2020: JUSTIFICATION OF APPROPRIATION ESTIMATES FOR THE COMMITTEE ON APPROPRIATIONS 9 (2020), https://www.epa.gov/sites/default/files/2019-03/documents/fy-2020-congressional-justification-all-tabs.pdf [https://perma.cc/6QLY-2875].

430. *Drug Pricing Investigation: AbbVie*—Humira and Imbruvica, U.S. H.R. COMM. ON OVERSIGHT & REFORM 5 (2021), https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/Committee%20on%20Oversight%20and%20Reform%20-%20AbbVie%20Staff%20Report.pdf [https://perma.cc/T9Y9-M765].

431. U.S. ENV'T PROT. AGENCY, *supra* note 429, at vii.

Medicare spending on Darzalex (daratumumab), 2024	$5.6 b[432]	U.S. spending on FDA food regulation, 2022	$1.14 b[433]
U.S. sales for AstraZeneca's Tagrisso (osimertinib), 2022	$5.44 b[434]	U.S. spending on EPA's environmental justice program, 2022	$0.28 b[435]
U.S. annual spending on screening colonoscopies	$27.5 b[436]	Total federal spending on public health, 2019	$13 b[437]

As noted, most spending on drugs and screening is not optional; private payers and the federal government are obligated by law to reimburse these expenses.[438] When evaluating drugs, the United States uses a fairly liberal standard to measure cost-effectiveness: a threshold of $100,000–$150,000 per life-year saved.[439] At this threshold, the cost of saving one year of life for one person could hire two starting-level public health employees

432. Walker, *supra* note 426.

433. U.S. FOOD & DRUG ADMIN., *supra* note 427, at 15.

434. *Full Year and Q4 2022 Results*, ASTRAZENECA 11 (2023), https://www.astrazeneca.com/content/dam/az/PDF/2022/fy/Full-year-and-Q4-2022-results-announcement.pdf [https://perma.cc/TX96-38BV].

435. U.S. ENV'T PROT. AGENCY, EPA-190R23001, FISCAL YEAR 2024: JUSTIFICATION OF APPROPRIATION ESTIMATES FOR THE COMMITTEE ON APPROPRIATIONS 20 (2023), https://www.epa.gov/system/files/documents/2023-03/fy-2024-congressional-justification-all-tabs.pdf [https://perma.cc/LS67-9LHV].

436. Halpern et al., *supra* note 111, at 1172.

437. Matthew McGough et al., *How Has U.S. Spending on Healthcare Changed over Time?*, HEALTH SYS. TRACKER (Dec. 20, 2024), https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time [https://perma.cc/ZQ7D-K6RU]. The 2019 figure is used because there was a temporary surge in public health funding after 2020, due to the COVID-19 pandemic. *See id.*

438. *See supra* Part II.C.

439. Cherla et al., *supra* note 278, at 3. These measurements, of course, cannot alter legally mandatory coverage decisions.

with master's degrees for one year.[440] Amid efforts to reign in federal spending and resistance to increasing taxes,[441] subsidization of ex post, privatized cancer care helps maintain an artificial scarcity of public dollars.

The privatization of cancer, and other social problems, can drain public dollars needed for large-scale regulatory efforts. Critics of enormous U.S. healthcare spending—a frequently derided problem[442]—might look to the way we have turned to expensive corporate products and services to mitigate problems solvable at the public level. National health expenditures are projected to grow 5.4% annually between 2022 and 2031.[443] Cutting back on spending for hyper-privatized products that minimally enhance longevity could free funds for public approaches.

3. Impairing Social Policy

The previous Section considered how private systems can siphon public health dollars. As I argued in *The Deregulation of Cancer*, public regulatory institutions are failing to prevent cancer—most prominently due to underfunding.[444] To date, the main way we have reduced cancer mortality is through state

440. This is based on a starting salary of $60,000 per year. *See* Rich Griset & Jasmine Suarez, *These Jobs Require a Master's Degree in Public Health—and Pay $100K and Up*, FORTUNE (Mar. 30, 2023), https://fortune.com/education/articles/these-jobs-require-a-masters-degree-in-public-health-and-pay-100k-and-up [https://perma.cc/KF46-QNL8].

441. *See* Tami Luhby, *Here's How the House GOP Majority Will Try to Curb Federal Spending and Taxes*, CNN: POL. (Jan. 10, 2023), https://www.cnn.com/2023/01/10/politics/house-rules-package-republicans-federal-spending/index.html [https://perma.cc/5C6G-8HXN].

442. *See, e.g.*, Austin Frakt & Aaron E. Carroll, *Why the U.S. Spends So Much More than Other Nations on Health Care*, N.Y. TIMES (Jan. 2, 2018), https://www.nytimes.com/2018/01/02/upshot/us-health-care-expensive-country-comparison.html [https://perma.cc/U4M2-A6AU] (critiquing how much the United States pays for healthcare); SILVER & HYMAN, *supra* note 20 (investigating the healthcare system's flaws); STEVEN BRILL, AMERICA'S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM (2015) (discussing extreme U.S. healthcare costs and the various players in the U.S. healthcare system).

443. Sean P. Keehan et al., *National Health Expenditure Projections, 2022–31: Growth to Stabilize once the COVID-19 Public Health Emergency Ends*, 42 HEALTH AFFS. 886, 886 (2023).

444. Aaron, *supra* note 10 (manuscript at 54) (demonstrating how barriers like underfunding can deregulate agencies like the FDA and EPA and thus prevent them from protecting against cancer).

tobacco regulation and litigation in the 1990s.[445] But tobacco regulation today is faltering,[446] as is regulation of cosmetics, food additives, air, and water.[447]

Regulatory failures contribute to cancer being the second leading cause of death in the United States, taking more than 600,000 Americans to the grave annually.[448] And cancer rates are increasing, including among U.S. youth.[449] A new study from the NCI found that cancer rates for Gen X are higher than for Baby Boomers, suggesting "cancer incidence in the [United States] could remain unacceptably high for decades to come."[450] One study author added, "[i]s there anything that gives us hope that things are going to turn a corner for the Millennials . . . ? What we found is, no."[451] And what of Gen Z?

Privatization, put simply, places public health on the back-burner—cancer prevention is an afterthought in a medicalized, individualized, privatized system. Wendy Parmet, similarly, has argued that courts' overruling of government COVID-19 measures has led to the privatization of COVID-19 policy—leaving corporations to institute measures piecemeal.[452]

Privatization may also compromise broader social policy. As to climate change, Shelly Welton critiques our reliance on net-zero pledges by corporations—atomistic decisions that reflect poor cooperation and neglect social values that government

445. *Id.* at 9.

446. *Id.* at 21.

447. *Id.* at 7 (arguing that cosmetics, food additives, air, and water have been "devastated by deregulation").

448. *Id.* at 7, 16 (investigating how, by deregulation, the United States has allowed cancer to "run rampant").

449. *See* Siegel et al., *supra* note 78, at 1 (noting "increasing incidence for 6 of the top 10 cancers"); Abbott, *supra* note 81 (revealing that cancer rates among people under fifty increased between 2000 to 2019).

450. Ronnie Cohen, *As They Enter Their 60s, Gen Xers Projected to See Higher Cancer Rates than Boomers*, NPR (June 20, 2024), https://www.npr.org/sections/shots-health-news/2024/06/20/nx-s1-5010707/cancer-rates-younger-gen-x-boomers [https://perma.cc/ELE8-Z8JP].

451. *Id.*

452. *See* Wendy E. Parmet, *Employers' Vaccine Mandates Are Representative of America's Failed Approach to Public Health*, ATLANTIC (Feb. 4, 2021), https://www.theatlantic.com/ideas/archive/2021/02/privatization-public-health/617918 [https://perma.cc/Z74E-G84D] (arguing that because of U.S. Supreme Court decisions, individuals and the private sector are burdened to implement COVID-19 preventative measures).

policy can better guard.[453] Several scholars have argued that privatized approaches in environmental law failed to demand the public investment and restructuring needed to address climate change.[454] The environmental provisions of the Inflation Reduction Act of 2022 (IRA), a landmark policy, are largely an incentive program for private investment in clean energy.[455] Climate experts warn that these incentives could produce little change in greenhouse gas emissions, if public energy infrastructure is not updated.[456] The IRA also subsidizes clean hydrogen power, but industry has lobbied for permission to use less climate-friendly processes that could turn hydrogen into "an outright reverser of climate gains."[457]

Privatized policies occupy legislators' time and the public's attention, and they may distract from approaches that are less marketized or individualized.[458] They can also backfire, particularly if (1) the incentives are not calibrated to generate public goods, or (2) the public sphere is too weak to guard against exploitation.[459] Unfortunately, industry has a vested interest in building its own power, which for some companies entails eroding the public sphere's capacity to support public values.[460]

---

453. *See* Welton, *supra* note 16, at 171 (arguing that the private sector often utilizes a disjunctive, atomized net-zero approach, which undermines widespread decarbonization efforts).

454. Britton-Purdy et al., *supra* note 67, at 1804–05.

455. Sanjay Rajagopalan & Philip J. Landrigan, *The Inflation Reduction Act – Implications for Climate Change, Air Pollution, and Health*, LANCET REG'L HEALTH, Jul. 2023, at 1, 1 (suggesting that the IRA's "main strategy" for reducing greenhouse gas emissions is clean energy investment incentives).

456. *See* Jesse D. Jenkins et al., *Electricity Transmission is Key to Unlock the Full Potential of the Inflation Reduction Act*, PRINCETON UNIV. REPEAT PROJECT (2022), https://repeatproject.org/docs/REPEAT_IRA_Transmission_2022-09-22.pdf [https://perma.cc/ZH2Y-5JNF] (stating that energy transmission expansion must be accelerated to actualize clan energy's benefits).

457. *See* Julie McNamara, *Climate Benefits of Hydrogen Are at Risk as Fossil Fuel Industry Pressures Mount*, SCI. AM. (Nov. 6, 2023), https://www.scientificamerican.com/article/climate-benefits-of-hydrogen-are-at-risk-as-fossil-fuel-industry-pressures-mount [https://perma.cc/EL7W-H9M9] (arguing that the fossil fuel industry is lobbying to turn the hydrogen tax credit into one that encourages heavily polluting projects that rely on upstream methane leakage, carbon offsets, and electrolyzes).

458. *Cf. supra* Part II.A.2 (discussing impairment of public health policy from cancer's privatization).

459. *See supra* Part I (discussing problems with privatized approaches given insufficient public input or control).

460. *See supra* Part I.C.

4. Inequity

The marketization of social problems is overlaid on a socially stratified country, rife with inequity—across race, class, gender, and much more. This Section describes privatization's relationship with inequity, inherent in forcing disadvantaged communities to purchase private, marketized goods on their own wages. I will begin with cancer and expand the lens.

Cancer accounts for the most patient cost of any disease.[461] The financial costs frequently upend families and cause patients to skip care or move in with friends or family.[462] According to one study, about 50% of patients with 1 of 4 common cancers declare bankruptcy within 10 years of diagnosis.[463] For racial and ethnic minorities, cancer is more likely to lead to indicators of financial hardship, like declaring bankruptcy, borrowing money to pay for care, or being unable to pay.[464] Majority-Black census tracts have higher rates of dying from cancer; similar disadvantages are seen for low-income communities.[465]

Without strong public regulation of food, tobacco, and carcinogens writ large, private individuals are responsible for avoiding exposures—and who but wealthier people have the time to research carcinogens, the resources to live in communities with less air pollution, or, generally, the wherewithal to

461. Aaron A. Laviana et al., *Trends in the Cost of Cancer Care: Beyond Drugs*, 38 J. CLINICAL ONCOLOGY 316, 316 (2019).

462. *See, e.g.*, Noam Levey, *She Was Already Battling Cancer. Then She Had to Fight the Bill Collectors*, NPR (July 9, 2022), https://www.npr.org/sections/health-shots/2022/07/09/1110370391/cost-cancer-treatment-medical-debt [https://perma.cc/4K5V-FN4C] (showing that of indebted adults who within five years had cancer treatment, or had a family member who received cancer treatment, 74% skipped or delayed medical care due to costs and that 29% changed their living situation, such as by moving in with friends or family).

463. *See* Scott D. Ramsey et al., *Financial Insolvency as a Risk Factor for Early Mortality Among Patients with Cancer*, 34 J. CLINICAL ONCOLOGY 980, 983 (2016) (showing that around 50% of patients with breast, colorectal, lung, and prostate cancers declare bankruptcy within 10 years).

464. *See* K. Robin Yabroff et al., *Financial Hardship Associated with Cancer in the United States: Findings from a Population-Based Sample of Adult Cancer Survivors*, 34 J. CLINICAL ONCOLOGY 259, 260, 262–63 (2016) (indicating that racial minority cancer survivors face greater financial hardships than other cancer survivors).

465. Inas Abuali et al., *Disparities in Cancer Care—A Call to Action*, CANCER CELL, Jan. 9, 2023, at 1, 1 (demonstrating that cancer survivorship rates are less in majority-Black and low-income communities for "a wide variety of cancers, including breast, lung, prostate, and colorectal cancers").

privately protect their health? "Social inequalities are evident at every step of the cancer continuum, starting from the individual's exposure to risk factors and the likelihood of developing cancer, to whether information relating to the cancer is collected and counted, through access to screening and diagnostic facilities."[466]

Similar points have been made about climate change. Ruhan Nagra has observed that Black and Brown communities often lack the resources to relocate away from climate change risks[467]—a private solution to a public problem. And for reproductive rights, critics of the "choice" framework established in *Roe* argue that the private right to an abortion neglected structural barriers and resource differences that eroded racial and gender equity after *Roe*.[468]

Privatized solutions can generate inequity by forcing competition on an uneven playing field.[469] Markets gate access based on private wealth.[470] On the other hand, public policy can create public goods (e.g., regulatory floors) that, being non-excludable, accrue to the benefit of all.[471]

B. DE-PRIVATIZATION IN FIVE DIMENSIONS

Now that we have surveyed the core risks of privatized governance, the five-part theory of privatization provides a useful scaffolding for developing publicizing policies that infuse the

466. Diana Sarfati, *Why Social Inequalities Matter in the Cancer Continuum*, *in* REDUCING SOCIAL INEQUALITIES IN CANCER: EVIDENCE AND PRIORITIES FOR RESEARCH 15, 15–16 (Salvatore Vaccarella et al. eds., 2019).

467. Ruhan Sidhu Nagra, *Relocating Justice*, 74 DUKE L.J. 441, 467 (2024).

468. *See* Murray, *supra* note 47, at 2050 (arguing that *Roe*'s "choice" framework ignored institutional, economic, and identity-based barriers to "choice," and it did not offer a positive constitutional entitlement to ensure access); Rebecca L. Rausch, *Reframing* Roe*: Property over Privacy*, 27 BERKELEY J. GENDER L. & JUST. 28, 31 (2012) (asserting that "choice" becomes limited when the right to privacy yields no positive rights to governmental support or funding).

469. *See* Britton-Purdy et al., *supra* note 67, at 1784 ("'Neoliberal' premises undergird many fields of law and have helped authorize policies and practices that reaffirm the inequities of the current era.").

470. *See id.* at 1790 (noting that market approaches, which show fealty to summative conceptions of social welfare, offer "no means to analyze, let alone counter, contemporary concentrations of wealth and power").

471. Daniel G. Aaron, *Public Health in the Opioid Litigation*, 53 LOY. U. CHI. L.J. 11, 29–30 (2021); *see supra* Part II.B (discussing community vs. individualized approaches).

management of social problems with public values. I will use the example of cancer to show the utility of the model.

Un-Delegation: The delegation of cancer operated principally through automatic coverage provisions that endowed private efforts with public subsidies.[472] To undo this form of privatization, we might simply dial back automatic coverage. Payment reductions could operate across the board or target ineffective or undertested drugs and services. One study found that using value-based pricing for drugs could save $373 million *annually per drug*.[473] These savings could be spent on public cancer approaches.

De-Individualization: We could de-individualize cancer by restoring and strengthening public prevention efforts. Strengthening the regulation of our air, water, and food supply carries public health promise and could accrue to the benefit of all Americans. Further discussion of potential regulatory efforts is available in *The Deregulation of Cancer*.[474] We might also rethink policies that place undue emphasis on individualized interventions and serve as political tools, such as the Cancer Moonshot.

De-Marketization: De-marketization can involve restoring prohibitions on behaving like market actors and curbing incentives that foster marketization. Within health law, there is a larger crisis of the corporatization of medicine and an unnecessary distance between physicians and the patients they serve.[475] We might restore prohibitions of the corporate practice of medicine[476] or restrict physician advertising to disallow marketization.[477] We might also tone down the incentives for quasi-public

472. *See supra* Part II.A.

473. Kai Yeung et al., *Value-Based Pricing of US Prescription Drugs: Estimated Savings Using Reports from the Institute for Clinical and Economic Review*, JAMA HEALTH F., Dec. 6, 2022, at 1, 2 (finding that applying value-based pricing at $100,000 per quality-adjusted-life-year could reduce median annual drug spending by $373 million).

474. Aaron, *supra* note 10.

475. *See supra* note 146 (listing literature exploring said crisis). The New England Journal of Medicine has recently launched a paper series called "The Corporatization of U.S. Health Care." *See* Debra Malina et al., *The Corporatization of U.S. Health Care — A New Perspective Series*, 393 NEW ENG. J. MED. 81 (2025).

476. Zhu et al., *supra* note 146, at 967 (examining how states can strengthen their laws governing the corporate practice of medicine).

477. *See supra* Part II.C (describing marketization's impact on the healthcare system).

institutions, like cancer centers, to maximize profit, such as by removing the bonus for prescribing chemotherapies.[478]

Uprooting Capture: A voluminous literature discusses the problem of capture and how to mitigate it.[479] As to cancer, capture could be addressed by heightening FDA evidentiary standards for new drugs; placing legal guiderails on the evidence needed for endorsement by the USPSTF (e.g., emphasizing measures of net benefit); improving financial conflict-of-interest rules for the FDA, oncology centers, and oncologists; and increasing the amount of research funding from government.

De-Privatizing Culture: The arts must find novel ways of telling stories about public values and public systems. Personal stories of struggle without considering root causes may drive privatization by reinforcing the importance of individualized, marketized approaches. De-privatizing culture may, ironically, fall more within the ambit of (private) filmmakers and authors. It may be possible for governments to spur de-privatization, however, by (1) providing greater funding to the arts and humanities, including through universities; (2) releasing documents through transparency initiatives, which can feed into journalism and storytelling; and (3) considering government participation in the arts in specific, constrained ways.

Per the latter proposal, government participation in the arts could raise concerns about propaganda, as occurred during World War II under the leadership of the Office of Strategic Services—the precursor to the Central Intelligence Agency—according to a declassified memorandum.[480] Some agencies already take a public-interest approach to communication, including the FDA, whose YouTube channel is peppered with cartoons and informational videos about public health and medicine.[481] Movies about public values can be successful, as evidenced by Erin

478. *See supra* Part II.C.2 (describing financial incentives in cancer care).

479. *See supra* Part I.B.

480. Pearse Redmond, *The Historical Roots of CIA-Hollywood Propaganda*, 76 AM. J. ECON. & SOCIO. 280, 284–85 (2017) (explaining the history of pre-Central Intelligence Agency government propaganda, including a 1943 Office of Strategic Services memorandum that discusses propaganda's benefits to the government).

481. *See U.S. Food and Drug Administration (@US_FDA)*, YOUTUBE, https://www.youtube.com/user/USFoodandDrugAdmin [https://perma.cc/65AS-VXV3] (generating and hosting videos relating to health, wellness, medicine, and the government).

Brockovich's tale of a community's struggle with water contamination and cancer.[482]

Seeing privatization across five dimensions can be helpful to devising solutions that repair regulatory structures, tackle community problems, and generate public goods. Learning from cancer's history, the Environmental Justice (EJ) Movement may be a model for how to achieve publicization.

C. DE-PRIVATIZATION THROUGH SOCIAL MOVEMENTS

Despite arguing that cancer has been privatized, this Article fully acknowledges that we have numerous public-facing cancer regulatory regimes dating to a surge in public authority in the 1960s and 1970s.[483] What triggered this development, and how have publicizing reforms been achieved in the past?

The history of cancer law might provide us a path of recourse for de-privatization: namely, social movements. Indeed, the EJ Movement, by consistently pressing for a community approach to cancer, has successfully transformed cancer in marginalized communities into a social problem mandating not more chemotherapy but a structural response.

The EJ Movement is an umbrella term referring to many "primarily local, grassroots response[s]"[484] to the "disproportionate siting of polluting infrastructure and other undesirable land uses in Black and Brown communities, their disparately high exposure to pollution and other environmental hazards, and the resulting adverse effects on human health and the environment."[485] Developing after World War II into the 1970s and 1980s,[486] it became one of the fastest-growing movements in the

482. ERIN BROCKOVICH, *supra* note 400.

483. Aaron, *supra* note 10 (listing cancer statutes).

484. Sheila Foster, *Justice from the Ground Up: Distributive Inequities, Grassroots Resistance, and the Transformative Politics of the Environmental Justice Movement*, 86 CALIF. L. REV. 775, 776 (1998).

485. Rebecca Bratspies, *"Underburdened" Communities*, 110 CALIF. L. REV. 1933, 1947 (2022) (footnotes omitted).

486. Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 808 (2020) (stating that the EJ Movement began in reaction to the environmental movement in the 1970s and 1980s); LUKE W. COLE & SHEILA R. FOSTER, FROM THE GROUND UP: ENVIRONMENTAL RACISM AND THE RISE OF THE ENVIRONMENTAL JUSTICE MOVEMENT 20–31 (2001) (discussing the crystallization of different "tributaries" of the EJ movement in the 1970s and 1980s).

United States.[487] Much of the burgeoning literature on the U.S. EJ Movement[488] explicitly discusses the impact of, and disparities in, cancer.[489]

Rather than press a medicine- and screening-heavy approach to cancer, the EJ Movement has emphasized environmental causes of cancer that amplify the risk of millions, as well as structural and community solutions needed for cancer prevention.[490]

One historical foundation of the EJ Movement was Love Canal.[491] As this town was built atop a chemical disposal site,

487. Foster, *supra* note 484, at 776.

488. *See, e.g.*, Richard J. Lazarus, *Pursuing "Environmental Justice": The Distributional Effects of Environmental Protection*, 87 NW. U. L. REV. 787 (1993); Vicki Been, *What's Fairness Got to Do with It? Environmental Justice and the Siting of Locally Undesirable Land Uses*, 78 CORNELL L. REV. 1001 (1993); Foster, *supra* note 484; Eileen Gauna, *The Environmental Justice Misfit: Public Participation and the Paradigm Paradox*, 17 STAN. ENV'T L.J. 3 (1998); Welton, *supra* note 16; Sarah Schindler, *Architectural Exclusion: Discrimination and Segregation Through Physical Design of the Built Environment*, 124 YALE L.J. 1934 (2015); Bratspies, *supra* note 485; Harris & Pamukcu, *supra* note 486; Sheila R. Foster & Brian Glick, *Integrative Lawyering: Navigating the Political Economy of Urban Redevelopment*, 95 CALIF. L. REV. 1999 (2007); Scott L. Cummings & Ingrid V. Eagly, *A Critical Reflection on Law and Organizing*, 48 UCLA L. REV. 443 (2001); Allegra McLeod, *Abolition and Environmental Justice*, 69 UCLA L. REV. 1536 (2023); Khiara M. Bridges, *The Dysgenic State: Environmental Injustice and Disability-Selective Abortion Bans*, 110 CALIF. L. REV. 297 (2022); Geneva E.B. Thompson, Comment, *The Double-Edged Sword of Sovereignty by the Barrel: How Native Nations Can Wield Environmental Justice in the Fight Against the Harms of Fracking*, 63 UCLA L. REV. 1818 (2016); Richard L. Revesz, *Regulation and Distribution*, 93 N.Y.U. L. REV. 1489 (2018); Kurt Wohlers, Note, *The Particle Problem: Using RCRA Citizen Suits to Fill Gaps in the Clean Air Act*, 121 MICH. L. REV. 325 (2022); Note, *RCRA as a Tool for Environmental Justice Communities and Others to Compel Climate Change Adaptation*, 131 HARV. L. REV. 2409 (2018); Ariela Migdal, Note, *RCRA in the Workplace: Using Environmental Law to Combat Dangerous Conditions in Sweatshops*, 75 N.Y.U. L. REV. 1843 (2000); Dayna Bowen Matthew, *Structural Inequality: The Real COVID-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help*, 108 GEO. L.J. 1679 (2020).

489. *See* Bridges, *supra* note 488, at 318, 324, 331 (describing cancer rates in Lakota women, reproductive cancer rates generally, and Cancer Alley cancer rates); Wohlers, *supra* note 488, at 330–33 (using railyard-adjacent community cancer impacts as a case study for cancer as a larger environmental justice issue); Lazarus, *supra* note 488, at 805 (highlighting that 90% of steelworkers most heavily exposed to pollutants are nonwhite and that their respiratory cancer rates are 8 times higher than otherwise expected).

490. *Cf.* COLE & FOSTER, *supra* note 486, at 15–16 (discussing how the EJ Movement focuses on environmental impacts and community health).

491. *Id.* at 20–22.

residents developed high rates of cancer, miscarriages, and other health problems.[492] They organized and pressed for help.[493] This activism led to government home buyouts and mass departure, turning Love Canal into a ghost town.[494] Shortly after the Love Canal disaster, Congress passed the Comprehensive Environmental Response Compensation and Liability Act (CERCLA), which increased federal authority over toxic sites.[495]

Episodes, like Love Canal, dotting the country led to the merging of the so-called anti-toxics movement with the civil rights movement.[496] Eileen McGurty summarizes the history of these groups' merging: In the late 1960s and early 1970s, environmental activists adopted civil rights positions, and civil rights leaders realized the importance of environmental policy to safeguarding air and water for communities of color.[497] The relationships between these groups "helped to blur the distinction between environmentalism and social justice causes" and create the EJ Movement.[498]

In responding to Love Canal and other disasters, the EJ Movement helped drive a suite of environmental laws that reshaped our relationship with carcinogens, including the Clean Air Act, the Clean Water Act, the Toxic Substances Control Act,

492. *See* Heather Smith, *Love Canal: The Toxic Suburb that Helped Launch the Modern Environmental Movement*, GRIST (May 30, 2016), https://grist.org/justice/love-canal-the-toxic-suburb-that-helped-launch-the-modern-environmental-movement [https://perma.cc/VZ3R-5U5Z] (explaining health impacts on Love Canal residents).

493. *See id.* (describing Love Canal residents organizing protest groups).

494. *See id.* (recounting that the federal government provided 15 million dollars in grants and loans to the state to buyout the remaining Love Canal homes).

495. Matthew Beyer, *CERCLA and the DOD Dilemma: Challenges and Opportunities*, ENV'T L. INST. (Feb. 11, 2019), https://www.eli.org/vibrant-environment-blog/cercla-and-dod-dilemma-challenges-and-opportunities [https://perma.cc/38ZE-MACW] (asserting that CERCLA was passed in response to Love Canal).

496. *Cf.* Eileen Maura McGurty, *From NIMBY to Civil Rights: The Origins of the Environmental Justice Movement*, 2 ENV'T HIST. 301, 302 (1997) (describing how the 1978 Warren County, North Carolina environmental and civil rights advocacy efforts merged).

497. *See id.*

498. *Id.* at 318. *But see* COLE & FOSTER, *supra* note 486, at 31 (describing a 1991 summit as the first conscious bringing together of the "disparate strands" of the EJ Movement).

and the Federal Insecticide, Fungicide, Rodenticide Act, as well as the establishment of the EPA.[499]

Today, the EJ Movement rages on, most famously in Louisiana's Cancer Alley, an infamous stretch of over 300 industrial facilities between Baton Rouge and New Orleans, heavy in racial and ethnic minorities.[500] In some areas within Cancer Alley, lifetime cancer risk is forty-seven times what the EPA deems acceptable.[501] Activists in Cancer Alley have successfully defeated proposed facilities to be added to the already industrialized region.[502] In 2021, President Biden, citing Cancer Alley, signed new executive orders related to climate change and environmental justice.[503] These orders were designed to "make environmental justice a part of the mission of every agency" and to "address the disproportionate health . . . impacts on disadvantaged communities."[504] The Biden Administration also announced a White

499. *See* COLE & FOSTER, *supra* note 486, at 29–30 (explaining how the EJ Movement shifted to a litigation and lobbying approach that brought environmental laws). These laws were also criticized for shifting away from a social-justice orientation. *See id.* at 29 (criticizing the shift away from public participation and mobilization). Nevertheless, they do represent community victories over cancer, in the face of industry opposition. *See* ROBERT N. PROCTOR, CANCER WARS: HOW POLITICS SHAPES WHAT WE KNOW AND DON'T KNOW ABOUT CANCER 76–81 (1995) (describing industry opposition to environmental regulation).

500. *See* Bridges, *supra* note 488, at 330–31 (describing Cancer Alley and its demographics); Pam Radtke, *In 'Cancer Alley', US Chemical Giants Mount Campaign Against Grassroots Organizers*, GUARDIAN (May 4, 2023), https://www.theguardian.com/environment/2023/may/04/cancer-alley-louisiana-environment-oil-industry-opposition [https://perma.cc/U57S-BAGA] (explaining how industry groups are attempting to counter the grassroots movement in Cancer Alley).

501. Lisa Song & Lylla Younes, *EPA Calls Out Environmental Racism in Louisiana's Cancer Alley*, PROPUBLICA (Oct. 19, 2022), https://www.propublica.org/article/cancer-alley-louisiana-epa-environmental-racism [https://perma.cc/C3PK-6V6U].

502. Nicole Greenfield, *Advocates Are Sparking a Revolution in Louisiana's "Cancer Alley,"* NAT'L RES. DEF. COUNS. (Nov. 10, 2022), https://www.nrdc.org/stories/advocates-are-sparking-revolution-louisianas-cancer-alley [https://perma.cc/B7MK-R2G7] (summarizing the recent Cancer Alley environmental justice wins).

503. Robert Taylor, *The US Ignored Louisiana's 'Cancer Alley' for Decades. Will Biden Finally Take Action?*, GUARDIAN (Feb. 1, 2021), https://www.theguardian.com/commentisfree/2021/feb/01/us-louisiana-cancer-alley-biden-climate-orders [https://perma.cc/R3N5-TXAY].

504. *FACT SHEET: President Biden Takes Executive Actions to Tackle the Climate Crisis at Home and Abroad, Create Jobs, and Restore Scientific*

House Office of Environmental Justice[505] and brought investigations into states' environmental racism.[506] The impact of Biden's efforts remains to be seen.

Why was the EJ Movement successful in reframing cancer into a public issue? Social movements are inherently attuned to group injustices.[507] But also, those in the Movement recognized the importance of forging intersectional coalitions to counteract corporate power and racial subordination.[508] Their stories and their messages resonated with the public. Historically a powerful avenue for change, social movements may be one of the main counterbalances to the corporate power that has driven much of the privatization discussed in this Article. There are more people than corporations, and a strong movement can combat large corporate public-relations efforts. As health is a fundamental resource that people crave, health movements have historically been powerful implements of social change.[509] For example, anti-tobacco grassroots organizing has been historically successful in legal change, even as the American Cancer Society sat on

---

Integrity Across Federal Government, WHITE HOUSE (Jan. 27, 2021), https://web.archive.org/web/20250118020939/https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/27/fact-sheet-president-biden-takes-executive-actions-to-tackle-the-climate-crisis-at-home-and-abroad-create-jobs-and-restore-scientific-integrity-across-federal-government [https://perma.cc/N8AZ-H998].

505. Lisa Friedman, *Biden to Create White House Office of Environmental Justice*, N.Y. TIMES (Apr. 21, 2023), https://www.nytimes.com/2023/04/21/climate/biden-environmental-justice.html [https://perma.cc/5AQH-NDWF].

506. *See* Delaney Nolan, *The EPA Is Backing Down from Environmental Justice Cases Nationwide*, INTERCEPT (Jan. 19, 2024), https://theintercept.com/2024/01/19/epa-environmental-justice-lawsuits [https://perma.cc/BW2W-R9BH] (reporting that the Biden Administration's EPA brought over a dozen Title VI discrimination suits in nine states to pursue environmental justice).

507. *See* Christopher T. Begeny et al., *The Power of the Ingroup for Promoting Collective Action: How Distinctive Treatment from Fellow Minority Members Motivates Collective Action*, J. EXPERIMENTAL SOC. PSYCH., May 5, 2022, at 1, 1 (arguing that intergroup mistreatment garners attention and collective action).

508. *See* Phil Brown et al., *Embodied Health Movements: New Approaches to Social Movements in Health*, 26 SOCIO. HEALTH & ILLNESS 50, 53, 62, 64 (2004).

509. *See id.* at 51 (2004) ("Social movements dealing with health are very important influences on our health care system, and a major force for change in the larger society."); *cf.* Nolan, *supra* note 506 (using EJ Movement examples, like Flint, Michigan, to show Biden's response to collective action).

the sidelines, given its "complex constituencies" and goal of retaining donors from tobacco-growing states.[510]

Today, the EJ Movement focuses on poor communities of color—who generally are exposed to the most pollution[511]—but there is no reason why a broader coalition cannot be formed. Despite the sense of racial division today, such division was also powerful during the Civil Rights Movement, yet environmental groups included White activists.[512] Through conversation and advocacy, we must change the cultural conversation of cancer to emphasize a public response.[513] Because privatization shifts power and benefits from public to private, there is tremendous public value in reclaiming this power and shifting our approach to cancer to something that benefits us all. A movement, modeled after the EJ Movement—perhaps when it was more intersectional during the 1960s and 1970s[514]—could reframe cancer into a community problem. It could mitigate health inequities that have frustrated advocates for years, while forging cross-racial alliances at the convergence of multiple interests.[515]

How might public-interest attorneys, agencies, and politicians cooperate to foster a cancer social movement? Or perhaps a larger publicization movement? Admittedly, these efforts would run headlong into the cultural narrative exalting private solutions to cancer; this culture should be a primary target of the movement. Political messaging that builds cross-racial solidarity about cancer—emphasizing the stake of white Americans in environmental injustice—could reshape electoral politics.

---

510. *See* ALLAN M. BRANDT, THE CIGARETTE CENTURY: THE RISE, FALL, AND DEADLY PERSISTENCE OF THE PRODUCT THAT DEFINED AMERICA 288 (2007) (arguing that grassroots advocacy groups were better situated to fight for tobacco regulations than organizations with "complex constituencies," like the American Cancer Society).

511. *See* Foster, *supra* note 484, at 776 (explaining that the EJ movement largely emerged from resistance to "siting of hazardous waste facilities in poor communities and communities of color").

512. *See* McGurty, *supra* note 496, at 302 (explaining that from 1968 to 1975, both Black and white activists began incorporating Civil Rights claims in their environmental causes).

513. *See supra* Part II.E.

514. *See* McGurty, *supra* note 496, at 313.

515. *See, e.g.*, Derrick A. Bell, Jr., Comment, Brown v. Board of Education *and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 518 (1980) (arguing that the convergence of Black and white interests made *Brown v. Board of Education*'s decision inevitable, but, afterwards, there was a divergence in interests).

Intersectional messaging has been thoroughly discussed by Ian Haney López.[516] There is already momentum behind pro-public messages: About 75% of Americans want tighter limits on smog; 75% desire a crackdown on corporate crime; 70% hope the United States will transition to 100% clean energy; and more than 66% want higher taxes on corporations and the rich.[517]

Strategic messaging could highlight the harms stemming from private, corporate conduct and turn cancer (and privatization) into an electoral issue, using people's fear of cancer to refocus from political scapegoats, like immigration and transgender people,[518] to the second leading cause of death in the United States. Politicians are already tapping into cancer anxieties, with Robert F. Kennedy, Jr. promising to cleanse our food supply of harmful chemicals.[519] The Democratic party should likewise embrace this issue, which could fuel discourse about and amplify the political importance of public health. Agencies, non-profit organizations, and public figures can buttress this strategy by highlighting the lack of government oversight over the things we eat, drink, and breathe. Together, we should aim for a broad-based movement to revitalize the public sphere.

CONCLUSION

The privatization of cancer is of interest to the sprawling world of oncology. But it is much more: It is a playbook for how industry can use legal rules to accrue power, damage public health and the public fisc, and cause innovation failures, all the while painting themselves as our saviors. That a mixture of legal rules derived from insurance law, FDA law, and patent law effected a stealth privatization of cancer raises questions about

516. *See* IAN HANEY LÓPEZ, MERGE LEFT: FUSING RACE AND CLASS, WINNING ELECTIONS, AND SAVING AMERICA (2019) (discussing political intersectional messaging).

517. Daniel G. Aaron & Leslie P. Francis, *Health Law and Bigotry Distractions*, 52 J.L. MED. & ETHICS 350, 351 (2024); ROBERT WEISSMAN & JOAN CLAYBROOK, THE CORPORATE SABOTAGE OF AMERICA'S FUTURE 7 (2023).

518. Aaron & Francis, *supra* note 517, at 350 (arguing that different types of bigotry, including political scapegoating, are used to distract discourse from public health improvements).

519. *See* Mandy Taheri, *What RFK Jr's MAHA Plan Says About Chemicals in Food*, NEWSWEEK (May 22, 2025), https://www.newsweek.com/rfk-jr-maha-report-chemicals-food-2075969 [https://perma.cc/C6J5-6WPP] (reporting that Kennedy seeks to transform the U.S. food system away from "ultra-processed foods" with synthetic dyes and chemicals).

what other regimes may be privatized. This is not to say that industry has no role in solving social problems but, rather, that our privatized societal approaches are lopsided.

This Article breaks down privatization into five categorical forms: delegation, individualization, marketization, capture, and cultural privatization. These processes effect privatization by shifting control, the target population, access, the beneficiary, and the cultural understanding from public- to private-centered. It is my hope that, using this theory, legal scholars identify privatization in other legal settings to better characterize the scope of private power and how it was secured in the first instance. Jon Hanson and David Yosifon have described the concept of "power blindness" as referring to people's difficulty seeing structural factors that are "cognitively hidden (often in plain sight), easily camouflaged and naturalized as mere background."[520] It is critical for legal scholars to review the conjunction of legal rules and who those rules serve to empower. I also welcome refinements to this theory of privatization, as this Article is far from the last word.

Even more, this Article used the stark example of cancer to highlight privatization's risks: innovation failures, draining the public fisc, impairing social policy, and inequity. Privatization, then, can cost more than money: One may have to pay in public values like access, universality, and even innovation—a commonly advanced reason for privatization. Privatization scholars might consider extending privatization theory to new areas that traditionally have not been associated with privatization and mining them for insights.

Consider three potential new areas of privatization:

1. The emphasis on disarming individual domestic abusers through extreme violence protection orders, the subject of the Supreme Court's recent decision in *United States v. Rahimi*,[521] rather than comprehensively regulating gun possession and gun sales by corporations. The Supreme Court's interpretation of the Second Amendment may be foreclosing a public response to firearms.[522]

520. Hanson & Yosifon, *supra* note 60, at 195.

521. 144 S. Ct. 1889 (2024).

522. *See, e.g.*, Eric Ruben et al., Essay, *One Year Post-*Bruen*: An Empirical Assessment*, 110 VA. L. REV. ONLINE 20, 20 (2024), https://virginialaw

2. Legal scholars and health organizations have often pressed for a medicalized response to opioid addiction,[523] rather than targeting root causes, including the misconduct of opioid companies and cartels[524]—unchecked due to public regulatory failures.[525]

---

review.org/wp-content/uploads/2024/02/Ruben_Book.pdf [https://perma.cc/P6KF-FYJW] ("In the year after *New York State Rifle & Pistol Association v. Bruen*, a steady stream of highly publicized opinions struck down a wide range of previously upheld gun restrictions."). More generally, the Supreme Court's jurisprudence may be interfering with public law goals. *See, e.g.*, Daniel T. Deacon & Leah M. Litman, *The New Major Questions Doctrine*, 109 VA. L. REV. 1009 (2023); Richard J. Lazarus, *The Scalia Court: Environmental Law's Wrecking Crew Within the Supreme Court*, 47 HARV. ENV'T L. REV. 407 (2023); Elizabeth Sepper, *Free Exercise Lochnerism*, 115 COLUM. L. REV. 1453 (2015); Amy Kapczynski, Response, *The Lochnerized First Amendment and the FDA: Toward a More Democratic Political Economy*, 118 COLUM. L. REV. ONLINE 179 (2018), https://www.columbialawreview.org/wp-content/uploads/2018/11/Kapczynski-THE_LOCHNERIZED_FIRST_AMENDMENT_AND_THE_FDA_TOWARD_A_MORE_DEMOCRATIC_POLITICAL_ECONOMY.pdf [https://perma.cc/2MGT-TU9D]; Wendy E. Parmet, *From Deference to Indifference: Judicial Review of the Scope of Public Health Authority During the COVID-19 Pandemic*, 17 ST. LOUIS U. J. HEALTH L. & POL'Y 1 (2023); Lawrence O. Gostin & Sarah Wetter, *The Supreme Court Is Harming Public Health and the Environment*, 329 JAMA 1549 (2023); Daniel G. Aaron & Avery E. Emery, *US Supreme Court Limits on the Power of US Health Agencies*, 331 JAMA 1441 (2024); Renee Farmer & Daniel G. Aaron, Loper Bright*'s Deregulatory Synergies*, 55 SETON HALL L. REV. 1697 (2025); Daniel G. Aaron et al., *Supreme Court Cases on Affirmative Action Threaten Diversity in Medicine*, PROC. NAT'L ACAD. SCIS., Apr. 25, 2023, at 1; Daniel G. Aaron & Sonya R. Chechik, *Health Regulation at Risk: The Supreme Court and Women's Health*, 40 J. GEN. INTERNAL MED. 2773 (2025).

523. *See, e.g.*, Taleed El-Sabawi, *Carrots, Sticks, and Problem Drug Use: Law Enforcement's Contribution to the Policy Discourse on Drug Use and the Opioid Crisis*, 80 OHIO ST. L.J. 765, 765 (2019) (noting there is "growing support for the idea that problem drug use should be treated like a chronic medical disease").

524. *See, e.g.*, Daniel G. Aaron, *Opioid Accountability*, 89 TENN. L. REV. 611, 611 (2022) (calling for corporate accountability in the opioid crisis); U.S. DRUG ENF'T ADMIN., U.S. DEP'T OF JUST., DEA-DCT-DIR-010-24, NATIONAL DRUG THREAT ASSESSMENT 2024, at 2 (writing that two Mexican cartels have "effectively eliminated any competition in U.S. markets" and "have caused the worst drug crisis in U.S. history"); Jack Wolthuis & Daniel G. Aaron, *Designating Cartels as Terrorist Organizations: The Wrong Path to Addressing the Illicit Fentanyl Crisis*, 115 AM. J. PUB. HEALTH 1211, 1211 (2025) (arguing medical intervention has been the main avenue for combatting opioid addiction).

525. *See* Hemel & Ouellette, *supra* note 409, at 1–2 (describing regulatory and innovation failures that contributed to the opioid crisis); Mariano-Florentino Cuéllar & Keith Humphreys, *The Political Economy of the Opioid Epidemic*, 38 YALE L. & POL'Y REV. 1, 65 (2019) (noting "diluted" and slow regulatory governance); Nick Miroff et al., *Cause of Death: Washington Faltered as*

3. The "astounding amount of intellectual attention and financial investment" in Food is Medicine programs—which deliver healthy food through healthcare systems[526]—while neglecting structural repairs to our food system.[527] This emphasis on privatized, medicalized solutions has been criticized for benefitting the food industry.[528]

I worry that we are sleepwalking into a privatized society with a hollowed-out public response to pressing social issues. But there is hope. The theory provided in this Article can help identify, understand, and reverse privatization in the law. And, as we saw with cancer in the 1960s and 1970s, social movements can press on privatized structures in service of reinvigorating our government's role in social policy.

Fentanyl Gripped America, WASH. POST (Dec. 12, 2023), https://www.washingtonpost.com/investigations/interactive/2022/dea-fentanyl-failure [https://perma.cc/C6FC-U59X] (arguing that the DEA under administrations from both parties has suffered regulatory failures regarding illicit fentanyl).

This is not to undersell the important health impact of medication for opioid use disorder, or the risks scholars have identified with targeting cartels. *See, e.g.*, Stacey A. Tovino, *Dialing In or Dialing Out? The Relationship Between State Telemedicine Law and Access to Buprenorphine*, 12 TEX. A&M L. REV. 1595, 1600–01 n.8–9 (2025) (discussing evidence behind buprenorphine for opioid use disorder); Jennifer D. Oliva & Taleed El-Sabawi, *The "New" Drug War*, 110 VA. L. REV. 1103, 1106–07 (discussing the failures of the war on drugs); Wolthuis & Aaron, *supra* note 524 (establishing how targeting cartels can be used as pretext to consolidate political power).

526. Alyssa J. Moran & Christina A. Roberto, *A "Food Is Medicine" Approach to Disease Prevention: Limitations and Alternatives*, 330 JAMA 2243 (2023).

527. *See, e.g.*, Emily M. Broad Leib & Margot J. Pollans, *The New Food Safety*, 107 CALIF. L. REV. 1173, 1173 (2019) (arguing for a more comprehensive definition of food safety); Cameron Faustman et al., *Ten Years Post-GAO Assessment, FDA Remains Uninformed of Potentially Harmful GRAS Substances in Foods*, 61 CRITICAL REVS. FOOD SCI. & NUTRITION 1260 (2021) (analyzing the FDA's regulatory failures with regard to food additives).

528. *See* Moran & Roberto, *supra* note 526, at 2244 (asserting that the food industry perpetuates a personal responsibility narrative to consumers to prevent regulation, but the industry still benefits).