

# PRICING LIFE: DEBATING THE ISSUE

Western Cape Branch Meeting, February 2004

In a leader in *The Economist* of 29 November 2003 outlining serious issues concerning HIV and AIDS, the writer states: 'The trouble is that the recent price reductions [of antiretrovirals] were achieved through an aggressive campaign promoting generic copies of patented pills. This has reduced corporate incentives to invent new AIDS medicines,'<sup>1</sup>

*The Economist's* argument is not new: the issues of patent rights protected putatively at the expense of human lives as drug prices of lifesaving medication exceed any affordable norms – and arguments that generic agents proliferate at the expense of future research and the progress of medical science – abound in the literature.

In the now inevitable situation of the South African government's commitment to the use of generic antiretrovirals (ARVs) as outlined in the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment,<sup>2</sup> the future of the branded drug manufacturers in a continent that accounts for less than 5% of pharmaceutical sales worldwide is called into question. Similarly, the future of pharmaceutical research efforts aimed at combating this and future plagues, particularly in Africa – given the dire need for cheaper and cheaper drugs – is repeatedly raised as a matter of concern. Balanced against these issues are the harsh realities of rampaging illnesses too expensive to treat in the developing world, and a continent dying in the presence of effective medicines freely available in the First World.

The critical issue of reasonably priced drugs resulted in a groundbreaking case when the Competition Commission of South Africa found pharmaceutical giants GlaxoSmithKline and Boehringer Ingelheim to be in violation of the Competitions Act following the Treatment Action Campaign (TAC)'s complaint about excessive pricing of ARVs. In an out-of-court settlement, the companies agreed to allow voluntary licensing and substantive generic competition of certain of their branded products.<sup>3</sup>

This case was the most recent in a long line of court cases and activist pressure to provide ARVs to South Africans reeling under the weight of being the hardest-hit nation on the planet as far as AIDS is concerned. These actions, taken together, have resulted in a South African government initiative to provide ARVs to those who need them. The plan is to put 1.4 million people on ARV drugs by 2009<sup>4</sup> – in the public sector alone – and to achieve this largely by using generic versions of patented products. These issues were at the core of a debate recently held under the auspices of the Western Cape Branch of the SA HIV Clinicians Society.

The debate was held between the National Manager of TAC, Nathan Geffen, and Chirfi Guindo, CEO of Merck, Sharp and Dohme (MSD) SA, a subsidiary of the world's largest pharmaceutical company, Merck & Co., Inc., based in the USA and the supplier of one of the essential agents proposed in the South African government's roll-out plan, namely the non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz.

Geffen was speaking for TAC, the activist organisation at the forefront of the drive to provide lifesaving ARVs to the millions of people dying of AIDS because they cannot

afford to buy drugs. Guindo was representing MSD, which for hundreds of years has been developing lifesaving medicines in various fields, including vaccine development and ARV therapy.

By way of background Geffen said that the debate was being held because of a 'disappointing response' to correspondence between the TAC and MSD which had left the activist group under the impression that the pharmaceutical company was not going to let generic alternatives to efavirenz be manufactured and allowed onto the market.

TAC has been nipping at the MSD's heels since the beginning of February, when it threatened to stage a picket outside the offices of the company to demand that it give non-exclusive voluntary licences on a 5% royalty fee basis

**Steve Andrews and Marilyn Keegan** report on a debate held by the Western Cape Branch of the SA HIV Clinicians Society in February 2004.

to any generic company that met objective criteria for quality and manufacturing standards. The picket had come about because stocks of the paediatric version of MSD's ARV, efavirenz (Stocrin 50 mg), used in the treatment of HIV infection in children over the age of 3 years, had been perceived to be temporarily unavailable.

A letter had been sent to Guindo drawing attention to the serious consequences of stock shortages: resistance to the particular ARV medicine can develop if patients default. The letter pointed out that in the case of an NNRTI such as efavirenz, resistance is not limited to the particular drug in question but affects all other drugs in the same class, such as nevirapine. This would potentially limit the future treatment options of children currently using an efavirenz-based regimen. The picket had been called off in the hopes of open dialogue on the subject.<sup>5</sup>

Geffen's opener in the debate was that TAC was not so naïve as to demand that MSD or any large multinational pharmaceutical company should give its drugs away for free or at no profit. 'There is not much we want except healthy competition between generic and branded companies so that we can get good prices for drugs. The TAC wants drug companies to make a reasonable profit, but we object to excessive pricing where 1 000% mark-ups are not uncommon.'<sup>6,7</sup>

'We believe this to be unreasonable, and our case against GlaxoSmithKline and Boehringer Ingelheim amply demonstrated this. Branded companies, despite the costs of research and development, have had ample time to bring their prices down.'

Geffen made a direct appeal to Guindo and MSD: 'Let the generic companies enter the market with you and allow competition from at least five of them to manufacture efavirenz by granting voluntary licensing.'

Geffen noted a general lack of transparency and information regarding the actual cost of manufacturing efavirenz and queried whether the current private sector cost price of R297 (excluding VAT) for the 600 mg dose in 200 mg capsule form and the proposed price of R200 a month for the 600 mg tablet (as yet unregistered) was a reasonable one. Conceding that efavirenz was more difficult to produce than nevirapine, he pointed out that TAC was currently buying nevirapine at a cost of R100 a month.<sup>7,8</sup>

Although he did not back away from his call for generic competition, Geffen noted that it had not been MSD, but rather the Medicines Control Council, that had been complicit in delaying registration of the 600 mg efavirenz tablet despite multiple approaches by many clinicians, MSD and TAC itself. Registration has been delayed by over a year

and, said Geffen, 'the reason for this was unclear. We are unsure as to whether it has arisen because of a lack of political will or sheer incompetence or both.'

Brandishing a copy of *This Day*,<sup>9</sup> Geffen asked whether MSD would be joining the exit of multinational drug manufacturers from South Africa as reported on the front page of the newspaper. The article had reported that the pharmaceutical companies, unhappy about proposed legislation that would exert tighter controls and transparent pricing mechanisms, had allegedly begun to prepare exit strategies from South Africa. Geffen called the threat to pull out 'tantamount to blackmail' and questioned whether MSD would be one of the exiting companies. Guindo denied this, saying that the article was 'nonsense' and stating unequivocally that MSD is in 'investment mode in South Africa' and is increasing its staff recruitment, research collaborations and multiple corporate and social investments in the country.

Guindo's rebuttal began with a brief presentation about MSD, traditionally a cardiovascular and musculoskeletal medicines manufacturer, which later made inroads into the anti-infective and vaccine markets. He outlined the two-pronged MSD strategy for African and developing countries, which includes:

- research and development, including vaccine research, especially in the field of HIV and AIDS, and
- since March 2001, a worldwide pricing strategy of selling MSD drugs to developing countries at no profit.

He gave a brief outline of MSD's Mectizan Donation Program, the largest private/public partnership in the developing world. In this programme, Mectizan (a once-yearly dosage) is given free of charge to prevent and treat onchocerciasis (river blindness).

Guindo cited his company's various corporate social investments, including a \$50 million donation since 2001 (with equal donation from the Gates Foundation) for the prevention, care and treatment of 17 300 HIV and AIDS patients in Botswana, the largest government treatment programme of its kind in Africa. He also mentioned that MSD invests \$40 million in clinical research every year and many other grants and training programmes.

In response to the argument that there were no generics to compete with efavirenz, Guindo pointed out that the biggest ARV market in the world today is Brazil, with 138 000 patients being treated.<sup>10</sup> All ARVs in the programme were bought by tender process, and yet no efavirenz generics are used. (Geffen's later response by e-mail on this issue was that Brazil had threatened a compulsory licence on efavirenz, compelling MSD to drop their price in this country.)

Guindo also argued that while efavirenz was available in generic form in Kenya and parts of West Africa, these products are currently more expensive than the branded MSD drug.

The most serious points of difference between Geffen and Guindo were the actual cost of making the drug, and lack of transparency regarding drug pricing.

Geffen asked MSD to engage with the Department of Health regarding the use and pricing of efavirenz in the ARV roll-out; to dissociate with the article in *This Day*; to allow five generic manufacturers voluntary licences to manufacture the drug at a 5% royalty fee; and to provide transparency about the pricing of drugs.

Guindo reiterated MSD's commitment to the whole of Africa and South Africa in particular and cited experience in Botswana and the onchocerciasis programme. He stated that they were already engaging with the government and the ARV task force and firmly disassociated MSD from the article alleging drug disengagement from South Africa. He was very enthusiastic about MSD's continued presence in this country – particularly in the ARV field – and said the drugs were being provided at cost.

Pressed by Geffen on the generic issue, Guindo responded: 'We invite any company with serious intentions of making a generic equivalent to efavirenz to submit a serious proposal and bring the necessary technical documents to the boardroom table. So far, despite the noise that has been made about generic alternatives, no one has come forward!'

While the chair kept the temperature of the debate steady, there were seemingly insurmountable differences between the parties. One of those sticking points was Chirfi Guindo's refusal to spell out research and development costs for efavirenz, despite repeated prompting by Geffen.

One of the more probing questions from the floor was from Gary Maartens, Professor of Clinical Pharmacology at UCT, who wanted to know why one could make a 600 mg tablet of efavirenz for R200 whereas three 200 mg capsules cost R350 to manufacture. Guindo's response was that manufacturing processes had improved and costs had thus been curtailed by the time it came to producing the tablet. This referred back to Geffen's pointed arguments regarding the lack of comparative data between branded and generic efavirenz molecules, without which meaningful cost comparisons could not be made.

To accusations that MSD is making excessive profits on the sale of efavirenz, Guindo held firm to his earlier statement that the drug was already being sold at cost, and responded, 'It is disrespectful to suggest that there are no compassionate people in the pharmaceutical industry. We value the role that activists have played in making government accountable to people living with HIV and AIDS, but to suggest that we are all a bunch of greedy profiteers is neither fair nor accurate. There are people in the pharmaceutical industry that also have a heart; it's not just TAC that has a heart.'

Nathan Geffen would not budge from his (and TAC's) position that efavirenz could be sold for less in South Africa and contended that sales of the drug here constitute a relatively small percentage of MSD's total sales. If, for example, all HIV and AIDS patients in South Africa used an efavirenz-based regimen and that efavirenz alone cost R600 a month, the profit to MSD would only be a mere 125th of 1% of the company's total annual profits. 'A substantial price reduction for this drug to this country would be insignificant in the larger scheme of things,' he said.

*The Economist* argues both sides when it makes the following point: 'To ensure that new drugs are developed, it is essential to preserve drug firms' patent rights in rich countries, so that they can recoup their vast investment. To develop drugs appropriate for the world's poorest victims, public money for drug research is needed too.'<sup>11</sup>

*On 5 April 2004, MSD South Africa announced that it would grant a non-exclusive generic licence for the production of efavirenz to Thembaleni Pharmaceuticals (Pty) Ltd at a 0% royalty fee.*

#### REFERENCES

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