

TRAINING MANUAL
FOR PATIENT ADVOCATES AND ORGANISATIONS

AFFORDABILITY OF MEDICINES AND DIAGNOSTICS

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INTRODUCTION

This training manual¹ was developed as part of the Affordability Project of AIDS Action Europe². The objective is to educate patient advocates and patient organisations on certain key aspects of the pricing mechanisms of medicines, to elaborate on the use of generic versus original medicines, and to advise on some advocacy tools that patient activists, advocates and their organisations can use to facilitate the affordability of medicines and diagnostics. We use examples from the fields of HIV and related co-morbidities (TB and HCV) in order to demonstrate essential phenomena and tools in this work. However, that much of this knowledge can be easily transferred from one specific disease area to many others, as pharmaceutical developers and manufacturers use very similar pricing schemes in different disease areas, and healthcare systems or other payers face similar challenges when trying to secure access to medicines.

One of the key learning objectives of this manual is to make sure that patient advocates and organisations become capable of and trained for advocacy for a global system of research and development, innovation, and intellectual rights on the pharmaceutical markets that facilitates rather than hinders the access to medication for all who need it.

We shall examine, in some detail, what the research, development and manufacturing of medicines and diagnostics entail; how the prices of medicines are set; how payers decide on what and how to finance in different healthcare systems (health technology assessment); what advocacy and activism means in this context; what is the TRIPS agreement and its safeguards (flexibilities); the DOHA Declaration; and how meaningful advocacy can be done. Throughout the manual, the specific points of advocacy intervention will be **highlighted in red**, which is then discussed and processed in the practical training exercise.

Reflective questions and examples are **marked with green**. Please stop for a moment at these paragraphs and try to reflect on your own work and learning process. Please note that this manual is heavily annotated with footnotes that contain additional information and resources that you may find interesting for your further research and learning.

This manual is structured in modules to facilitate a training, and accompanied by a set of presentation slides and notes that allow the organisation and conduct of specific courses on the subject matters of the affordability of medicines and advocacy.

¹ Cover image source: http://naturehacks.com/wp-content/uploads/2013/03/dreamstime_s_14533386.jpg

² <http://www.aidsactioneurope.org>

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GLOSSARY

AAE	AIDS Action Europe
AIDS	Acquired Immunodeficiency Syndrome
EATG	European AIDS Treatment Group
EMA	European Medicines Agency
EU	European Union
EUPATI	European Patients' Academy for Therapeutic Innovation
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HTA	Health Technology Assessment
IP	Intellectual property
PLHIV	People living with HIV
QALY	Quality Adjusted Life Year
SoC	Standard of care
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights agreement
WHO	World Health Organisation
WTO	World Trade Organisation

MODULES

The following is a recommended structure for a training course organised in order to convey the contents of this manual. However, the information and referenced materials can also be read and processed separately.

Module 1 – Affordability, pricing of medicines, innovation and intellectual property rights

Module 2 – General advocacy methodology

Module 3 – Case study: The example of Sovaldi® (sofosbuvir)

Module 4 – Drawing up an advocacy plan for affordability – interactive exercise

Module 5 – Summary and evaluation

It is strongly recommended to read the manual, and especially to work through the case study *before* attending the associated training event. Please note that this manual is heavily annotated with footnotes that contain additional information and resources that you may find interesting for your further research and learning.

Module 1 – Affordability, pricing, innovation and IP

1.1 Affordability

There are various definitions for the term “affordability” of medicines and diagnostics. The WHO sees affordability as a key concept but admits that it is somewhat vague and difficult to describe precisely³. Some patient organisations working in the field see affordability as the way of securing a standard of medicine at a price that does not impose an unreasonable burden on health budgets and household incomes⁴. There is one common point in these definitions: All of them treat affordability as a concept relative to the economic/financial situation of households (or statistically meaningful individuals).

There is legitimate criticism of this approach, especially from patient activists who, above everything else, want to make sure that access to medicines is not hindered by the price of these. This hints to the consideration of perhaps leaving the hard-to-define concept of ‘affordability’ behind and claiming cheaper medicines that allow **easier access** to them. The key tenet in this thinking is that the current pricing and access mechanisms do not secure satisfactory levels of access to medicines and diagnostics. It seems reasonable, therefore, to consider a comprehensive overhaul of the concept.

Another point to consider is that there is difference between affordable access to medicines versus affordable access to health care. For example in Latvia and a number of other EU Member States HIV drugs are covered 100%, whereas access to health services (diagnostics, surgeries, dental, oncological etc.) is limited with pay as you go scenarios occurring in 50%-75% of all cases.

One suitable approach may be to start from the cost of production of the medicines, if transparent, and focus on the key aspect that the payer (state) and the patients (households) should be able to pay for the medicines they need.

In organization for economic co-operation and development (OECD) and EU countries, one basic goal of health policy-making and health-systems functioning is adequate access to essential health-care services for all people, based on need rather than ability and willingness to pay. An important framework to monitor, assessing and analysing the delivery of health interventions to those who need them is used by WHO and is the TANAHASI model (Tanahashi 1978). This recognizes five different aspects of coverage when trying to analyse problems of coverage. I. Availability, II. Accessibility, III. Acceptability, IV. Contact, V. Effective Coverage. Based on the Tanahasi method is easier, more systematic and credible to assess the current situation of medicines’ affordability.

³ <http://www.who.int/bulletin/volumes/90/3/10-084087/en/>

⁴ This definition is used by the European AIDS Treatment Group for its own advocacy work in affordability.

Availability coverage shows the proportion of people for whom sufficient human and material resources (e.g. technologies, facilities, medicines, etc.) have been available – the ratio of resources to the total population in need.

Accessibility coverage refers to the proportion of people for whom health services are accessible in terms of their location, distance or travel time. This includes not only physical access and travel facilities but also affordability (e.g. financial barriers to access such as user fees, catastrophic health expenditures, transport costs).

Acceptability coverage is the proportion of people for whom health services and programmes are acceptable in terms of culture, beliefs, religion, gender or age. This also includes affordability in relation to people's perceptions of the value of health services and expected costs.

Contact coverage is the proportion of the population that has used health services and has contacted a health services provider. Continuity of access is a crucial component of this dimension.

Effective coverage is the proportion of people who have received successful interventions (e.g. accurate diagnostic tests, evidence-based treatment, adherence to prescribed treatment, etc.).⁵

⁵ World Health Organization – EUROPE: Barriers and facilitating factors in access to health services in Greece, Charalampos Economou.

There are various definitions for the term “affordability” of medicines and diagnostics, yet no one shared widely by all organizations and bodies.



<http://www.zembrin.com/wp-content/uploads/2013/02/money-in-medicine-800x305.jpg>

When discussing the affordability of medicines and diagnostics, another important factor is the human rights based approach. The World Health Organisation states⁶ that health is a universal human right, while the European Union provides (in theory) equal access to healthcare services to all EU citizens in all Member States⁷. Patient advocates can and should validly rely on this perspective when saying that **access to affordable medication or treatment is part of this universal human right**. You will see later how various freedoms of the European Union interplay with intellectual property regulations to create an intricate landscape that is particularly difficult to navigate.

1.2 How does the medicine get from the company to the patient?

Let's see, very schematically, how the medicine reaches the patient from the pharmaceutical company. The systems can often be very different in various countries, but this 'inventory' will still be helpful in determining points of attention and intervention for patient advocates and organisations if they want to make sure that prices are controllable. Not all points of intervention will be feasible in all cases. Not always data is available and transparent procedures are set. Not all stakeholders or factors will be there in all systems. It is

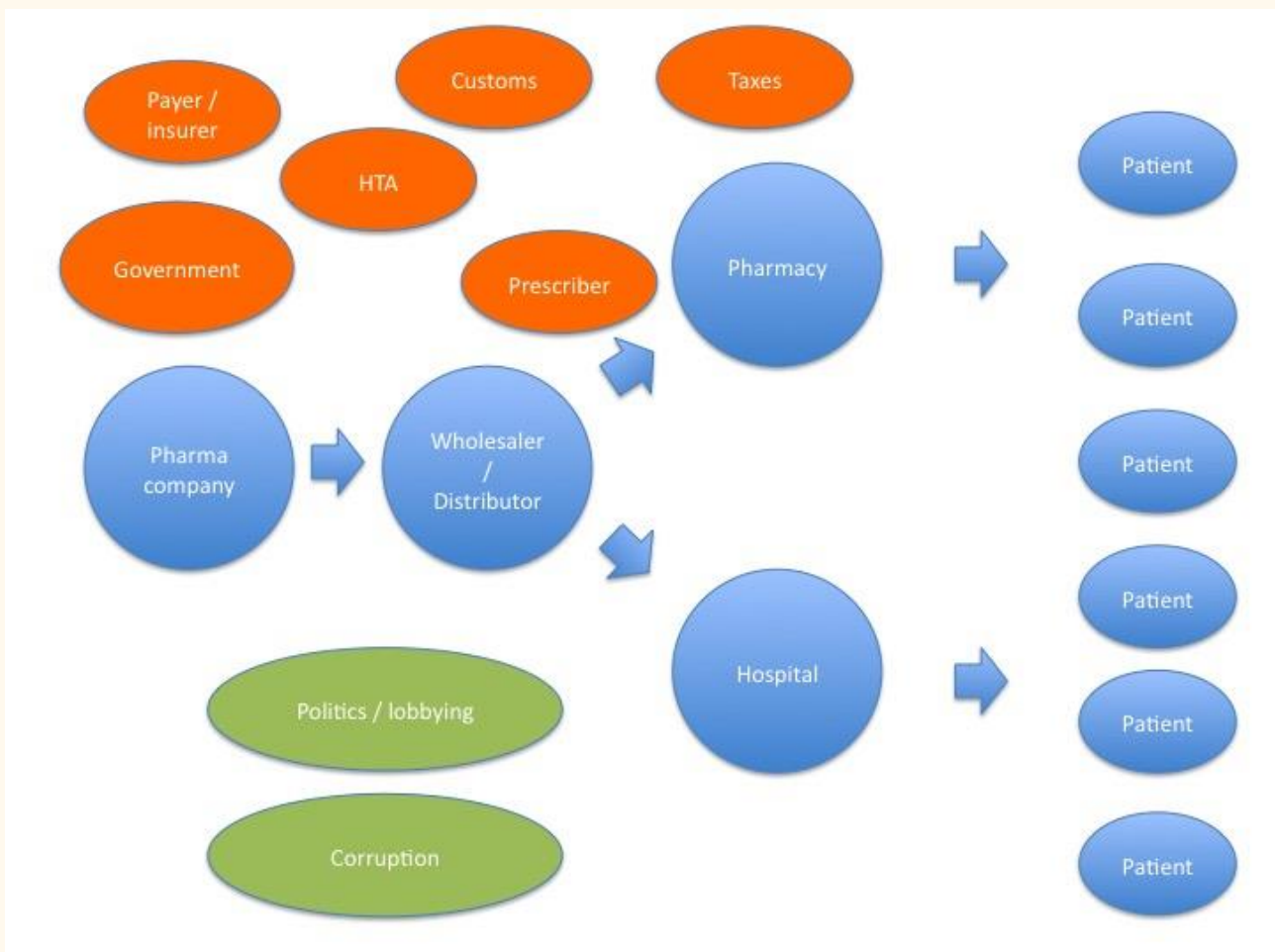
⁶ http://www.who.int/hhr/activities/Right_to_Health_factsheet31.pdf

⁷ http://ec.europa.eu/health/cross_border_care/policy/index_en.htm

more to be treated as a list of possible stakeholders. We suggest that patient advocates can and should interact with all participants of this chain to a larger or smaller extent.

What looks like a straightforward structure (manufacturer > wholesaler > pharmacy/hospital > patient) is riddled with a lot of confounding factors. Even if patient representatives and their organisations cannot always tackle these directly, it is advisable to acknowledge them in your work.

While we recognise and acknowledge the importance of (legal and illegal) trade of medicines over the internet, this chapter relies on the legal systems that are customary in the EU Member States. Having said that, there are growing movements that aim at establishing a semi-legal ‘shadow market’ for medicines. The establishment of ‘buyers’ clubs’ for HCV medicines in the UK is one example, which is very similar to what happened in the USA in the middle of the eighties⁸. These membership-based groups import generic medicines from India and/or China to treat patients who would otherwise have to wait for very long to access treatments that are prohibitively expensive in most European countries.



⁸ The movie *Dallas Buyers Club* gives a good introduction to the phenomenon: <https://youtu.be/U8utPuIFVnU>

Some data concerning the above scheme: add in the green circles another one called “lack of transparency”. Regarding the blue and orange shapes, maybe try to organise them a bit differently to insist on the phases and relationship between players. Be more specific when the orange factors intervene in the chain. And also spread the drawing so that factors are placed in chronological order: custom on import (if there is), government to set price, payer/insurer to reimburse, maybe using more arrows. Researchers as another blue circle, must be add at the very first of the beginning a long with pharma company, as pharma is not the only body that invests or finances R&D.

All factors and stakeholders can (and usually do) influence each other. It is thus important to seek transparency in this process. Patient advocates should strive to get involved **in all stages of the process** and with all stakeholders.

Political involvement, lobbying and corruption are not the same. Even patient organisations can legitimately do lobbying, which has proved to be very successful in a number of cases. However, it is not uncommon in several EU Member States that physicians get incentives from pharmaceutical companies if they prescribe their medicines rather than those of a competitor. Also, there has been some information of systemic corruption in healthcare systems: A report from the European Commission (October 2013) states that “...corruption in the health sector occurs in all EU MSs and that both the nature and the prevalence of corruption typologies differ across the EU Member States. The study shows that there is no single policy in the successful fight against corruption in the health sector”.⁹

The importance of the pharmaceutical industry

The pharmaceutical industry plays an important role in the economies of many EU Member States. They are large employers and often major contributors to the GDP of the given countries.

The pharmaceutical industry is not the only source that invests in biopharmaceutical R&D. Statistics show that the contributions of universities, states, not-for-profit or charity entities are smaller but still substantial. One article from 2013 warns of the reduction of public participation in research and development funding¹⁰. Statistical data on European Union Member States indicate a drop in research spending after the economic crisis, and slow but insufficient growth since then. One Eurostat analysis warns that more efforts are needed if Europe wants to meet the 2020 targets in research and development¹¹.

Therefore their economic and political reach may go beyond what one would assume at first sight. When doing advocacy, you may face arguments that are based on this substantial fact, which may also generate

⁹ http://ec.europa.eu/dgs/home-affairs/what-is-new/news/news/docs/20131219_study_on_corruption_in_the_healthcare_sector_en.pdf

¹⁰ http://www.pharmatimes.com/article/13-10-08/European_health_R_D_spend_stagnating.aspx

¹¹ http://ec.europa.eu/eurostat/statistics-explained/index.php/Europe_2020_indicators_-_research_and_development

some unexpected pushback: some stakeholders like trade unions may not necessarily be interested in much lower medicine prices as that could jeopardise their jobs.

You may wish to think about your own respective national systems and try to identify points of intervention where advocacy can be done for more affordable medicines. How important is the pharmaceutical industry in your local or regional settings? How many people are employed in this sector, and what is its role in the economy? Do you think that shareholders can be lobbied and convinced to surrender part of their profits to increase access to medicines? What public opinion says about the industry and how can be moved in favour of add some pressure to stakeholders to surrender part of their profits? Are there any interesting examples of the civil society (advocacy, campaigns, etc) that assist on that?

1.3 Pricing of medicines

The methodology of pricing pharmaceuticals has evolved into a complex and arcane science. One study from sources close to the industry suggests that conjoint analysis, game theory and system dynamics should be deployed and understood simultaneously to achieve sustainable and profitable pricing¹². We often also find that different processes and factors influencing the price of a given medicine **are confidential between the developers and manufacturers, and the manufacturers and payers (insurers or healthcare funds)**.

In this section we shall rely on a variety of sources when examining the issue and importance of medicines pricing from the patients' perspective. Although there is ample literature that describes the theory and empirical findings in the field, the patients' experience may sometimes be completely different and a lot simpler:

Medicines are too expensive, and so patients who need them don't have access to them.

We shall demonstrate that this statement unfortunately holds even if the picture is a lot more nuanced. We rely on examples from the HIV and HCV fields partly because of their relevance for the reader, and partly because patient/civil advocacy in these disease areas has been more developed and often more successful than in other illnesses. Through these examples we will also demonstrate some best practices for advocacy and activism projects/actions in order to improve the affordability of medicines. We are confident that some of these examples and best practices can be adapted and translated for other disease areas, too.

The entire medicine or biomedical development process is quite complicated and expensive. Most estimates say that the cost of bringing a new medicine to the market ranges around 1.6 billion euros¹³. Some other

¹² http://www.lodestonemc.com/files/pdf/LS_WP_Art_of_Pricing.pdf

¹³ <http://www.bbc.com/news/health-27130098>

estimates suggest that this figure is closer to 5 billion euros¹⁴. Analysts warn that comparing the development costs of different medicines in different disease areas may not make any sense at all, especially because pharmaceutical companies use different (confidential) business models, which may or may not include factors like the costs of development of failed compounds in the process, the purchase of a molecule from a third party, or marketing costs.

Questioning today's R&D models is a very important area in which many activists have contributed worldwide. Additionally, there is an open-ended meeting of the WHO the spring of 2016 that targets an open agreement for an equitable biomedical R&D system with agreed guiding principles. The experience with several new compounds shows that the argumentation around the different cost elements included in the price (especially in the launch price) of a medicine still fails to justify the very high price applied by the manufacturers, especially in case of original medicines (the case of Daklinza® [daclatasvir] will be discussed later in detail).

The study of Management Sciences for Health (2012), also a piece of recommended literature by the WHO, gives the following summary on the particular characteristics of pricing medicines:

“In a market economy, the interaction of producers and consumers determines the price of goods and services. Understanding the theory of supply and demand helps explain how prices are determined, and this theory also explains how responsive (elastic) both supply and demand are to changes in price. For example, medicines that are not considered essential and that the buyer could credibly refuse to purchase will have more elastic prices, whereas the prices of medicines that are considered essential and that the buyer must obtain will be inelastic, meaning buyers will be less sensitive to higher prices.

Factors that interfere with the ability of the market to efficiently produce and allocate goods and services are said to result in ‘market failure’. An example of market failure is when buyers do not have the same level of knowledge; for example, some buyers might pay more than others for the same medicines because they are unaware of what everyone else is paying.

When buyers or sellers have market power (monopoly or monopsony), they can distort how the market price mechanism works. For example, in absolute monopolies (one seller) and oligopolies (a few sellers), the seller has significant ability to set prices, because the consumer has limited choices. This distortion allows the seller to command a price that is higher than would have prevailed under more competitive situations. In a monopsony, where the government has market power as the only large buyer in the market, the government acts on behalf of consumers to obtain better prices.

In addition to these economic theories of price determination, prices for medicines are influenced by the fact that medicines have certain traits that set them apart from other consumer products. For example, consumers need expert advice to make rational choices between using and not using a medicine and about what kind of medicine to use. This advice is provided by prescribers, who may not know or even care about the price of medicines. Medicines also serve as an investment in future health, which may be difficult for the consumer to value.

¹⁴ <http://www.forbes.com/sites/matthewherper/2013/08/11/how-the-staggering-cost-of-inventing-new-drugs-is-shaping-the-future-of-medicine/>

The literature unanimously concludes that medicine price differences exist between countries, even when comparing between or within the strata of industrialized, middle-, and low-income countries. Price variation within countries is more likely in less price-regulated markets, such as the United States; however, prices vary in other countries, where public, private, and non-governmental (not-for-profit) sectors procure medicines separately. Variable prices for medicines within and between countries often result from

- the pharmaceutical manufacturer selling the same product for different prices;
- intra- and inter-country differences in the margins charged in the post-manufacturing supply chain by wholesalers, distributors, and pharmacists, as well as taxes and co-payments levied by the state.

Conducting pharmaceutical price comparisons is challenging, but such assessments can identify price variations and provide valuable information on their source and on interventions that can help reduce medicine prices. For example, margins and taxes charged along the pharmaceutical supply chain can add significantly to the final price of medicines; however, governments can control these mark-ups by enacting price-control policies and eliminating tariffs and taxes. In addition, buyers of pharmaceuticals should assess their own position in the marketplace and use tactics such as price negotiations, pooled procurement, and information sharing to increase their market power.” (2012:9.2)

This otherwise very useful and concise description misses any references to the role of the civil society (including patient organisations) in this process. It is, indeed, a relatively novel concept, but we shall nevertheless highlight some of the key intervention points here for further reference in this manual.

“In a market economy, the interaction of producers and consumers determines the price of goods and services”, reads the first sentence. The text also admits, however, that medicines (and any health technology) are not a conventional good or service. We should add here that neither are patients conventional consumers. A closer look at the above text reveals that **the term ‘consumer’ does not in fact refer to the patients** (who *actually* consume/use medicines, diagnostics etc.) but to the payers (the state or insurers).

“[...] consumers need expert advice to make rational choices between using and not using a medicine and about what kind of medicine to use. **This advice is provided by prescribers, who may not know or even care about the price of medicines.** Medicines also serve as an investment in future health, which may be difficult for the consumer to value”, states the above discussion. Evidence from the HIV/AIDS field shows that there are plenty of possibilities and well-oiled mechanisms that allow direct interaction between the communities of PLHIV, academia and the pharmaceutical industry, manifested in the form of the European Community Advisory Board on HIV/AIDS (ECAB) (Bereczky 2013). While there is an increasing number of similar community advisory boards in other disease areas, and these mechanisms are also actively supported by the European Union¹⁵, it is essential for all patient organisations to maintain and spread these and similar mechanisms in order to provide shortcuts and communication channels through often bureaucratic and non-transparent central systems. This is especially important in political systems that have not yet been able to reduce corruption in their healthcare establishments.

¹⁵ http://ec.europa.eu/health/systems_performance_assessment/docs/eurobaro_patient_involvement_2012_en.pdf

“**Conducting pharmaceutical price comparisons is challenging**, but such assessments can identify price variations and provide valuable information on their source and on interventions that can help reduce medicine prices”, says another statement above.

However, this is one of the areas where patient organisations and representatives can and should play a role. Please also refer to the point on community-based research in the Resources section below. NGOs, advocates, patient organisations are usually able to conduct sound, scientifically valuable research with the added value of insight and better access to certain data or populations. Some pharmaceutical companies and universities have already started to include community-based research into their methodologies¹⁶.

We should note here that there are certain voices, even within the pharmaceutical industry, that see the current systems and processes as unsustainably complex and expensive. While the delicate balance between time to market, safety and efficacy of medicines and reasonable profits should be maintained, the system is, to a certain extent, crumbling. In an article published in the Forbes Magazine in 2013¹⁷ an industry expert not only points out that about 95% of experimental medicines fail during the development process, but also that the cost of development has increased by several factors over the last decades. One of the major hurdles seems to be that only large companies with highly developed infrastructures are able to develop novel medicines up to the marketing phase, while these same companies operate at much higher cost than smaller, more streamlined businesses. The same article also points out one interesting trend in which pharmaceutical companies try to spread the development costs to other payers – this now purely economic, financial and business-minded, and ultimately political approach **almost unavoidably eliminates the basic interests of the patients** from the process.

This type of research, i.e. projects conducted by patient organisations, may very well extend to the area of pricing and affordability. For example, one ongoing project of the EATG tries to collate all data from the different manufacturers concerning prices in the different countries in the HIV field. The resulting table is not only informative for the community, but it is also an important advocacy tool towards manufacturers, regulators and payers to demonstrate anomalies and inconsequential behaviour in the entire pricing process.

When discussing the general processes of pricing on the pharmaceutical market, there are certain common factors and terms that we need to understand better¹⁸.

Another comprehensive description of the same concept is given by Health Action International’s “Politics of Medicines” website¹⁹.

¹⁶ Positive Action research projects by ViiV Healthcare are a good example.

¹⁷ <http://www.forbes.com/sites/matthewherper/2013/08/11/how-the-staggering-cost-of-inventing-new-drugs-is-shaping-the-future-of-medicine/>

¹⁸ Image source: <http://www.abpi.org.uk/our-work/library/industry/Pages/medicine-development-process.aspx>

¹⁹ <http://www.politicsofmedicines.org/articles/pharmaceutical-r-d>

1. Innovation

The pre-discovery and drug discovery stages usually involve intensive research and investment into development. Some pharmaceutical manufacturers prefer purchasing molecules and processes from smaller biotech businesses and medicine developers (or perhaps even just acquire them together with their development portfolios). Having said that, one very common and usual argument by all pharmaceutical developers and manufacturers is that the cost of discovery also needs to be included in the final prices. It is therefore advisable for patient activists to **extend their search for information also to the origins of the medicine**.

2. Development

Clinical research and development is a long, complicated and arduous process. It is usually where the bulk of the costs are generated. The science of clinical trials, studies and development in general is too complicated to be discussed in the frames of this course material²⁰. It should suffice to know that while clinical development is indeed very complex, it is also where patient advocates or expert patients are easiest to involve. For example regulators in the European Union, and particularly EMA, are required by their own rules to **include patients in every stage of pharmaceutical product development and approval**²¹. This is exactly the stage in the life cycle of a product where patients can firmly plant themselves into the process so that their voices cannot be ignored even when prices and reimbursement are negotiated and decided. Patient involvement in the HTA process helps.

Guidelines and recommendations for the involvement of patients in HTA mechanisms are no longer uncommon. Health Technology Assessment International, a non-profit association of HTA bodies and experts has developed quality standards for patient/citizen involvement²². They also provide a compilation of good practices of such involvement from around the globe²³.

3. Transparency

In some countries, the law requires both the pharmaceutical industry, and the regulators and payers to be transparent about their negotiations. However, in most cases these processes, especially price and reimbursement negotiations are confidential, and patient representatives are often completely excluded from the process. There is a strong push²⁴ on both²⁵ sides²⁶ of the Atlantic to make sure that pharmaceutical pricing and negotiations with the public hand become and remain transparent.

²⁰ A very thorough introduction to and discussion of clinical trials and patient involvement in the clinical development process is given by EUPATI through its courses for expert patients and its open access toolbox. <http://www.patientsacademy.eu/index.php/en/>

²¹ http://www.ema.europa.eu/ema/index.jsp?curl=pages/partners_and_networks/general/general_content_000317.jsp&

²² http://www.htai.org/fileadmin/HTAi_Files/ISG/PatientInvolvement/v2_files/Info/PCISG-Info-ValuesandStandards-30-Jun14.pdf

²³ http://www.htai.org/fileadmin/HTAi_Files/ISG/PatientInvolvement/EffectiveInvolvement/Good_Practice_Examples_Feb_2015.pdf

²⁴ <http://www.cnn.com/2015/09/18/a-new-plan-to-control-rising-prescription-drug-prices.html>

²⁵ <http://www.usnews.com/opinion/economic-intelligence/2015/10/05/a-smarter-way-to-lower-prescription-drug-prices>

In its comprehensive technical report on the access to new medicines in Europe²⁷, the WHO points out: “Both the supply and prices of new medicines are often fixed in framework agreements between governments and pharmaceutical producers and **the negotiation process is generally rather opaque**. [...] countries need to strengthen cooperation and share their experiences if transparency is to be achieved and gaps in medicines pricing policies are to be filled.”²⁸ This is a field where the involvement of patient advocates and organisations not only seems logical but also very productive, although even the WHO report fails to discuss this aspect in greater detail (pages 70 and 106).

4. Parallel imports, compulsory licensing, differential pricing

One of the phenomena closely associated with the entire conundrum around medicine pricing and related intellectual property rights is what happens upon the exhaustion of rights. The exhaustion of rights is a legal concept, which is applicable to Europe more than the USA. It arises due to ‘conflict’ between the facts that patents are nationally limited in scope, whereas free movement of goods is allowed across borders in the EU (Articles 28-30 of EC Treaty). Simpler put: patents can be registered in different European states, trade licenses can be obtained for them, and then they can be freely traded across the EU as the free movement of goods is one of the main pillars of the EU. Price differentials between Member States (particularly price controls on pharmaceuticals) give an incentive to import from cheaper to more expensive Member States – this is called **parallel importing**²⁹. This practice is not permissible in all Member States, and it also causes much controversy in the pharmaceutical industry.

Generally speaking, medicine manufacturers and distributors will be interested in avoiding parallel imports and exports as it disrupts their pricing strategies. They set one price for one country, and perhaps a lower one for another country, which may lead to exports of the medicine from the country where it is cheaper to the country where it is more expensive, but behind the back of the company. Parallel imports are the consequence of a contradiction between the right of Member States to conduct price negotiations with the pharmaceutical companies directly on the one hand; and the fundamental freedom of movement of goods and services across the EU on the other.

The principle of exhaustion of rights, mentioned above, states that when a product is put into the market in any European country by the owner of the patent or with their consent, then the owner cannot subsequently object to the movement or marketing of the product within other member states of the EU – their right is deemed exhausted once it is placed on the market in any one country.

²⁶ http://www.nytimes.com/2015/07/23/business/drug-companies-pushed-from-far-and-wide-to-explain-high-prices.html?_r=0

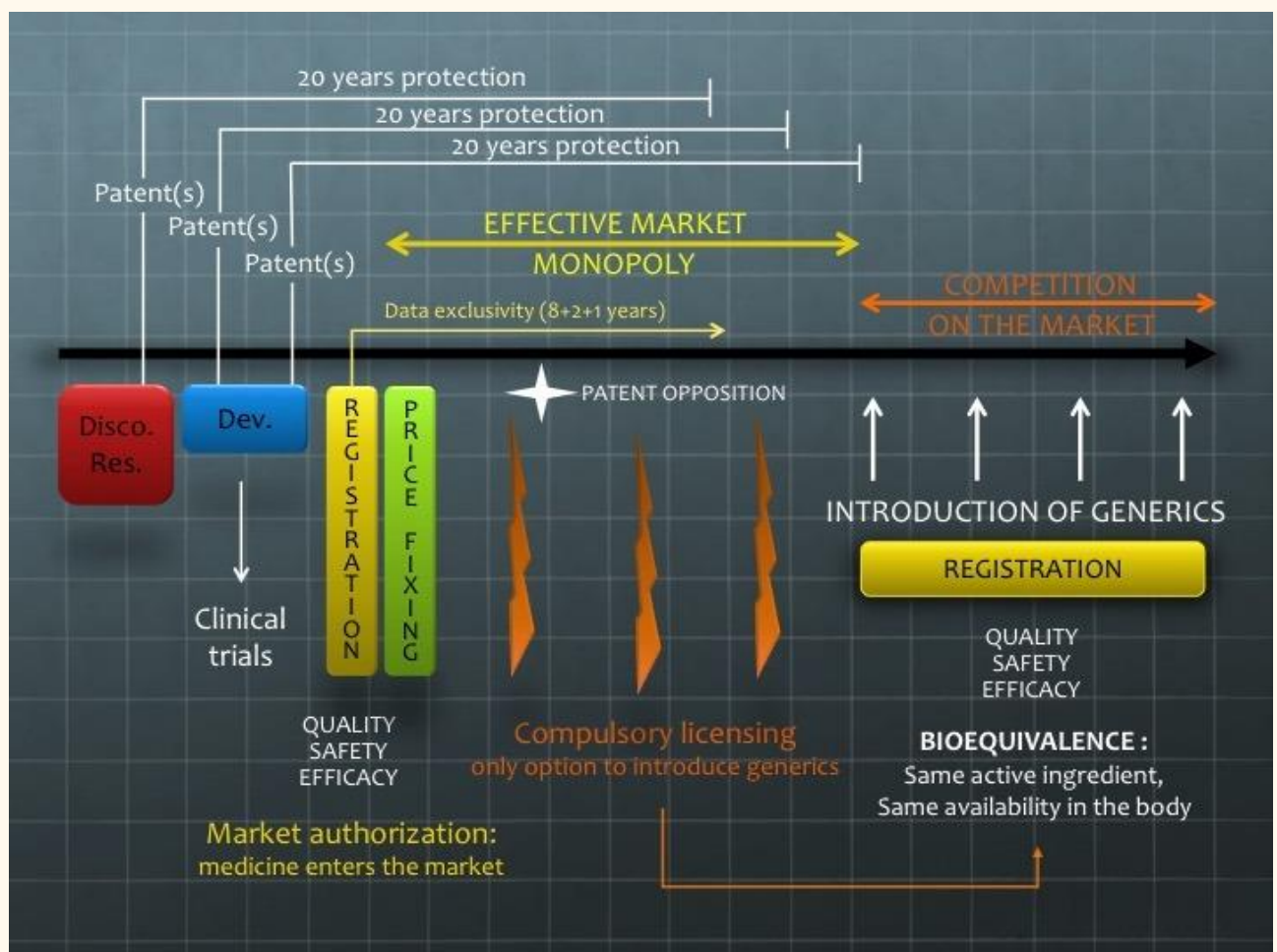
²⁷ <http://www.euro.who.int/en/health-topics/Health-systems/medicines/publications2/2015/access-to-new-medicines-in-europe-technical-review-of-policy-initiatives-and-opportunities-for-collaboration-and-research-2015>

²⁸ <http://www.euro.who.int/en/media-centre/sections/press-releases/2015/03/new-who-report-shows-that-transparency-and-cooperation-help-to-reduce-high-prices-for-new-medicines>

²⁹ https://en.wikipedia.org/wiki/Parallel_import

Consequently, pharmaceutical companies try to find other ways to limit this process without jeopardising their freedom to apply different prices in different countries.

According to the definition of the World Trade Organisation (WTO), “**compulsory licensing** is when a government allows someone else to produce the patented product or process without the consent of the patent owner. It is one of the flexibilities on patent protection included in the WTO’s agreement on intellectual property — the TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement”.³⁰ Usually, government uses this measure very rarely, in case of wars or emergencies, but according to the TRIPS agreement, there does not need to be an emergency for this measure to apply. If a government chooses to issue a compulsory license, it still has to pay the patent holder. There is also a separate rule that aims to prevent importing generic products from countries with a compulsory license into more developed markets.



Differential pricing and tiered pricing

³⁰ https://www.wto.org/english/tratop_e/trips_e/public_health_faq_e.htm

*Differential pricing*³¹ is a relatively new phenomenon in the pricing strategies used by pharmaceutical companies, and it is also rather controversial. Manufacturers use different prices for different countries or regions on the basis of various criteria: usually the GDP or other welfare or economic indicators of the country, and set the price of their products on that basis. “The pharmaceutical industry has been cautious about significantly changing its pricing models, despite the theoretical appeal of differential pricing and its success in improving access to medicines in low- and middle-income countries. This reluctance is caused mainly by concerns that differential pricing could erode profit margins in lucrative high and middle-income markets and high distribution channel markups in low income countries could dilute much of the benefits of differential pricing to poor end-patients”, states the WHO.

Tiered pricing is essentially the same concept as differential pricing. It entails the pricing of medicines in different countries or regions according to their economic capacities. However, as the WHO points out, this method can produce inferior results to real competition and distort the market: “it often involves arbitrary divisions between markets and/or countries, which can lead to very high prices for middle-income markets; and it leaves a disproportionate amount of decision-making power in the hands of sellers vis-à-vis consumers”³².

The WHO also provides an easy glossary of these legal concepts and how they affect access to medicines³³.

Activists arguing for differential pricing often face the argument from companies that differential pricing allows parallel imports and exports, which is something they want to avoid.

5. Original vs. generic products³⁴

When a pharmaceutical company develops and gets a marketing license for a new medicine, it is made available to patients under a brand name with patent protection. The pharmaceutical industry is no longer solely a national or even a regional business. Companies seek to market new medicines worldwide. The costs of medicines development are tremendous. Therefore, industry wants to market on a global basis to ensure their return on investment. Only a limited time is available for this purpose. After expiration of patent or data exclusivity, generic companies can market their generic products. The generic company will no longer need to demonstrate non-clinical or clinical test results for their products before obtaining a marketing authorisation.

What is a generic medicine?

³¹ <http://apps.who.int/medicinedocs/en/d/Js18390en/>

³² <http://apps.who.int/medicinedocs/en/d/Js19031en/>

³³ <http://www.who.int/trade/glossary/story002/en/>

³⁴ This section adapted from the EUPATI training material on HTA. ©EUPATI under Creative Commons, 2015

A generic medicine is one that is developed to be similar to an original medicine that has already been approved by a regulatory authority. Once the protection for a product expires, e.g. patent or regulatory protection (data exclusivity), the company no longer has exclusive rights to sell the medicine, and other companies can then manufacture and sell a comparable medicine with the same active product ingredient (API). This new version is usually referred to as a 'generic'. A generic medicine contains the same active ingredient as the original medicine and is used at the same dose to treat the same disease(s). *A company can only make available a generic medicine to patients once the patent for the original medicine has expired and the generic has been approved.* However, there are certain exceptions like *voluntary licensing* and *compulsory licensing*. The importance of generics is that they are usually cheaper than the original because generic manufacturers incur lower development costs.

As for all medicines, generic medicines must obtain a marketing authorisation before they can be made available to patients. Generic medicines are marketed under a different name to the original medicine. For example, paracetamol is a chemical ingredient found in a number of painkillers sold as original medicines, but is also sold as a generic.

Marketing authorisations are granted after the regulatory authorities have conducted a scientific evaluation of the generic medicine's quality and bioequivalence, which means that the generic works within an acceptable range of activity compared to the original. The original name of the medicine containing sofosbuvir is Sovaldi®. There are generic versions under the names MyHep® or Hepcinat®.

While two medicines, the original and the generic, will have different brand names, appearance, and packaging, they will have the same active ingredients and, effectively, can be considered to be the same medicine. This could cause some confusion if it were not for the *generic name*, which is shared by all brands of the medicine. This is common for pain medications, for which active product ingredients, such as paracetamol and ibuprofen, are used as the basis for many of the painkillers that can be bought in pharmacies.

Notably, approved generic medicines are regulated in the same way as the original medicines, and manufacturing facilities and conditions must be of an equally high standard. Following the approval of a generic medicine, the company producing it must commit to collecting and reporting additional safety data.

The key advantage for a generic medicine over the original is cost, with generics generally being cheaper than originals, therefore being preferred by many physicians, insurers/payers, and hospitals. While there is sometimes some debate about the difference between the cost and the price of the medicines, both tend to be lower in case of generics as the generic manufacturers usually have to carry lower development costs, so that they can also offer the same compounds at lower prices.

Generic medicines thus cost less than the original medicine *and it is one way to keep costs of healthcare lower and offer broader access to patients.*

A generic medicinal product has:

- the same composition (qualitative and quantitative) in active substances as the original medicinal product (typically brand-name product),
- the same pharmaceutical form (tablet, syrup, inhaler, etc.) as the original medicinal product, and
- it has been shown (bioavailability studies) to interact with the body in a similar manner (bioequivalence) to the original medicinal product.

Because generic medicines cost much less, and because there has been a lack of information on the manufacturing processes and quality requirements of generics, it's fair to question whether or not they are truly equal. There have been problems reported by people who changed from the branded medicine to its generic, and vice versa. In most cases the problems seem to stem from the variation in the inactive ingredients (e.g. allergy to an inactive ingredient). But as for all medicines, appropriate regulatory approval processes are necessary to assess quality, safety and efficacy of generic medicines. It is advisable for patient organisations and advocates to **collect and disseminate information on generics**.

Bioavailability and bioequivalence

Bioavailability is a measurement of a rate and extent to which a drug reaches the blood circulation (which is the bloodstream) so that it becomes available at its site of action.

There are different ways of assessing bioavailability. The most common method is to conduct a pharmacokinetic study, in which the medicines are given orally and it is measured how much of the active ingredient of the medication is actually absorbed and detectable in the bloodstream.

Bioequivalence means that two drugs would be for all intents and purposes the same. When it acts on its target (site of action) – for example, a receptor in the brain – the brand name and the generic medicine should deliver the same amount of active ingredient to the target site. In bioequivalence studies, when you compare a brand name (original) medicine with a proposed generic equivalent, there are certain standards for determining whether the certain parameters are similar enough to declare them bioequivalent.

As for all medicines, generic medicines must obtain a marketing authorisation before they can be marketed. The marketing authorisation applicant is not required to provide the results of non-clinical tests and clinical trials if he can demonstrate that the medicinal product is a generic medicinal

product of (bioequivalent to) an original medicinal product authorised for not less than eight years in a EU Member State or in the European Community.

An authorised generic medicinal product shall not be placed on the market until 10 years after the initial authorisation of the original product. The 10-year period can be extended, to a maximum of 11 years. To obtain this extension, the marketing authorisation holder must, during the first eight years, get an authorisation for one or more new therapeutic indications which bring a significant clinical benefit in comparison with existing therapies.

Marketing authorisations are granted after a regulatory authority, such as the European Medicines Agency (EMA), has conducted a scientific evaluation of the medicine's efficacy, safety and quality. The EMA is responsible for assessing applications from companies to market generic medicines in the European Union (EU). Patient advocates and organisations should be **vigilant when such renewals happen only to extend the patent protection** of a product but does not add any clinical benefit or significance to the therapeutic option ('evergreening'³⁵).

Role of patients and patient organisations

Patient organisations currently have no role in the regulatory process for generic medicines marketing authorisation. Patient organizations and civil society must be trained to be able to advocate in all phases of the medicine chain.

6. Price and volume

As we have already demonstrated, there are many factors and aspects at play when pharmaceutical companies decide on the price of a new medicine. However, one can discern one basic business model behind these decisions: Whether the company goes for a low volume – high price, or a high volume – low price model³⁶.

The high volume – low price model (with sufficient supply of generics) has proven very successful in the HIV field. This is why much advocacy in the fields of HCV and certain cancer drugs is done for the use of the same model. Sovaldi® (sofosbuvir) and other HCV drugs provide an example for the low volume – high price pricing model. It appears that this model cannot be tackled unless there is a good and reliable supply of the medicines needed, thus the upscale of generic production seems inevitable.

³⁵ <https://en.wikipedia.org/wiki/Evergreening>

³⁶ <http://www.who.int/bulletin/volumes/87/7/08-058925/en/>

1.4 Intellectual Property regulations³⁷

Intellectual property (IP) in the context of medicines primarily refers to the use of *patents*, *supplementary protection certificates* (SPC) and *data exclusivity* along with a few other special forms of IP. Once again, this is an extremely complex area that cannot be described in complete detail in this manual. We shall, however, give a general outline of the most important concepts, and highlight the points of intervention where patient advocates may make a meaningful and useful input into the process.

What is a patent?

A patent is an exclusive right registered with a state or publicly recognised registry, with a physically stored, precise description:

- Granted in respect of an invention.
- A patent must be suitable for industrial application.
- The invention must be new (novelty)³⁸.
- It must involve an inventive step.
- Patents are normally valid for 20 years from the date of filing (full patent).
- Renewal fees are payable at certain stages throughout the 20 years.

When a patent expires, the molecules and/or processes protected by the given patent open up for use. Theoretically this is the time when generic manufacturers can have access to the given medicine and start manufacturing. However, you will notice that there are certain exemptions from this rule. Patents can be extended and prolonged; products are sometimes evergreened¹⁶; the infringement of patents is not at all rare; and governments can, under certain circumstances (war, large-scale epidemics, and humanitarian reasons), lift patent protection and order the compulsory licensing of products. Patents are territorial: valid, applicable and enforceable in the territories where they are approved. Separate applications in every country are costly and time consuming. Patient activists should be aware of these **tools and measures**, and should also try to use them to the extent possible. This will allow us to come closer to a global system of pharmaceutical development and innovation that is more respectful of the needs and asks of patient communities, and is based more on equity and fairness than on the drive to generate more profits. By extending patent registrations to larger regions and by further pooling patents for easier and cheaper use, a system that is more equitable and respectful of the needs of patients can be envisaged. The Medicines Patent Pool is an initiative that tries to achieve this in the field of HIV, HCV and tuberculosis in low- and middle-income countries. MPP is a United Nations-backed public health organisation. Through its innovative business model, the MPP partners with governments, industry, civil society, international organisations, patient groups and other

³⁷ Originally developed by Hibernia College, this section adapted from the EUPATI training material on HTA. ©EUPATI under Creative Commons, 2015

³⁸ Please note the example of Sovaldi® (sofosbuvir) and the refusal of the Indian regulator to register it due to the lack of novelty.

stakeholders to forecast, prioritise and license needed medicines. The organisation encourages generic manufacture and the development of new formulations through patent pooling³⁹.

What is an exclusive right?

- ‘Exclusivity’ confers upon its holder, for a limited period, the right to exclude others from exploiting (making, using, selling, importing) the patented invention, except with the consent of the patent owner.
- Patents encourage innovation by monetary means; they represent a trade-off of disclosure in return for monopoly.
- Patents have the effect of incentivising innovation but at a cost to consumers – they allow a higher price to be charged than if there were no patent in existence (welfare loss).
- Considerable time and expense is involved in securing patents – they have to be secured in every country or territory.

What is an SPC?

The Supplementary Protection Certificate (SPC) is an extension to the patent term available for certain types of patent (including human or animal use or plant protection) to compensate for the reduction in the effective patent life due to regulatory approval timelines. This option, available under a regulation of the European Council⁴⁰, means that if the regulatory registration (and marketing authorisation) of a product takes too long, then the patent may not provide sufficient protection for the patent holder to generate a return on its investment.

The duration of the SPC is calculated as a term equal to the period that elapsed between the date on which the application for the patent was lodged and the date of the first authorisation to place the product on the market in the European Economic Community, reduced by five years.

What is data exclusivity?

It is a separate system of intellectual property protection that exists irrespective of patent law. It affords a period of data (and hence market) exclusivity under European regulatory provisions to the company generating the pre-clinical and clinical trial data supporting a marketing authorisation application. Data exclusivity covers all the data for the product, including registration data and data for subsequent indications, formulations and so on for 8 years.

³⁹ <http://www.medicinespatentpool.org/about/>

⁴⁰ Council Regulation 1768/92/EEC (Preamble)

After data exclusivity expiration, a generic product may receive a label for all indications and formulations, regardless of when the data for the innovator product was filed during the life cycle. Marketing exclusivity may be extended to 11 years if a significant new indication was added during the first 8 years on the market.

All of this is extremely complex and difficult to navigate. Of course, patient organisations and advocates cannot be expected to command the legal knowledge that is needed to tackle this system legally to the full extent. However, we shall demonstrate later that **there can be alternative systems and arrangements** that secure fair and equitable access to medication, the protection of the value of intellectual efforts put into innovation, and also make sure that medicine development and manufacturing are not entirely loss producing activities.

1.5 The significance of free trade agreements and TRIPS

While free trade agreements (notably the Trans-Pacific Partnership⁴¹ and the Trans-Atlantic Trade and Investment Partnership⁴²) are aimed at facilitating the free flow of goods and services across continents, and the reduction of trade barriers, such as tariffs, between countries and whole regions, they have also been subject to a lot of criticism. One of the many contentious issues is the treatment of medicines and intellectual property rights in these transcontinental treaties.

Negotiations around both free trade agreements discussed here happened mostly under confidential circumstances. Only after much pressure on the various stakeholders⁴³ it became possible for the civil society and the general public to understand better what the proposed measures and their consequences are, especially in terms of extending patent protection for original medicines and trying to limit the availability of generic medicines on the markets.

As one analysis⁴⁴ points out: “the proposed provisions patients will severely restrict access affordable, innovative medicines. [sources] revealed that the USTR and Obama Administration have decided to aggressively prioritize the interests of multinational pharmaceutical and medical companies over patients worldwide and at home”. “[P]rovisions will bar the entry of generic competition into the market allowing for brand-name drug companies to retain their monopoly market and set drug prices at exorbitantly high prices”. Another major concern with the free trade agreements is that they go beyond and, to a certain extent overrule and limit, the so called “flexibilities” granted in the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement of the World Trade Organisation (WTO)⁴⁵.

⁴¹ https://en.wikipedia.org/wiki/Trans-Pacific_Partnership

⁴² <http://ec.europa.eu/trade/policy/in-focus/ttip/>

⁴³ http://www.politicalcapital.hu/wp-content/uploads/PC_FES_KeletiFordulatVagyUjEgyensuly_Tanulmany_20150325.pdf

⁴⁴ <http://blogs.plos.org/speakingofmedicine/2013/12/06/how-a-free-trade-agreement-threatens-your-health-and-the-health-of-the-people-you-care-about/>

⁴⁵ https://www.wto.org/english/tratop_e/trips_e/trips_e.htm

TRIPS flexibilities

According to the WTO's own definition, Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement "is an attempt to narrow the gaps in the way these rights are protected around the world, and to bring them under common international rules. It establishes minimum levels of protection that each government has to give to the intellectual property of fellow WTO members. In doing so, it strikes a balance between the long-term benefits and possible short-term costs to society. Society benefits in the long term when intellectual property protection encourages creation and invention, especially when the period of protection expires and the creations and inventions enter the public domain. Governments are allowed to reduce any short-term costs through various exceptions, for example to tackle public health problems. And, when there are trade disputes over intellectual property rights, the WTO's dispute settlement system is now available."

The TRIPS Agreement allows governments the use of compulsory licensing for pharmaceuticals (and other patents) in certain well-defined cases. Please see previous sections for a more detailed description.

1.6 Health Technology Assessment⁴⁶

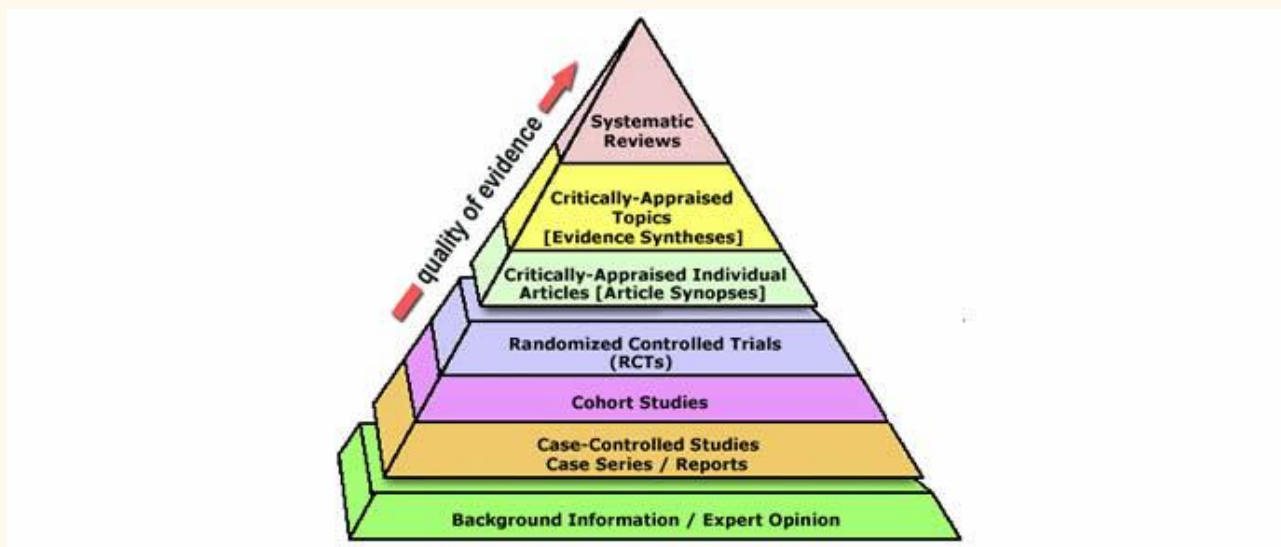
One of the main achievements of the many years of development in medical science is that more and more people can live longer with chronic health conditions. Over the last 100 years we have seen former lethal diseases like diabetes, hypertension (high blood pressure), HIV infection or certain cancers, transform into manageable chronic illnesses that cannot be cured but allow the patients to live long healthy lives with proper medication.

Medicines cost money and, like on any other commercial market, competition on the market of treatments and medications means that often there is a large choice. New options are often costly, and it is the essential interest of the industry to convince payers that the cost they charge is justified. Thus healthcare systems or other payers of medical treatments need to make informed decisions on which treatment to choose and why. As resources are scarce (and often shrinking), healthcare systems face budget cuts, or budgets are often fixed for one or several years ahead. This also means that reliable and scientifically sound methodologies are needed to judge the relationship of the price and the efficacy of a medicine. The question simply is: *Is it worth buying this medicine?*

HTA is based on a systematic review and assessment of evidence on the given health technology.⁴⁷

⁴⁶ This section adapted from the EUPATI training material on HTA. ©EUPATI under Creative Commons, 2015

⁴⁷ Image source: <http://publichealthconsultinggroup.com/wp-content/uploads/2014/06/Evidence-Based-Approach.jpg>



However simple this may sound, the situation is much more complicated. Many treatments are to be taken or used for years, even decades. Biomedical development doesn't stop – there are new alternatives or new data coming up. Economic models need to be complex enough to factor in the human needs, social circumstances, local requirements etc. Several models of pharmacoeconomics have evolved over the last decades that try to look at the cost vs. efficacy of biomedical treatments and interventions. One of the most common, and rapidly spreading methodology is *Health Technology Assessment* (HTA).

Some of the many questions that HTA tries to answer include:

- Do new treatments entering the market add value compared to currently available options?
- If we invest into a new treatment, what else do we need to give up on? How big is the opportunity cost?
- What are the priorities and how do we decide them? Should it be cardiovascular diseases, or infectious diseases, etc.?

HTA is a method to assess the following factors in order to answer these (and a few more) questions. HTA systematically assesses the

- clinical effectiveness and/or
- cost effectiveness and/or
- social and ethical impact

of a health technology. This means that HTA is not limited to the assessment of pharmaceuticals, but both the impacts on the lives of patients, and on the healthcare system are assessed. A 'health technology' means any intervention that may be used to prevent, diagnose or treat a disease, or used for rehabilitation or long-term care, or to promote health in general. Thus, HTA may extend to vaccines, diagnostics, medicines, surgical procedures, devices, screening programmes, healthcare system organisations, even educational programmes (such as prevention education for sexually transmitted diseases, or general hygiene education).

Many EU Member States have distinct HTA bodies integrated either in their healthcare or health insurance systems. In some countries these are independent bodies; in some others they are called differently but do essentially the same work. The European Commission has set up a voluntary network for organisations engaged in health technology assessment⁴⁸. As this is a relatively new scientific methodology, its standardisation is under way⁴⁹. One key aspect is that **patients and their organisations should make sure that they are included in the process**. This is not only required by European Union legislation⁵⁰, but also a key interest for those who are most concerned by new or existing treatment or diagnostic options: the patients themselves.

The assessment process relies on international evidence (clinical trials) about the new technology compared with the best standard of care (SoC) used in the local healthcare system with the objective to determine whether the new options offers any *added value*. Thus HTA tries to inform healthcare decision makers on

- whether a health technology should be used
- how it is used the best
- which patients will benefit the most from it.

HTA is then in fact a bridging function between scientific evidence and decision-making. It is based on the assessment and critical review of scientific data and evidence, followed by the appraisal of these when experts (including patients) form an opinion on whether the technology should be available in the given healthcare setting, whether, and at what level it should be reimbursed.

1.7 Inclusion of patients in health technology assessment

Patients and their organisations should play an essential role in HTA (Facey et al. 2010). Patients contribute real-life experience to the process by providing systematic evidence and first-hand rapport on what it means to live with a given disease, to take a certain medication, or to undergo a certain procedure. Any technology may look tremendously alluring and simple, yet the situation may be completely different in real life.

The increased involvement of patients and their organisations in HTA is an objective of the EMA, too. A comprehensive guideline for HTA bodies on how this can be best done is developed by EUPATI in 2016 as one of the key deliverables of this EU funded initiative. This document is not in the public domain at the time when this manual is being written, but will describe in detail how HTA bodies should interact with patient organisations, how integrity and transparency can be maintained, what kind of support and training patients and their representatives need etc.

⁴⁸ http://ec.europa.eu/health/technology_assessment/policy/network/index_en.htm

⁴⁹ Health Technology Assessment International (HTAi) is one important umbrella organisation.

⁵⁰ http://ec.europa.eu/health/technology_assessment/docs/2014_strategy_eucooperation_hta_en.pdf

This new development, however, also means that patient organisations and patient experts must be prepared, to some extent, to get involved. New spaces for interaction are being created, and advocacy organisations must be able to enter these new spaces with sufficient knowledge and preparedness.

Therefore patient organisations need targeted advocacy to make sure that they are included in HTA bodies and processes. Experience shows that this is only possible if patient organisations and expert patients (Kielmann, Cataldo 2010) can demonstrate sufficient levels of knowledge and scientific understanding of their conditions and the available treatment/intervention options. Therefore education and scientific preparedness are key.

Evidence provided by patients should include, but is not limited to, the following information:

- The nature of the illness (chronic/acute, common/rare, life threatening, debilitating etc.)
- Impact of the illness on the patient's daily life
- Psychosocial issues: stigma, exclusion, disfigurement, mental wellbeing etc.
- Impacts of the existing and the proposed technology (treatment or intervention)
 - Side effects
 - Dose variations
 - Fit to daily life
- Most valued outcomes of a treatment for the patient
 - Relief of symptoms
 - Return to work/normal activities
 - Fewer hospital visits etc.

Experience shows (e.g. in the HIV field) that patient inclusion is successful and meaningful if patients can build a systematic body of evidence for these aspects. Therefore it seems advisable to develop and maintain a collection of documents and other systematic evidence that can facilitate this work, or to **make sure that patients are included in the process** in the first place. This evidence should be clearly structured, based on facts rather than emotions, and include clear reference to sources, methods, findings and limitations.

Patients should make sure that they continuously engage with those who run clinical trials: investigators, contract research organisations, academic institutions and the pharmaceutical industry. Patients can give the most useful input on the relevance and importance of outcomes. Often, patient organisations can play an essential role in bringing together stakeholders that may otherwise find it difficult to collaborate.

Health Technology Assessment International⁵¹, a global network for professionals working in HTA provides some very useful documents for patients as well. Their glossary of the terms used in HTA⁵² is a useful resource for all expert patients involved in any pharmacoeconomic work.

⁵¹ www.htai.org

Patient involvement should happen prior to the HTA process to help the design of studies thus making sure that they respect the patient population's needs. Patients should also be able to suggest topics and technologies for HTA.

QALY

One key concept in HTA is the Quality Adjusted Life Year⁵³ – QALY for short. “Since health is a function of length of life and quality of life, the QALY was developed as an attempt to combine the value of these attributes into a single index number”¹⁸. This discrete number describes the number of life years gained through a medical intervention (health technology) adjusted for their quantity and quality. One QALY equals one year in perfect health. Health technologies are then assessed on the basis of how many QALYs they add to the life expectancy of a patient. The QALY cost of a health technology is calculated, and insurers (or other payers) will consider the cost of one QALY added per patient to decide if the price of the medicine (or other intervention) is reasonable. This also allows the comparison of different interventions. HTA experts use these calculations and comparisons, in combination with other factors, to decide on whether or not a medicine can be reimbursed in the given healthcare system.

Health Technology Assessment International provides a thorough training webinar for patients and patient organisations on HTA, which explains in considerable detail what the role of HTA is, and how patients and citizens can (and why they should) get involved⁵⁴.

⁵²

http://www.htai.org/fileadmin/HTAi_Files/ISG/PatientInvolvement/Glossary/HTAiPatientAndConsumerGlossaryOctober2009_01.pdf

⁵³ https://en.wikipedia.org/wiki/Quality-adjusted_life_year

⁵⁴ <http://www.htai.org/webinars/pcisg-intro-hta/>

Module 2 – Advocacy in general

For the purposes of this manual and the work described here, we shall make a difference between ‘advocacy’ and ‘activism’.



Patient advocates and media representatives negotiate with Michel Sidibé, the Executive Director of UNAIDS in Geneva in 2014

Advocacy is often thought of as an act of publicly representing an individual, organisation, or idea and used as an umbrella term for many intervention tactics such as speaking, writing or acting in support for or against an issue or cause, policy or group of people.



Some of the same patient advocates demonstrate against the shortcomings in the global response to HIV in Melbourne in 2014

Activism, on the other hand, may have a less favourable reputation but it is no less important. Activism is described as a policy of taking direct action to achieve a political or social goal.

Both are tools to create social and political change, and both can be equally important parts of a strategy for any NGO or other political organisation to achieve a certain objective, and patient organisations are no exception.

The line between advocacy and activism may be blurred sometimes, but this should not prevent patient advocates from planning strategies and actions with this theoretical difference in mind. One of the reasons is that the planning and implementing actions in one or the other category will require different resources, skills and people.

2.1 Anger



We shall also discuss this perhaps unconventional yet very important point: the affective, emotional aspect of activism and advocacy⁵⁵. Emotions – feelings like anger, compassion, outrage and love, play an essential role in what patient activists do. Denying emotions when a mother fights for access to medication for a dying child, or when a young gay man does not want to die of AIDS at the age of 25, is myopic. Emotions are not ‘childish’; they are a part of life. Decision-makers, even academia, often support the idea that having

⁵⁵ Image source: <https://actuplondon.wordpress.com/2015/12/10/for-immediate-release-activists-charge-hep-c-conference-demanding-access-to-medication/>

emotions is unprofessional. This denial of the validity of emotions becomes a tool, however unconsciously used, to belittle patient (or any civil) movements because it questions their ‘impartiality’ and their judgment-making capacities.

Bereczky (2013), and to a certain extent Wienold (2002) describe the role of anger, and the way in which anger was gradually transformed into activism in the HIV/AIDS field. “From the earliest days of treatment activism fuelled by frustration and anger and the unethical conduct of clinical trials (where patients were encouraged not to take their drugs to find out whether they were in the placebo arm), incensed by neglect by the federal government of the US (Wienold 1997:18), there is a clear line of history how activism crossed from the US to the UK, and then to the European continent.” (Bereczky 2013:12) This process took many years and has not stopped.

The situation is very similar in many regards when we look at advocacy around affordability. For example there is a profound sensation of grass-root dissatisfaction, frustration and anger in the field of hepatitis C, where complete cure has been possible since 2013, but the prices of compounds used in this field are prohibitively high. Unlike in case of certain cancer drugs where the efficacy and long-term usefulness of some new treatments may be questionable⁵⁶, HCV has become a curable disease, but the number of patients in treatment should be orders of magnitude larger than what medicine prices allow in order to curb and eventually stop the HCV epidemic. It appears in 2015 that the anger caused by the pricing practices of pharmaceutical companies and the often non-transparent deals of payers could lead to sufficient leverage across patient and activist communities to build effective political responses.

2.2 How to do advocacy?⁵⁷

These recommendations are largely based on the history and experience with patient advocacy in the HIV/AIDS field.

The history and importance of activism and advocacy in the HIV field is discussed very thoroughly in the literature (e.g. AVERT⁵⁸, The AIDS Activist History Project⁵⁹ etc.). For the purposes of this manual, we rely on the summary video presentation from this author⁶⁰ compiled for the training of expert patients in various diseases areas by EUPATI⁶¹.

⁵⁶ <http://www.technologyreview.com/featuredstory/520441/a-tale-of-two-drugs/>

⁵⁷ Adopted from the EATG HIV/AIDS Treatment Advocacy Manual, ©EATG, 2010 <http://www.eatg.org/gallery/180937-1346846614.pdf>

⁵⁸ <http://www.avert.org/professionals/history-hiv-aids/overview>

⁵⁹ <http://www.aidsactivisthistory.ca>

⁶⁰ https://www.academia.edu/15626872/Patient_advocacy_basics_-_A_narrated_video_presentation

⁶¹ <http://www.patientsacademy.eu/index.php/hu/>

The backbones of patient advocacy are solid knowledge through self-education and a conscious representation of interests. These two factors suggest that

science and policy are inseparable

in any advocacy work. This suggests that you should not only know what you want to achieve, but also understand how to achieve it best. This may seem straightforward and easy, but in actual fact there are several factors that make this process complex and demanding.

2.2.1 The setting

2.2.1.1 Knowledge is privilege

Currently, the academic and scientific establishments are rather closed and difficult to access even if open source knowledge production and distribution have become increasingly accessible around the globe. Nevertheless, it takes time, patience and some effort to demonstrate to other, especially academic stakeholders and representatives of the medical profession that patients have something relevant to say in the research and development, and also in price setting processes.

2.2.1.2 Illness can be disempowering

There is evidence in the literature that all chronic illnesses are stigmatising and incur a certain level of discrimination against the person suffering from an illness (Weiss et al. 2006). This is a specific issue that is often forgotten, or just treated as a “point of complaint” by patient communities. But this factor needs to be acknowledged and dealt with specifically in order to make sure that any advocacy work is done on equal footing and from an empowered stance.

2.2.1.3 Stakeholders have diverging interests

Patient organisations and advocates need to acknowledge that all stakeholders in the processes and work around the affordability of medicines will have very different, sometimes diametrically opposing interests. Scientists will want to make sure that they can do research under fewer limitations to test their hypotheses. Payers will want to pay less while providing a reasonable quality of healthcare. Politicians will want to make sure that their constituencies are represented. The industry will want to make a profit - even if not any price, but they carry this responsibility towards their investors. Finally, patients will want good quality and reliable treatment at prices that are affordable to the state and the individual. Mapping out and navigating amongst these interests is key to the success of advocacy work.

2.2.1.4 Structures are undeveloped

Even though the European Union and its pharmaceutical regulator, the European Medicines Agency specifically requires patient involvement in all stages of medical research, development and licensing⁶², this is not at all perfectly implemented, partly for the lack of structures and standards of patient involvement. There are some isolated examples for cooperation with and involvement of patients in the affordability and pricing processes by the industry, and reimbursement negotiations between the states and pharmaceutical manufacturers, but the landscape is generally characterised by the lack of transparency.

2.2.2 Resources

Rather than offering complete solutions that fit all situations, we shall concentrate on the resources that patient advocates and their organisations have, or should acquire, to be successful in their work for affordability.

2.2.2.1 It's your body

It is about your body and your environment, and what happens to them – so you should know best. This, however, means thorough and systematic learning and self-development about the disease or disease area that you work in. This will put you on par with researchers and experts. If doctors, nurses and scientists could learn the subject matter, then what would prevent you or other members of your community from learning the same? Understanding medicine (or any other scientific field) is not a divine gift – it is hard-earned knowledge. While knowledge is often treated as a privilege, much of the biomedical and economic knowledge needed for advocacy work are in the public domain and relatively easily accessible.

2.2.2.2 Information is key

Amass information systematically and in a conscious and targeted way. Social media can be a very good tool for collecting grass-root evidence, but you need to be cautious, and fact-check information flowing from the community. Dedicate specific resources to collecting, analysing and assessing information, and try to understand how all of that fits into the bigger picture. Knowing what information to share when and with whom is one of the most important advocacy tools.

2.2.2.3 Focus on joint interests

Rather than complaining about how everybody wants to achieve something different, and how disempowered patient communities are, try to map out and concentrate on what the joint interests of all stakeholders are, and start from there. There will always be common points in the process: Experience in the HIV/AIDS field shows that universal access to treatment, effective prevention and the slowing down of the epidemic are topics that allow relatively easy alignment of all stakeholders. In this case it does not matter if they support your cause for moral, financial or perhaps political reasons. The bottom line is: It allows you to get closer to

⁶² http://www.ema.europa.eu/ema/index.jsp?curl=pages/partners_and_networks/q_and_a/q_and_a_detail_000082.jsp

your goal. Of course, you should always remain clear and transparent about what you want to achieve – in this case affordable medicines and diagnostics.

2.2.2.8 Becoming bold innovators

It is becoming increasingly acceptable⁶³ and legitimate for patient community organisations to propose and conduct research projects for their respective disease areas. Community based and/or participatory research is becoming one of the ways of improving the quality and relevance of healthcare interventions⁶⁴. This is an encouraging development that allows patient organisations to build up the courage and pursue research initiatives, which can actively contribute to a realistic and feasible system of medicine pricing.

2.2.3 Developing an advocacy plan

Although there isn't a one size fits all approach to developing an advocacy plan, many years of good practice have shown that the following methodology does help to achieve successful advocacy projects with sustainable outcomes.

2.2.3.1. Setting priorities

Setting priorities means that you have to choose one objective over several others. In others words, when you decide for a priority, you also decide that you will not do some other things. This may lead to discussions and debates within your own ranks. We suggest therefore starting your work with building up sufficient evidence for why you want to do one thing rather than something else, so that you can sufficiently convince your peers and other stakeholders.

This also inevitably means that you need to talk to your own community to understand clearly what they want. Does your objective make sense to the others, and is it useful for them?

For example you want to make sure that a certain rather pricey medication is available for prevention purposes, so you decide to fight for lower prices of that compound. But there is immediate pushback from communities in lower and middle income countries saying that they don't even have money for treatment in their systems – fighting for cheaper prevention is the least of their concern. However, negotiating with the pharmaceutical manufacturer and the payers requires a wide coalition of the entire community. How do you handle the situation? How do you tweak or change your priority to ensure inclusion and alignment of stakeholders?

2.2.3.2. Using SMART objectives

⁶³ http://www.amfar.org/uploadedFiles/_amfarorg/Articles/Around_The_World/GMT/2015/GMT-EIA-051515.pdf

⁶⁴ http://www.cdc.gov/pcd/issues/2014/13_0176.htm

Common practice in management science⁶⁵, the SMART technique has proven very useful for the civil sector, as it provides a simple tool to design meaningful projects and facilitates the planning process.

Objectives should be

Specific

Measurable

Agreed-upon

Realistic

Time-bound.

Dedicate time to making sure that all of these aspects are adequately tackled when drawing up a plan.

For example saying “HIV medication should be accessible for everyone who needs it” does not meet these criteria, even though it may be a completely legitimate overarching, political objective. But for a project, it is much more purposeful to attain more specific objectives. A better formulation could be “An increase of 50% should be achieved in the number of HIV infected individuals (PLHIV) who receive treatment in this region over a period of 18 months.” This is specific and measurable, and is hopefully based on a consensus within community. It also seems to be realistic, and is time-based, which again makes it measurable.

2.2.3.3. Collecting evidence

Your advocacy work will not be credible or authentic unless you can support your arguments with hard evidence. Sometimes the starting point of your work will be a piece of evidence, e.g. the number of people dropping out from the HIV treatment cascade⁶⁶ in a given country or region. But less concrete objectives also need robust, scientific and systematic evidence to be convincing. Therefore it is best to start all work with a collection of evidence, a register of data, papers, documents that you consider relevant to support what you are trying to achieve. Evidence from the community is certainly relevant, even if it seems anecdotal and doesn't meet the scientific rigour of journal papers. However, it must be systematic and credible. Try to fact-check data you receive from the community, and try to fit these data into a broader grid of evidence. Other stakeholders might be very well armed with data and facts, and patient advocates and organisations often have to start from a disempowered stance. You will want to make sure then that the credibility and soundness of your arguments is not something you have to worry about.

Scaling up treatment access by 50% as mentioned above is neither easy nor cheap to do. But collecting scientific evidence in support of such a measure should not be too difficult. You can use national and EU

⁶⁵ <https://www.projectsmart.co.uk/smart-goals.php>

⁶⁶

[http://www.amfar.org/uploadedFiles/_amfar.org/Around_the_World/MSM\(1\)/GMT%20HIV%20Treat%20Cascade%20120213.pdf](http://www.amfar.org/uploadedFiles/_amfar.org/Around_the_World/MSM(1)/GMT%20HIV%20Treat%20Cascade%20120213.pdf)

statistics; recommendations from clinical societies; epidemiological studies; and feedback from the community on the psychosocial impacts of being on treatment and not infectious. All of these should be combined into a directory of facts and arguments in support of your cause.

2.2.3.4. Drawing a power map

The power map is a straightforward but very useful exercise. You should simply take a piece of paper and make a list of all of your

- allies and supporters
- adversaries and opponents
- neutral partners
- target audiences (not yet involved but should be)

for the given project or objective.

Don't forget about potential adversaries and opponents! Also spend some time on thinking about how this grid of your contacts and target audiences relate to each other. Are there any points in this network where you can or should use diplomacy? What are the right tools to use to approach your partners, and how can you tackle opposition?

Advocacy and activism can include a wide range of tools. You can organise quiet talks and candid negotiations with partners. Letters, private or open, may be useful in other cases. Personal interactions and smaller or larger meetings, conferences are also suitable tools. A stronger impact can be made through press releases, public campaigns, signature collections and the use of social media. Finally, demonstration, die-ins, sit-ins, rallies can also be completely justified in certain cases.

The choice depends on the cause you represent, but make sure that you have the possibility to escalate your response in case of any pushback. Therefore it is usually counterproductive to start immediately with an angry demonstration before you have tried to negotiate with other stakeholders. For example there might be religious or otherwise fundamental organisations that oppose the extension of HIV treatment to a larger number of patients, and they argue that there is a better use of those resources. What other tools can you think of in order to argue against their standpoint? Are there any other creative ways of using available media and infrastructures that can help your work?

2.2.3.5. Making a budget

Money is usually tight in all civil, non-corporate settings. You will need to do some really careful planning, especially in case of long-term projects. Financial milestones need to be set, and you also need to monitor

them carefully. Not all civil organisations will have the resources to employ professional financial personnel for a project. However, most public, corporate or charity grants, and other funding come with detailed financial requirements that also ensure compliance with common sense requirements.

However, there are some really useful online tools that can help you plan and follow your budget:

- [This website provides](#) a list of online project management tools that NGOs can use.
- [Here is a list](#) of various free online budgeting tools.
- [This forum entry](#) provides a list of different sites that can be of use.

Please note that all of these tools and templates will need to be adapted to your specific project, local circumstances and legislation. Experience shows that planning the budget and trying to align funders from the earliest stages of any project will secure optimum outcomes. Don't despair if one or the other project does not get funding. Sometimes it is only a matter of formulating it the right way.

Fighting for better access to medicines for PLHIV may involve very different facets of work. This will also define the financial needs of the project. It is important to remember that even if you want to do advocacy that relies on volunteer work and the use of (seemingly) free social media channels, there can be inevitable costs that you need a certain contingency for. You may find out that internet domains can only be registered for a fee, or that you need to pay to acquire certain publications and data that you need. Even volunteers will need to be rewarded somehow: maybe you need to plan for coffee or food you buy for the meetings etc. All these need to be part of your advance budget.

2.2.3.6. Engaging allies and neutrals, anticipating opposition

Look at your power map and sort the organisations and people into the following categories again:

- allies, friends and supporters
- ambivalent and neutrals
- opponents and adversaries.

And then develop separate strategies as to how you will engage these stakeholders for your cause. Allies and friends may seem straightforward enough, and you have probably already developed your objectives and projects together with them.

However, it is also important to focus on neutral and ambivalent partners as they can be turned into supporters and convinced to be allies. And you will certainly also need a strategy to manage your adversaries, and you need to understand why they are (or could be) against your cause. These can be political, financial or prestige reasons - all of these issues need to be handled differently.

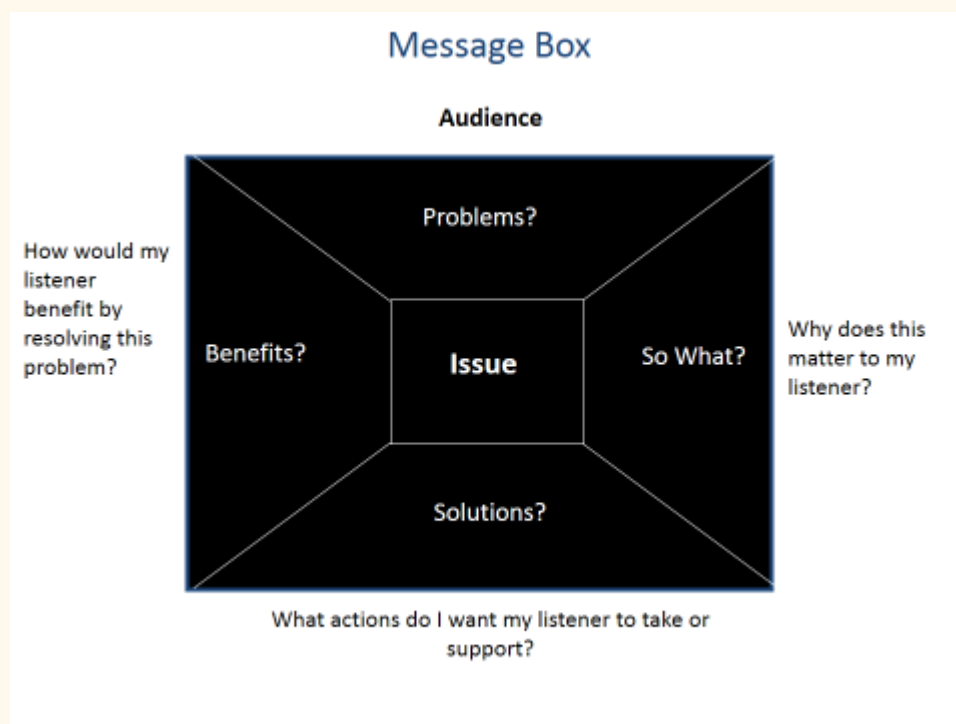
The above example about making sure that there is a 50% increase in the number of PLHIV in treatment seems like an easy sale to most stakeholders, but you will still have to argue differently to different people and organisations. Expect opposition even from the most unexpected places: For example some governments

or political parties may not be interested in any upscale of treatment for financial or moral reasons. For example a neutral party in this process may be schools that are not necessarily concerned with HIV, but will probably listen to messages about harm reduction, prevention and sexual health education.

2.2.3.7. Framing your arguments

Spend time on writing down your arguments and messages for each of your target groups. Share and discuss these with your co-workers. Imagine, or even play out debates within your group of colleagues with a member playing the ‘devil’s advocate’, i.e. an adversary stakeholder. This exercise also helps internal consensus building, which will ease your work with the general public and stakeholders, too.

The ‘message box’⁶⁷ technique is a good one for advance planning communications processes and standards around your project. The message box is a simple technique to frame your arguments for yourself and others.⁶⁸



Use separate message boxes for different audiences and messages.

2.2.3.8. Communication

⁶⁷ <http://images.nationalgeographic.com/wpf/media-content/file/OCEDMessageBox-cb1325007760.pdf>

⁶⁸ Image source: <http://gap2.eu/methodological-toolbox/the-message-box/>

It is essential that you are able to tell the stakeholders concerned and the world at large what you are doing and why. NGOs hardly ever command the resources necessary for any large media campaigns involving national press or television. This means that you will have to use some conventional and non-conventional channels. Draw up a communication plan before the project, which includes the key messages that you will want to convey. Anticipate that some communication measures may involve costs, so that this should be part of the budget.

Communication should be aimed externally AND internally as well. Especially if you rely on volunteers, you will need to make sure that the objectives remain clear, and that your team is sufficiently motivated. Transparency and openness have proven to be very useful in this process.

2.2.3.9. Showing leadership

Don't apologise. Mistakes should certainly be acknowledged and corrected, but many NGOs make the mistake (especially in settings where civil society is not strongly developed) that they apologise in advance for what they do.

You are convinced about the correctness of your cause, and you also know why you are working around that cause. There is no need to start your arguments with statements like “even though there are more pressing problems...”, “some might disagree, but...”. Make clear statements about what you are doing and how it will benefit your community and society at large.

2.2.3.10. Monitoring, evaluation, documenting and follow-up

Although it is a standard requirement in every funding agreement, you should always plan all your advocacy actions and projects with proper documentation, monitoring and follow-up in mind. Remember that this is your capital for any future work – it will allow you to show tangible, measurable outputs to future partners and funders.

There are some good monitoring and evaluation methodologies, even tools available on the internet. You probably don't need very professional tools unless you work on a larger project with substantial external funding. However, these usually come with specific predefined requirements for monitoring and evaluation. Are your internal processes clear, even if not described? Is there a clear structure for decision-making? Do you know who is responsible for what? Do your co-workers know how to reach you and each other, and how to respond to requests and questions?

Module 3 – Case study

Sofosbuvir

<https://www.chathamhouse.org/expert/comment/medicines-pricing-there-better-way#>

This is a reproduction of an article from the Chatham House Royal Institute of International Affairs. It gives a very good and concise description of the Sovaldi® (sofosbuvir) case, and it highlights most of the issues and phenomena discussed in this manual before with a clear focus on the practical implications. This is not the only case where affordability is a pressing problem – certain cancer drugs and a series of new compounds in rare diseases see very similar developments. The article also mentions the case of Turing Pharmaceuticals and Daraprim® (pyrimethamine).

Please take your time to also work through the links included in the material.

The Chatham House article is followed by a description of some advocacy measures by various organisations organised around Sovaldi® and some other HCV medicines. You should read these in conjunction with the case study. Please consider these measures from the perspective of usefulness, impact and community mobilisation, and also consider the lessons that can be drawn.

Read through the case study preferably before the related training event. You will then be requested to reflect on the case study and the entire topic on the basis of specific questions.

Medicines Pricing: Is There a Better Way?

 08 October 2015



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The pricing of medicines is under scrutiny as a result of recent controversial company decisions which are putting national health financing systems under severe strain. What can be done about it?

The pricing of medicines has always been an issue of great social, political and economic significance across the globe. Early in this century the price of treatments for HIV/AIDS was a *cause celebre* when patients in developing countries were being asked to pay \$10,000 per annum to purchase drugs which would keep them alive – which, of course, the overwhelming majority could not. A combination of public pressure by HIV activists, the availability of cheap generic versions of brand name drugs from India and additional financing from the international community resulted in treatment costs falling to \$100 or less per annum. As a result there are now 15 million people globally receiving treatment, and new HIV infections have fallen by one third. It is possible now to foresee the end of the epidemic – something few envisaged 15 years ago.

Yet the prices asked in 2000 for antiretroviral drugs pale into insignificance compared to those now being charged for some medicines. In 2013 Gilead Sciences received approval for its drug Sovaldi® for hepatitis C, selling at a cost in the United States of \$84,000 per 12-week course of treatment (or \$1,000 per pill), although it is heavily discounted in a group of developing countries. In 2014, all the new cancer drugs approved by the US regulator were priced higher than the equivalent of \$120,000 per annum. Most recently a small company, Turing Pharmaceuticals, achieved notoriety by increasing the price of a drug it acquired from another company from \$13.50 to \$750 per pill. In August this year, the UK competition authorities accused Pfizer, the world's largest pharmaceutical company, of raising prices for an anti-epilepsy drug to the extent that the NHS's bill for it rose from £2.3 million before 2012 to £50 million in 2013.

As the patents on their so-called blockbuster drugs expire, companies increasingly seem to be testing what the market will bear by trying to sell lower volume products at very high prices. But this is not small beer. Mainly as a result of its new hepatitis drugs, Gilead's global sales rose from \$9.7 billion in 2012 to \$24.9 billion in 2014 and its net income from \$2.8 billion to \$12.1 billion.

Thus pharmaceutical pricing is now again rising up the political agenda, particularly in the US where prices are largely unregulated. An electioneering Hillary Clinton has produced a plan to lower drug prices, as has Bernie Sanders, her fellow Democratic presidential hopeful, and Jeff Sachs, the influential economist.

Setting priorities

The fact is that most drugs actually cost relatively little to make. It has been estimated that Sovaldi® costs less than \$140 to manufacture for a 12-week course. The main controversy is about how much of the return companies make is necessary to finance the research and development (R&D) that leads to new discoveries, and how much represents the monopoly profits conferred by patents (or by the costs competitors would incur in bringing a drug to market) which enable exclusion of competitors for a decade or more. Another controversy is how countries at different income levels and purchasing power should contribute to these returns through different pricing levels.

Pharmaceutical companies base their defence of their pricing policies on the former proposition – without the pricing freedom allowed by patents R&D spending, which is costly and risky, would dry up. And, in any case, drugs like Sovaldi®, even at the price charged, more than pay for themselves in the cost of avoided hospital treatments (such as liver transplants). Critics point to the fact that that most companies spend more on marketing, and earn more in profit, than they spend on R&D and that they rank about the same as banks in their net profit margins.

From a public policy point of view the question is how much it is necessary to pay for the R&D we need and if the current system of financing R&D through drug pricing is the best way. Is potential profit the best way of setting R&D priorities? There are many diseases of great public health concern in the developing world which companies are not investing in because there is little prospect of profit – for example tuberculosis,

malaria, sleeping sickness and, topically, Ebola.

More relevant in the rich world is the threat posed by antibiotic resistance. Very few large companies now conduct antibiotic R&D because profitability, outside a few niche areas, is very low. As public health authorities around the globe are increasing their efforts to restrict antibiotic use to limit the spread of resistance, and ideally reserving new antibiotics to be used only as a last resort for that reason, it is easy to see that the sums for pharmaceutical companies simply do not add up under the current business model.

Towards a new model

A Chatham House working group has just published the report *Towards a New Global Business Model for Antibiotics* which proposes delinking revenues from sales volumes as a way forward. The report proposes that companies would be rewarded for antibiotic R&D in various ways, none of which depend on sales volume, so that it would be possible to earn a satisfactory return on investment even if a new antibiotic was left entirely on the shelf. This also benefits public health by removing the financial incentive to oversell these drugs. Jim O'Neill's Review on Antimicrobial Resistance has made [very similar proposals](#) which it continues to develop. Some companies, such as GlaxoSmithKline and AstraZeneca, also seem favourably disposed.

As the working group report makes clear, there are many steps still necessary to make a delinked business model operational. If companies can be fairly rewarded for R&D other than through the price of the product or sales revenues, then it opens the way for companies to sell their products at close to their much lower manufacturing cost. That way we might get the R&D and inventions we need at a price we can afford⁶⁹.

⁶⁹ See more at: <https://www.chathamhouse.org/expert/comment/medicines-pricing-there-better-way#sthash.KVDfKOUj.dpuf>

Advocacy actions around affordable HCV medication



- Outraged about the prohibitive prices of HCV medicines, activists organised a direct action against Gilead Sciences at the International AIDS Conference in Melbourne in 2014.
- The Civil Society Forum on HIV/AIDS⁷⁰ press released on the affordability of HCV treatment and called the European Commission and Member State government to increase access and affordability in November 2014:
<http://www.eatg.org/gallery/171363/Press%20release%20No%20one%20left%20behind%20conference%20CSF%2027112014.pdf>
- People affected by HCV in Spain had a major rally in front of the Ministry of Health calling the government to curb corruption and to increase access in February 2015:
<http://www.dailymail.co.uk/wires/ap/article-2904660/Thousands-protest-Spain-better-hepatitis-C-treatment.html>
- The board of directors of the European AIDS Treatment Group met the representatives of Gilead Sciences at their headquarters for a high-level discussion about prices and affordability of HCV medicines in September 2015. The outcome of the meeting was an informal agreement on more transparency of pricing and better collaboration with the patient communities.

⁷⁰ http://ec.europa.eu/health/sti_prevention/hiv_aids/civil_society_forum/index_en.htm

- Activists of ACT-UP London demonstrated against Gilead Sciences and medicine pricing at the European HIV and Hepatitis Co-infection conference in London in December 2015.
- Treatment Action Group (TAG) of the USA maintains a website and manual for HCV advocates that includes both treatment related scientific, and policy information:
<http://www.treatmentactiongroup.org/hcv/publications/training-manual-hcv-hiv>
- Several demonstrations and direct actions were organised in the USA to pressure Gilead Sciences into lowering the price of and increase the access to their HCV compounds:
<http://dailycaller.com/2015/06/16/investigation-the-inside-story-of-the-money-the-activists-and-the-cure-for-hepatitis-c/>
- The government of Egypt achieved a 99% price cut in the price of Sovaldi® for the treatment of almost all patients affected by HCV in Egypt:
http://www.hepmag.com/articles/egypt_sovaldi_discount_2831_25391.shtml
- The government of Portugal could negotiate a “substantial” price reduction on sofosbuvir based treatments in 2015: <http://www.hepctrust.org.uk/portugal-agrees-treat-13000-people-hepatitis-c-next-3-years>
- The research of Prof. Andrew Hill from the Liverpool University has shown for Daklinza® (daclatasvir) that 5 grams of this compound (needed to treat a patient) was more expensive than 5 grams of diamonds in 2015⁷¹, and that the profit margin of the manufacturing company reached three-digit ranges. This presentation and finding was a major catalyst for many advocates to take action against exorbitant medicine pricing: <http://www.hivandhepatitis.com/hiv-hep-coinfection/hiv-hcv-coinfection/5289-ias-2015-access-to-screening-and-treatment-key-issues-for-hepatitis-b-and-c-and-hivviral-hepatitis-coinfection>.

⁷¹ https://www.eiseverywhere.com/file_uploads/0feb2f649f53c33689c9f60ed1c3626f_AndrewHill.pdf

Module 4 – Advocacy for affordability – exercise

Let's summarise, and take a closer look at, the different advocacy points that we have found in the processes and systems of medicine pricing. Possible points of advocacy intervention are marked with red throughout the text above⁷².

Having worked through the case study on Sovaldi® above, let's take a closer look at different aspects of advocacy and possible interventions from the patient community that came up in the course of this material and the case discussed.

Health is a human right

What lesson do you draw from the above in terms of assuring that patients have access to affordable medication on the basis of the human right argumentation? How can this argument be used more and in a better way to make sure affordable access is there?

Patient advocates need to educate themselves

Expert patients and patient organisations are also multipliers of knowledge, coping strategies and empowerment. *How can this aspect contribute to the affordability aspect? How can information be shared quickly and efficiently so that swift and effective action becomes possible?*

Sharing the cost of medicines between the public hand and individuals

Not all, but most healthcare systems are based on some model of co-payment, i.e. many health insurance systems in Europe already work on the basis of some co-payment from the patients when actually accessing health care, using a health technology, or buying medicines. The impact of co-payment on patient behaviour has been studied to some extent. One research from Sweden⁷³ shows that the higher the rate of co-payment, the lower the rate of refills (hence adherence to medication) with epilepsy patients. Another study from the Czech Republic⁷⁴ calls the attention to the vulnerability of the elderly when it comes to co-payment, and the many negative consequences and in consequence that may result from a co-payment system that is not serving

⁷² Image source: <https://actuplondon.wordpress.com/2015/12/10/for-immediate-release-activists-charge-hep-c-conference-demanding-access-to-medication/>

⁷³ <http://eurpub.oxfordjournals.org/content/24/1/85>

⁷⁴ <http://www.ncbi.nlm.nih.gov/pubmed/18459476>

the patients' interest to access the best possible care. This same study also points out that the relationship of the doctor and the patient can also have an impact on the operation of the co-payment scheme.

How can this aspect be used as an argument in the affordability debate? Is this type of burden sharing relevant in case of very expensive medicines? What should be the standpoint of advocacy in general with regard to co-payment?

The Joint Procurement Procedure of the EU

The European Commission has been working on introducing and implementing a Joint Procurement Procedure⁷⁵ for medicines for several years⁷⁶. The first pilots with vaccines will happen in 2016. The key objective is to lower prices and simplify processes in the EU when it comes to the procurement of medicines.

How do you think patient advocates can facilitate this process? How can this development be used in advocacy work? Which element or level of advocacy is involved, and what can be expected outcomes?

Patients have protected rights

The rights of patients are theoretically well protected in the European Union. The European Medicines Agency Human Scientific Committees' Working Party with Patients' and Consumers' Organisations (more commonly known as the Patients' and Consumers' Working Party or PCWP) provides recommendations to the European Medicines Agency and its human scientific committees on all matters of interest to patients in relation to medicinal products⁷⁷. Patient communities are represented in this body through members delegated by the patient organisations or umbrella organisations, approved by the EMA on the basis of strict criteria.

How do you think this form of representation can be used to foster affordability? What can be done to make sure that the patients' voice is better heard and stronger?

Prescribers may not know or care about the prices of medicines

One of the key audiences, and also often one of the most important targets for patient advocates are representatives of the medical profession: doctors, nurses and other people who work in healthcare.

⁷⁵ http://ec.europa.eu/environment/gpp/pdf/toolkit/module1_factsheet_joint_procurement.pdf

⁷⁶ http://ec.europa.eu/health/preparedness_response/joint_procurement/index_en.htm

⁷⁷ http://www.ema.europa.eu/ema/index.jsp?curl=pages/contacts/CHMP/people_listing_000017.jsp

However, the opposite situation may also occur: when the payers or the national competent authorities to force prescribers, through regulations or administrative measures, to prescribe cheaper alternatives. As equivalent generic replacements are not always available for medicines, this often leads to inferior quality medicines being provided.

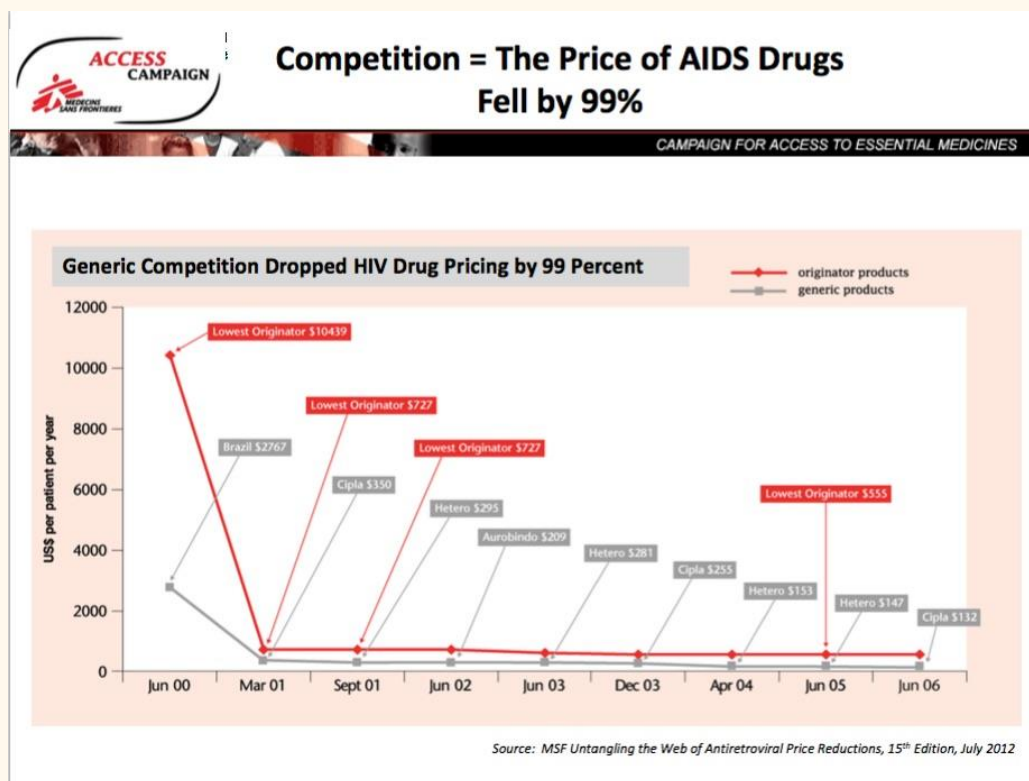
What do you think advocates can do to improve this relationship? How can the medical profession be included in the advocacy work for the affordability of medicines? What are the most characteristic and pressing issues in your local settings?

Patients should be involved with pharmaceutical companies directly

There are several models for the direct cooperation between patient organisations and pharmaceutical companies: the ECAB model being one of them (see page 15 for more detail). *How do you think patients can work with pharmaceutical companies but still preserve their impartiality and objective stance? What should be the key arguments of patient organisations to promote affordability? What can be an effective response from patient advocates if pharmaceutical companies use employment and economic growth in the countries and regions concerned as arguments for higher medicine prices?*

Demanding generic products

We know from the history of HIV/AIDS treatment that generic medicines could reduce the prices of medicines by 99% over a period of less than 10 years. Pushing for the wider use of generic products is one of the key advocacy areas for patient organisations to improve access to medicines and diagnostics.



However, the patient community often cannot wait until the patents expire, and medicines become generic, thus cheaper. Therefore intensive activism is needed to facilitate the use of generics through using alternative intellectual property and development models⁷⁸. The effectiveness, reliability and quality of generic medicines are unfortunately often misunderstood in the patient communities, too. This means, in turn, that patient experts also need to take care of educating their peers on the utility and quality of generic products.

The currently used systems and schemes of intellectual property protection with patents and other measures are not the singular method that can be used.

Aids Fonds, one of the leading HIV/AIDS organisations of the Netherlands and Doctors Without Borders Netherlands state⁷⁹: “There are proven solutions to guarantee universal access to drugs – not only to those who live in the poorest countries. These solutions focus on generic competition, such as compulsory licensing and patent opposition. We need expanded use of these existing flexibilities in patent law, especially for low- and middle-income countries, to lower medicine prices and to increase access to treatment. Moreover, we need to work towards alternative models that not only guarantees access to existing medicines, but that stimulates real medical innovation that is highly needed, to develop new treatments for HIV and tuberculosis”.

⁷⁸ This section is based on the lecture of Pauline Londeix of ACT-UP Basel delivered at the EATG Sitges VII Conference on 4 October 2015.

⁷⁹ https://www.artsenzonderegrenzen.nl/sites/default/files/PetitieAidsFonds_ArtsenzonderGrenzen-juni2015.pdf

What do you think can be done to promote the use of generics? Who would be the targets in your view in the course of advocating for the use of generic medicines? How can the use of generics be facilitated in a complex international legal and political situation? How can patient organisations make sure that, contrary to current practice, they are included in the marketing authorisation process of generic medicines? What can patient advocates and activists do to promote the more intensive use of TRIPS flexibilities? What are the feasible advocacy targets in the current political and economic environment? What combination of advocacy and activism, i.e. diplomacy and direct action is feasible and purposeful?

Module 4 – Advocacy plan

On the basis of the manual and the practical exercise, you should now try to develop an advocacy plan for a certain affordability related objective. Please follow the recommendations given in Module 2, and the guidance below.

1	Define an objective	Use the SMART technique
2	Devise a project	Is it relevant for your community, and it is doable?
3	Collect and organise evidence	Use an online tool to collect data and evidence in a systematic way
4	Develop a power map	List your partners and stakeholders, parties involved, and their relations – positive and negative alike. Discover your landscape.
5	Define your allies, neutral and adversary stakeholders	Use a visualisation tool (draw) to make it easier to understand.
6	Choose an advocacy tool	Quiet talks; letters; open letters; meetings; personal interaction; press release; media campaign; demonstration; direct actions etc.
7	Frame your arguments	Write it down instead of just thinking about it. Use the message box technique.
8	Develop a communication plan	Think of alternative channels and focus on social media.
9	Devise a budget	Use a free online tool if needed.
10	Devise a fundraising plan	Think outside the box. Contributions can be more than just money.
11	Develop an action list and timeline	Add names and dates. Be careful and not overly ambitious.
12	Develop a monitoring plan	Use photos, reports, interviews etc. to document your progress.

Module 5 – Summary and evaluation

You will be guided through a final summary and assessment of the learning outcomes of this manual and course by the course tutor/moderator along the following aspects. Feel free to add any further aspects or recommendations.

1. Do you have a clearer understanding of how the pricing of medicines is set?
2. Who are the key stakeholders when considering the affordability of medicines?
3. How would you describe the role, importance and influence of the pharmaceutical industry in Europe?
4. What are the positive and negative aspects of intellectual property rights in medicine pricing and affordability?
5. How do you think the voice and involvement of patients can be strengthened in affordability efforts?
6. Are you aware of any good practices from different disease areas that aim at improved affordability of medicines? How much of those can be adapted and how?

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