



# health bulletin

MARCH 2005

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## INTRODUCTION

Welcome to the CNE Health Monthly Bulletin. Our aim is to keep readers informed of important healthcare news and publications each month. Each bulletin will have a feature of the month and then summaries of news from around Europe and further afield where relevant. Comparative studies and journal articles will also be included, as too recent and forthcoming seminars and conferences.

We would like this to be as complete as possible, so if you would like to draw our attention to interesting news and thoughts, please do! Please email them to [healthletter@cne.org](mailto:healthletter@cne.org). Thanks in advance.

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## EUROPEAN HEALTH NEWS ROUNDUP

*EU, Accession States, UK, Pharmaceutical News*

### News from the EU

- + European Commission lays out Strategic Objectives for 2005-2009
- + EU Action Plan on Drugs
- + The EU Services Directive Row
- + The Spread of Reference Pricing – Johan Hjertqvist and Helen Disney
- + "Priority Medicines for Europe and the world" – BMJ Editorial

### European Commission lays out Strategic Objectives for 2005-2009

On 26 January 2004, the European Commission announced its strategic objectives for 2005-2009 period and its work programme for 2005. The Strategic objectives are listed under four main headings; 1) Prosperity (economic growth, competitiveness, higher productivity, more jobs); 2) Solidarity (social justice, environmental protection, cohesion); 3) Security (Hague programme, fighting crime and terrorism, managing immigration, environmental and health risks); 4) Europe as a world partner (new enlargements, neighbourhood policy, trade liberalisation, Millennium Development Goals for 2015).

In the Parliament, the Commission's priorities have been welcomed by centre-right EPP-ED group. The Socialists and the Greens on the other hand criticised them for putting too much emphasis on economic growth at the expense of social and environmental concerns.

The Commission has also adopted a work programme for 2005 with concrete initiatives to turn the strategic objectives into action. For example, under the heading of 'Prosperity', the proposed health-related measures include; 1) A proposal for a review of the medical devices directive in June; a proposal for a regulation on human tissue engineered products in July; and a proposal for the 7<sup>th</sup> Framework Research Programme for the period 2007-2013 in April.

For more information about the work programme, visit [www.europa.eu.int/comm/off/work\\_programme/index\\_en.htm](http://www.europa.eu.int/comm/off/work_programme/index_en.htm)

### EU Action Plan on Drugs

The European Commission adopted a new Drugs Action Plan for the period 2005-2008 on February 17th. Its aims to significantly reduce the high levels of drug use, drug trafficking and the damage caused to EU societies through drug related crime, health problems and social exclusion.

The action plan is designed to 'transpose the general objectives from the EU Drugs Strategy 2005-2012 into concrete actions.' These include general policy measures, specific programmes aimed at the prevention of drug use amongst young people, in the workplace and in recreational settings as well as measures for improving access to treatment programmes. Perhaps most importantly though, a set of measurable assessment tools and indicators has been introduced in to allow for a proper evaluation in each area.

[http://europa.eu.int/comm/justice\\_home/doc\\_centre/drugs/antidugs/docs/com\\_2005\\_45\\_en.pdf](http://europa.eu.int/comm/justice_home/doc_centre/drugs/antidugs/docs/com_2005_45_en.pdf)

### The EU Services Directive Row

Union's services directive - a proposal to liberalise the region's trade in services - is probably one of the most controversial pieces of legislation to be put forward by the Commission in recent years. But Charlie McCreevy, the internal markets commissioner overseeing the directive, is adamant that at least some parts of it should become law. "If you consider that the EU has been growing at a snail's pace over the past number of years, then it's obvious that we must do something pretty dramatic to create economic activity," he said in an interview with the BBC. "Seventy per cent of all the EU's GDP (gross domestic product) is from services, therefore it doesn't take a great mathematician to say we should concentrate [on that]."



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The idea is to create a truly single European market, breaking down the national barriers that make it difficult for European companies to work in other member states. But what's caused an outcry is confusion over the directive's "country-of-origin" clause which suggests that companies and individuals could provide services throughout the EU using the laws and regulations of their own country. Critics say this means that, for example, a Czech construction company would be allowed to set up shop in Germany using Czech labour standards and paying Czech wages, a trend - they argue - that would eventually erode the higher standards of social protection offered in richer EU states. There is also concern that the services directive applies to social services such as healthcare, with opponents warning this would lead to national standards being driven lower. So how does Mr McCreevy placate the critics?

"I have used the opportunity since I was nominated as commissioner to say that I would listen and take on board their concerns," he says. "There will have to be some changes in some of the areas that were put forward in the original directive."

Strong French and German opposition means that those changes are likely to involve protecting some areas of the economy, in particular healthcare. Many people believe that because these sorts of services serve a key social purpose, they should be excluded from unfettered competition. But that's not a view necessarily shared by the Commission. "The directive is controversial because it applies the same rules to healthcare and social services as it does to estate agents, fairground providers, advertising companies and private security firms," says David Rowland, a research fellow at the School of Public Policy at University College London. Healthcare is seen by the Commission as an economic activity, he says, and is therefore "a commodity to be traded across the EU much like any other." At the moment, there is no opt out for healthcare in the directive although many people do believe there will be at least some restrictions. "You could end up with aspects of health services being excluded, for example doctors' associations, but not nursing agencies," says Graham Copp of the think-tank, Centre for a Social Europe. In the meantime, though, there's still much confusion over how exactly the "country-of-origin" principle would apply. The problem, says Mr Copp, is that the directive "as well as having areas of concern is badly drafted."

Unice, the European employers federation, notes that the "country-of-origin" principle in the services directive appears to undermine another accepted EU law which stipulates that people from, say, Poland or Italy working in Germany or the Netherlands must adhere to the social standards and regulations of the country they are posted in. Certainly, the services directive as it currently stands says the "country-of-origin" principle will apply to companies providing temporary services elsewhere in the EU, but not to firms providing a permanent service. "In the way some of the articles in the directive are written there is perhaps a need to have some clarification or change in some of those particular areas," Mr McCreevy admits. But not everyone believes opposition to the services directive is based on genuine social concerns. "Lots of countries are terrified by how much more competitive the Czech Republic or Slovakia are," says Paul Hofheinz, of the Brussels-based Lisbon Council think-tank.

Supporters of the directive complain that opposition from countries like France, Germany and Luxembourg, which holds the current EU Presidency, have put the proposed legislation on hold.

They expect though that a big push for the directive will come from the UK, which supports moves to liberalise services and takes over the EU's presidency later this year. For Mr McCreevy there may be revisions, but there is no going back. "Hopefully I will be able to succeed in getting a directive through, which will open up the services market in the EU," he says.

(BBC Online - <http://news.bbc.co.uk/1/hi/business/4277511.stm>)

## **The Spread of Reference Pricing – Johan Hjertqvist & Helen Disney**

Examining the effect of the spread of the (originally Dutch) reference pricing model into Germany, Johan Hjertqvist argues that 'with political control systems focusing on the growth of health care costs rather than medications' outcomes it's likely this strategy will spread further.'

Reference pricing, which as Helen Disney discusses in her CNE Blog is also employed in New Zealand, is a system whereby the Government sets the price of pharmaceuticals by categorising them into different



treatment groups. The reimbursement prices of all the drugs in the group are then set according to either the price of the cheapest drug in that group (as in New Zealand), or the average price of group, as in Germany. While this system sounds like it would reduce pharmaceutical prices to the consumer, it is in effect, as Hjertqvist argues, 'just another way of rationing consumer access to pharmaceuticals.

Hjertqvist -  
[http://www.cnehealth.org/blog\\_archive/archive\\_hjertqvist\\_2005.htm#218](http://www.cnehealth.org/blog_archive/archive_hjertqvist_2005.htm#218)

Disney -  
[http://www.cnehealth.org/blog\\_archive/archive\\_disney\\_2005.htm#224](http://www.cnehealth.org/blog_archive/archive_disney_2005.htm#224)

## **"Priority medicines for Europe and the world" – BMJ Editorial**

'Few readers of the BMJ were probably aware or even cared that the presidency of the EU Council was held by the Dutch government during the second six months of 2004. Nevertheless, history is likely to remember the Dutch presidency with gratitude. For in the run up to it, the Dutch government commissioned the World Health Organization to develop a research agenda for the European Union that was based on public health needs for priority medicines.

The commendable report was published last November.<sup>1</sup> Masterminded by Warren Kaplan and Richard Laing, and using a new approach, it is a work of scholarship. It covers a wide range of critical issues and makes many far reaching research proposals for the European Union. But underlying these extensive data and careful analyses are some chilling implications.'

The editorial's author, Professor Michael Rawlins, goes on to argue that not only are contemporary notions of neglected diseases 'far too circumscribed', but that 'the pharmaceutical industry is clearly unable to meet the needs of people with neglected diseases.' His argument, however, is more balanced than his introduction would suggest, as he goes on to advocate a reduction in the regulatory barriers to drug development, and the necessity of improving coordination between primary and secondary disease prevention.

Read the remainder of this editorial -  
<http://bmj.bmjournals.com/cgi/content/full/330/7488/376>

## **News from the Accession States**

- + Strategic Analysis of the Opportunities for the Pharmaceutical and Biotechnology Industry in the New EU Countries
- + Polish Health Workers threaten strike over reforms

## **Strategic Analysis of the Opportunities for the Pharmaceutical and Biotechnology Industry in the 'New' EU Countries**

In contrast to subdued growth in the pharmaceutical markets of the former 15-state European Union (EU), pharmaceutical markets in the 'new' EU accession markets are expanding vibrantly. While the former has been increasing at eight per cent annually, the latter has been growing at the rate of 16.5 per cent over the past five years, offering exciting growth opportunities to pharmaceutical and biotechnology companies.

Globally, the EU healthcare industry is the second largest after North America. Estimated at nearly USD 7.0 billion, the pharmaceutical market in the 'new' EU countries- Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia- represents about eight per cent of the EU 15 market.

Both Poland and Hungary, which contribute 45 per cent and 23 per cent of the accession countries' total pharmaceutical market value respectively, have been growing by almost 20 per cent since 1998. With 'new' EU countries expected to make significant, long-term investments in order to achieve sustainable systematic changes to their healthcare systems and match EU regulatory standards, growth prospects in the region are expected to be considerable.

Propelled by the twin advantages of low costs and easy patient recruitment, the 'new' EU also offers tremendous scope for conducting clinical trials. Already, large multi-national pharmaceutical and biotechnology companies from Western Europe and from the United States are carrying out clinical trials on rare diseases and diseases relevant to large



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worldwide

markets.

Coordination and swift completion of clinical trials in the new EU have been facilitated by easily accessible, large and relatively under medicated patient populations as well as more structured healthcare systems. An additional advantage has been the availability of highly qualified investigators with lower pay scales than their western counterparts.

Moreover, with hourly wages in the 'new' EU countries pegged at a quarter that of western countries, pharmaceutical companies have been able to avoid their single largest cost: the opportunity cost of a delay in getting a drug to the market. This is particularly pertinent since delays in getting a drug to the market often work out to a daily loss of USD 1 million.

Identifying potential growth segments in the 'new' EU markets, Dr. Raju Adhikari, Frost & Sullivan says, "Mirroring the changing disease burden of the west, the anti-infectives market share has declined, whereas cardiovascular, central nervous system (CNS) and metabolic disease categories have taken over. Huge growth opportunities in asthma and oncology also exist and companies with products in these diverse areas are likely to be more successful in the 'new' EU markets."

However, even as the 'new' EU countries offer exciting prospects for biopharmaceutical and biotechnology companies, parallel trade is expected to remain the key concern. Typically, parallel trade activity occurs in inverse proportion to drug prices with the EU encouraging parallel importers in the belief that parallel trade promotes competition, thereby lowering prices.

With 'new' EU countries having lower average drug prices than Europe's western markets, parallel imports principally follow an east-west channel (with south-north channel to a lesser extent). The east-west parallel trade axis originates from the Czech Republic, Hungary and Poland whose domestic producers meet EU standards and criteria.

Parallel trade is currently estimated at USD 3.8 billion and is projected to last for a minimum of another five years. This practice is expected to wane when there is a single EU25 market - when price differences narrow sufficiently.

Several international drug companies have attempted to tackle parallel trade by applying restrictions to wholesalers, seeking to prevent export using legal loopholes, or removing or reducing the ex-manufacture price differentials of their products across the various EU states. Others, such as Schering AG, have attempted to limit parallel trade through a consistent European pricing policy and setting prices within a narrow band.

"Companies need to present compelling health economic data justifying a product's price and retain premium pricing in friendlier markets," adds Dr. Adhikari. "Further, companies need to upgrade existing approval dossiers in the candidate countries in order to comply with the EU laws - applies especially to domestic companies."

Several market entry issues also confront pharmaceutical and biotechnology companies keen to maximise on the economic benefits offered by the 'new' EU. For instance, with big pharma not dominating the 'new' EU market as it does the EU15 and the United States - the top position in four 'new' EU countries is still occupied by a local participant-acquiring a local company offers a means to gaining a foothold.

Medical News Today - <http://www.medicalnewstoday.com/medicalnews.php?newsid=20229>

## **Polish Health Workers threaten strike over reforms**

Polish doctors and nurses threatened a nationwide strike in mid-February over government plans to reform the health sector's finances. Some 200 trade union representatives demonstrated in front of parliament, where legislators debated a government bill proposing changes to the sector's financing rules, which protesters say could force hospitals to close.

Poland has been struggling for years to reform public finances for its cash-strapped state-funded hospitals. The government hopes the new measures will force hospitals to become more efficient and more stringent in their accounting. In July, parliament approved an emergency bill to prop up the crumbling healthcare system, which could otherwise face collapse this year.

The reforms would force state-financed hospitals -- which make up the vast majority of medical



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establishments in Poland -- to give up financial claims against the state in order to continue receiving government low-interest loans, so far keeping them afloat. The new rules would also allow private debt collectors to draw on hospital accounts dedicated for wages, until now out of reach. Union leaders, who have targeted individual hospitals around the country with strikes and hunger protests in the last five days, said they would call a nationwide strike if the bill was passed. "We are very determined. We are fighting for the life of our patients," Solidarity union official Maria Jolanta Ochman told Reuters. "If nothing changes, we will keep protesting all over the country." The Health Ministry argues the new bill would offer hospitals more help by promising them access to soft loans if they settle debts, forcing them to be more efficient. "This bill doesn't lead to the bankruptcy of hospitals -- it is meant to help hospitals," Health Minister Marek Balicki told a news conference. "It is supposed to prevent a critical situation."

(Reuters - <http://www.alertnet.org/thenews/newsdesk/L16695410.htm>)

## News from the UK

- + Reform Report on Cancer Treatment in the NHS
- + Medicines review to 'aid innovation'
- + Conservatives release health manifesto
- + £1b to be spent on private sector diagnostic tests

### Reform Report on Cancer Treatment in the NHS

London-based think tank Reform ([www.reform.co.uk](http://www.reform.co.uk)) released a report, *Cancer care in the NHS*, which revealed that increased expenditure on unreformed NHS services has failed to provide value for money. Written by two leading oncologists, Professor Karol Sikora and Dr Maurice Slevin, and Nick Bosanquet, Professor of Health Policy at Imperial College London, the report shows that over the last five years the NHS has invested nearly £2.0 billion in improving cancer services using a traditional public sector model. Poor value for money has been achieved for this huge investment. The National Cancer Plan is not

delivering as hoped and there are no reasons for expecting any dramatic improvements in the future.

Changes in the control of funding flow in the NHS have led several NHS agencies – Primary Care Trusts, Strategic Health Authorities, provider trusts, Cancer Networks and the Department of Health – getting involved in decisions on cancer. Some have little relevant expertise and many are overwhelmed. Cancer patients often live in poor health unnecessarily for long periods of time due to a lack of co-ordination of their care by overstretched treatment services.

The report concludes: "In the future the prevalence of cancer will rise trebling the number of people living with cancer in Britain to three million at any one time. This will put further pressure on process and outcomes. Real improvement will not be achieved by simply giving more money to a burgeoning bureaucracy. It requires a serious commitment to reform."

Read the coverage of the report in the Sunday Times – [Article, p.1](#).

### Medicines review to aid innovation

Having undertaken a review of the United Kingdom's existing pharmaceutical regulation, the Cabinet Office's business regulation team will consider changes to the rules governing a dozen areas that affect the research and sale of medicines. These measures are intended to maintain Britain's place as an international centre for research and development. This initiative follows lobbying from the pharmaceutical industry to lessen the burden of regulation, which was stifling Britain's comparative advantage and driving investment abroad. The current rules under examination include those governing clinical trials, animal testing and the prescription of generic drugs.

The moves have been welcomed by both Warwick Smith, head of the British Generic Manufacturers Association, and the Association of British Pharmaceutical Industry. The latter stressed that existing regulations on product testing were inflexible

### OFT chief calls for 'free markets'

Bob Sherwood, legal correspondent on the Financial Times reported that 'government procurement contracts might be opened up to a wider range of



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bidders were boosted [September 15, when]...the Office of Fair Trading warned that government bodies must be subject to the same competition rules as private companies. OFT head John Vickers 'stressed that good competition policy was not simply about controlling mergers and tackling cartels, but required pro-competitive regulatory reforms as well.' The OFT will ascertain whether small and medium-sized companies have fair access to contracts for among other things, NHS services. To read more:

<http://news.ft.com/cms/s/c305e7e4-078d-11d9-9672-00000e2511c8.html>

## Conservatives release health manifesto

The Conservative health manifesto, announced on February 17<sup>th</sup>, repeated the "Right to Choose" policy announced last year. Patients would be able to choose any hospital, public or private, which can provide a treatment at a cost equal to or below the NHS tariff. Patients would be given 50 per cent of the value of the NHS tariff if they choose to attend a more expensive private hospital. John Hutton, Minister of State for Health, said that the policy would divert £1.2 billion of NHS funding to private companies and Labour spokesmen said that the Conservatives' "had made a manifesto commitment to introduce charging for basic operations". A leader in the *Times* describes these responses as "shameless lies". It argues that the "Labour and Conservative health policies are more marked by their similarities than their differences .... The central, tax-based funding system has not been challenged. Both parties disregard ideological arguments in favour of a 'what works is what's best' approach. Both say they are prepared to let hospitals close. Both promise greater choice for patients." The leader argues that choice will lead to a much more efficient use of NHS resources. The introduction of choice for heart patients has meant that the Heart Hospital, a private institution bought by the NHS in 2001, has run out of work. It goes on to state that "choice will be the new challenge for the NHS", since "it is NHS culture, with its entrenched belief that the doctor knows best, that is likely to prove the greatest bar to patient choice". In the *Times*, Magnus Linklater writes about his experience of waiting for eight hours in Accident and Emergency on a Saturday night and states: "to learn the truth about new Labour's NHS try spending a night in an A&E department". The Conservatives also pledged to launch a "strategy" to improve the sexual health of young people.

See coverage in the Times -

[www.timesonline.co.uk/printFriendly/0,,1-2-1487646,00.html](http://www.timesonline.co.uk/printFriendly/0,,1-2-1487646,00.html)

## £1b to be spent on private sector diagnostic tests

John Reid, the Health Secretary, announced on Saturday that the Government would spend £1 billion on private sector diagnostic treatment. Mr Reid stated that about 11 per cent of scans would be provided by the private sector. He reiterated that no more than 15 per cent of total NHS care would be provided by the private sector in his political lifetime but said that the Government would not set a limit. Leaders in Saturday's *Sun* and *Mirror* both supported the move. The *Mirror* argued: "Critics will complain about the use of public money in the private sector. But patients desperate for treatment won't. What matters is how to provide the possible health care as quickly as possible." The *Sun* argued: "John Reid is right to want to shake up the existing system, which can't cope .... The important thing is that a speedy diagnosis can save your life".

See coverage in the *Guardian* -  
[www.guardian.co.uk/uk\\_news/story/0,,1417886,00.html](http://www.guardian.co.uk/uk_news/story/0,,1417886,00.html)

## Pharmaceutical News

- + New Drug Approval Process a Victory for Poor AIDS patients
- + How safe are anti-retroviral drugs?
- + Estimating the Cost of New Drugs Development: Is it really \$802m?

## New Drug Approval Process a Victory for Poor AIDS Patients

On January 25, 2005 the U. S. Food and Drug Administration (FDA) announced approval of the first triple therapy AIDS drug to be produced as a true generic product. The drug, to be manufactured by Aspen Pharmacare in South Africa, was approved in only two weeks time, and the FDA waived the application fee, typically set at \$500,000. This new FDA expedited process allows poor patients to take generic AIDS drugs that are known to be safe and efficacious.

This FDA result honours the Bush administration's commitment to make AIDS drugs of proven quality,



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safety and efficacy available quickly for patients with HIV/AIDS, be they generic or patented products. This approval validates the Fast Track Process set up by the FDA in May 2004. It is a process that now promises to bring a Gold Standard of drug quality to all AIDS patients. It provides a way for poor countries, committed to quality standards and equity in healthcare services, to deliver on that commitment to all of its citizens.

The FDA process provides an important alternative to what has turned out to be a questionable World Health Organization pre-qualification process. WHO has prequalified Indian copy or knock-off drugs, many of which had to be taken off its list when their bio-equivalence could not be proven. WHO began to disqualify some of these drugs in May 2004. In August, South Africa's drug regulatory agency labeled one of the WHO approved drugs "undesirable." This was followed by two Indian drug companies' voluntary withdrawal of their entire portfolios from the WHO approved list.

The FDA-approved combination AIDS drug regimen consists of two pills packaged together, taken twice daily. One pill is a fixed dose combination tablet – lamivudine and zidovudine – and the other is a single tablet of nevirapine. The first pill is the equivalent of the patented drug Combivir produced by GlaxoSmithKline, and the nevirapine tablet is the equivalent of the patented drug Viramune manufactured by Boehringer-Ingelheim. The companies holding patents to these drugs did not challenge the FDA's decision. Keeping the nevirapine separate from the combination therapy is important because of potential serious side effects from nevirapine. It can now be removed when such problems arise. Indian companies combined the drug stavudine with zidovudine and nevirapine into a triple dose combination. However, data from its clinical studies were never independently validated.

The U. S. government held fast to ensuring equity of access to ARV drugs of proven quality, safety and efficacy and was not willing to marginalize the uncompromising dictates of science and medicine. By putting the welfare of poor patients first, the U.S. stand on their behalf is a victory for them the world over.

## How safe are Anti-Retroviral Drugs?

Thomson Ayodele, Co-ordinator of the Institute of Public Policy Analysis in Lagos, recently argued in *This Day*, a Nigerian newspaper, that the proliferation of poor quality generic copies are threatening undermine their clinical effectiveness and potentially bring about new, drug-resistant strains of HIV.

As Mr Ayodele states, "ARVs [anti-retroviral] are no silver bullet. They do not cure AIDS. What they do, however, is to allow sufferers to live more normal lives. Putting a patient on ARVs is a long-term commitment, since the course of drugs must continue for life. The World Health Organisation (WHO) is responsible for recommending which particular ARVs are suitable for use in each part of the world. Currently there are about 89 products on the WHO pre-qualified list, 54 of which are anti-retrovirals for the treatment of HIV/AIDS.

The WHO is not a regulatory authority, and neither does it have the facilities nor experts to test and certify the quality of generic ARVs. Egged on by NGOs such as Medecins Sans Frontiers and the Clinton Foundation, the WHO has bet its shirt on recommending mass treatment programmes based on ARVs that have been copied from drugs patented by pharmaceutical companies. The WHO figures this is the cheapest way to get drugs to the millions who need them. Unfortunately, this short-sightedness has put the safety of several thousands of patients at risk."

The potential crisis herein is typical of many of the well-intentioned actions of NGOs in developing countries, whereby dubious short-term gains are leveraged successfully against probable future catastrophe. National governments must demonstrate leadership and not seek quick fixes to a problem that will take generations to alleviate. As Mr Ayodele recognises, "several progressive African countries have long ago realized that generic ARVs are not the only answer to the AIDS problem. Uganda and Senegal have managed to bring their infection rates under control through comprehensive education and awareness programmes. Their governments have also collaborated with the private sector to build clinics from where safe, quality and tested ARVs can be distributed. These are the things all African governments should be doing.

## Estimating the costs of New Drug Development: Is it really \$802m?



A new study undertaken by Christopher Adams and Van V. Branter of the Federal Trade Commission's Bureau of Economics suggest that the cost of developing a drug may be substantially higher than previously believed. Their work is based on, and replicates, DiMasi et al (2003) drug development cost estimates using their published survey cost estimates along with information from a publicly available data set. The results suggest that the expected cost of developing the average drug is even higher than the DiMasi et al (2003) estimate of \$802m (in 2000 dollars). The paper estimates the capitalized out-of-pocket cost per new drug to be between \$839m and \$868m (in 2000 dollars). The paper similarly estimates the expected cost of the average new drug with certain characteristics such as primary indication. It is shown that the expected cost of developing the average HIV/AIDS drug is \$479m, while the expected cost of developing the average rheumatoid arthritis drug is twice that, at \$936m. For one large

pharmaceutical company the expected cost of developing an average drug is \$521m, and for another large firm the cost is almost four times that number, coming in at \$2,119m. The results support DiMasi et al's claim that the average cost to develop a new drug is over \$800m while also suggesting that for some drugs the costs can be much higher or much lower. The results suggest that drug development costs can be influenced by numerous factors including regulatory policy as well as the pharmaceutical firm's own strategic decisions. The results further suggest that a great deal of care must be taken before using these numbers in public policy debates or interpreting them as a measure of actual drug development costs.

The study is available at the Social Science Research Website – [www.ssrn.com](http://www.ssrn.com)

## CONFERENCES AND EVENTS

### Upcoming Events in Europe

- + **10 March:** The Health Implications of an Expanded EU: Threats and Opportunities for the UK and Europe (London)
- + **18-20 March:** 7<sup>th</sup> Workshop on Costs and Assessment in Psychiatry: Financing Mental and Addictive Disorders
- + **13-15 April:** 10<sup>th</sup> European Forum on Quality Improvement in Healthcare 2005 (London)

#### The Health Implications of an Expanded EU: Threats or Opportunities for the UK and Europe?

Held in conjunction with the UK Department of Health, Health Protection Agency and World Health Organisation, the Royal College of Physicians is organising a conference on Thursday 10 March 2005.

On 1st May 2004 the European Union underwent an unprecedented expansion, with the accession of 10 new members, most of which had until recently been

part of the Soviet bloc. British tabloid headlines predicted catastrophe for the UK, with Eastern Europeans "filling NHS beds" or spreading infectious disease. At the same time, health policy makers looked to the new member states as a solution to a looming shortage of healthcare professionals, yet in the first 3 months after the enlargement, only 53 nurses had moved to the UK. This conference will attempt to discover the reality behind the rhetoric. It will be of interest to healthcare professionals and managers from many different areas.

Royal College of Physicians, 11 St Andrews Place, Regent's Park, London  
[www.rcplondon.ac.uk/calendar/2005/conf\\_2005\\_hioeu.htm](http://www.rcplondon.ac.uk/calendar/2005/conf_2005_hioeu.htm)

#### 7<sup>th</sup> Workshop on Costs and Assessment in Psychiatry: Financing Mental and Addictive Disorders

The International Center of Mental Health Policy and Economics (ICMPE) will be hosting the 7th Workshop on Costs and Assessment in Psychiatry: "Financing



Mental and Addictive Disorders” in Venice on March 18<sup>th</sup>.

Since 1990 a series of six workshops aimed at facilitating the integration of research performed in disciplines that evaluate the mental health field from different scientific perspectives have been organized in collaboration with the World Health Organization (WHO) and the World Psychiatric Association (WPA). National governmental institutions, in particular the US NIMH, the UK Department of Health and the Italian Ministry of Foreign Affairs, have also supported these activities. These workshops have enabled participants (psychiatrists, health economists, psychologists, medical sociologists, public health researchers and statisticians from universities, government agencies and hospital research units) to come together and discuss empirical findings from clinical and economic evaluation studies and seek ways of using this information in health policy decision making.

[www.icmpe.org](http://www.icmpe.org)

## **10th European Forum on Quality Improvement in Health Care 2005**

Only preliminary details are available at present. The conference will be held over three days at the ExCel centre in central London, and is jointly sponsored by BMJ Publishing Group, Institute for Health Care Improvement, NHS - National Patient Safety Agency, NHS - Modernisation Agency, and NHSU.

Register on-line at [www.quality.bmjgroup.com](http://www.quality.bmjgroup.com)

**If readers hear of – or are holding – other events, please let CNE know so that we can include them in this listing.**