

South Africa's Battle with AIDS & Drug Prices

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South Africa is mired in a health crisis as the rate of HIV infection reaches 22 percent of adults, including more than one in five pregnant women. The crisis is expensive. Drug treatment costs for AIDS range from \$15 000 to \$20 000 per year in the US, while per capita income in South Africa is only \$6 800.

In recent months the South African government has accused manufacturers of HIV/AIDS drugs of price gouging. In truth South Africa already pays some of the lowest prices found any where in the world. And within South Africa, public sector drug prices are a fraction of those the private sector pays. Moreover, in many ways the nation's government is exacerbating the crisis by threatening price controls and permitting a pharmacy "cartel" that keeps retail drug prices far above competitive levels.

South Africa benefits from international price discrimination

South African prices for AIDS drugs are already well below those in the United States and other developed countries. For example, while US consumers pay \$10.12 for AZT, South Africans pay \$2.16 (see Figure 1). For Didanosine, it's \$7.25 vs \$2.80. South Africa also pays less for both drugs than the Ivory Coast, another sub-Saharan country: \$3.48 vs \$2.80 for Didanosine, and \$2.43 vs \$2.16 for AZT.

The public sector benefits from domestic price discrimination

About 80 percent of South Africa's population relies on (mostly free) care through the public sector, while the remaining 20 percent relies on a private sector system much like that of the United States. Here too, the price discrimination between these sectors works to the advantage of low income patients. Prices are higher in the low-volume private sector and lower in the high-volume public sector. Government purchases account for 70 percent of industry volume but only 30 percent of revenues, while the private sector generates 70 percent of turnover on only 30 percent of volume. For example, for the asthma inhalant, Ventolin, the South African private sector pays R28.99 while the state sector pays R5.66. The world average price is R22.86 (see Figure 2).

Lack of competition in retail drug market

Although drug manufacturer prices in South Africa are among the lowest in the world, its retailers' markups in the private sector are among the highest. Just over half (55 percent) of the price of drugs (net of tax) in South Africa goes to the manufacturer, while wholesalers' margins add about 11 percent and retailers about 34 percent. By comparison, the manufacturer receives 65 percent of the price in Germany and 88 percent in Sweden.

Retail margins are high due to cartel-like distribution in a non-competitive retail market. Small retail pharmacies have successfully lobbied against corporately owned retail chain pharmacies as well as managed-care-type contracting with selected retailers.

Government hostility to pharmaceutical companies discourages investment

South Africa has enjoyed a comparative advantage in clinical research because of its high-quality medical schools, accomplished yet relatively inexpensive personnel, experience in dealing with both tropical and common diseases, and use of English as the primary language. However, due to hostile government actions, US multinational Merck put on hold a planned investment of R50 million (\$11 million). Eli Lilly and Pfizer have closed their plants, and Glaxo Wellcome has announced that it is withdrawing from manufacture.

Government refusal to accept free drugs

The South African government has so far refused to accept gifts of AIDS drugs from drug companies, arguing that accepting the donations would divert resources from other disease areas. Glaxo Wellcome has offered the drug Retrovir, which lowers mother-to-child transmission of HIV, at a preferential price and has also offered several thousand treatments free of charge. Bristol-Myers Squibb has committed \$100 million to women and children with HIV/AIDS in five Southern Africa countries, including South Africa. Pfizer and Boehringer Ingelheim (Germany) also have offered to donate AIDS medications. They were rebuffed because the Boehringer offer was “only” for five years and Pfizer’s offer had a “time limit”.

These actions raise the question of whether the government really wants to treat AIDS. Over the past several years the trend in the public sector has been to expand primary care and cut back on expensive, curative medicine. AIDS is apparently no exception.

The dangers of indiscriminate distribution of HIV/AIDS drugs

The growing AIDS epidemic in sub-Saharan Africa could be worsened by giving the medications in areas with inadequate health-care infrastructure to monitor the precise distribution and dosage. The US Centre for Disease Control (CDC) recently found that 75 percent of participants in the United Nations AIDS program in Uganda had drug-resistant HIV strains. By contrast, in the US – with good monitoring – only about 10 percent of patients harbour HIV strains resistant to AZT. If the drugs are dumped into an unsupervised setting in Africa without vigilant monitoring, virulent, drug-resistant strains of HIV could emerge to threaten AIDS patients worldwide.

Government policies exacerbate the problem

The government proposes to reduce the cost of medicines by controlling manufacturers’ prices and imposing a fixed dispensing fee on retail prices. A 1997 Act, currently under court challenge, requires the substitution of generic drugs for brand-name drugs (unless overridden by the doctor or patient) and authorises the Minister of Health to allow parallel imports by third parties of cheaper generic equivalents of patent-protected medicines. Drug research companies argue that generics violate their patents and are of lower quality. The pharmaceutical industry is also challenging the provision of the Act that requires them to post list prices and forbids any deviation. This so-called single-exit price would be monitored and controlled by a proposed governmental pricing commission. By making it illegal for manufacturers to negotiate discounts on prescription medicines with retailers, such laws keep prices for consumers high.

Conclusion

International drug companies did not create the AIDS crisis in sub-Saharan Africa. But they may be able to quell the crisis if governments will let them try. At present, government hostility in South Africa toward drug research companies is driving away the very resources needed to battle the HIV/AIDS epidemic.

Further reading

Meyer, SL, Lasser, M and Reekie, WD (1994) “Economics and the treatment of AIDS”, *Applied Economics*, Chapman and Hall, New York.

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