WITNESS STATEMENT TO AN OVERSIGHT HEARING BY THE SENATE COMMITTEE ON COMMERCE, SCIENCE AND TRANSPORTATION ON PRESCRIPTION DRUG IMPORTATION, 20 NOVEMBER 2003, BY DONALD MACARTHUR, SECRETARY GENERAL, EUROPEAN ASSOCIATION OF EURO-PHARMACEUTICAL COMPANIES

Concern over rising prescription drug prices in the US and in particular the heavy out-of-pocket financial demands placed on seniors to maintain regular drug treatment has led to a surge in cross-border purchases by patients via the Internet and other means. This in turn has triggered a debate as to whether parallel importation of prescription drugs from foreign countries should be legalised. The European Association of Euro-Pharmaceutical Companies (EAEPC) is delighted to be given this opportunity to contribute to this important debate. It can best do this by summarising the European experience of parallel trade with prescription drugs. This experience – gained over 20+ years – clearly shows that parallel trade is

- safe,
- uses only genuine, regulatory-approved products from original brand manufacturers,
- totally free of counterfeit, pirated and substandard products,
- able to stimulate price competition among otherwise monopolistic manufacturers,
- brings significant savings to payers and patients, and
- has no impact on the ability of the pharmaceutical industry to invest in R&D

It should be emphasised that parallel trade is very different from personal importation by individual patients, the main cross-border activity in the US so far. Parallel trade is a large-scale industry, a highly-regulated and thoroughly professional business-to-business activity that requires considerable investment in qualified staff, state-of-the art facilities and equipment, and rigorous quality assurance procedures. In 2002 alone, an estimated 140 million packs of medicines were traded across Europe's internal national borders.

EAEPC member companies have more experience of parallel trade in prescription drugs than any in the world. They enjoy excellent relationships with national and EU regulatory authorities in Europe, and would welcome dialogue with the FDA, other US authorities, as well as US politicians, payer and consumer groups. Visits to EAEPC member company facilities across Europe can also be arranged.

EAEPC

Established in 1998 with its registered office in Brussels, Belgium, EAEPC (www.eaepc.org) is the representative voice of pharmaceutical parallel trade in Europe. Through national association or individual company membership it encompasses over 70 firms from 15 of the 18 countries in the European Economic Area (EEA*). Together these firms account for well over 90% of medicines parallel-traded in the region.

* The EEA consists of the current 15 EU member states (i.e. Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom) plus Iceland, Liechtenstein and Norway

All products handled by EAEPC members have either national or pan-European regulatory approval, and are exclusively sourced from and sold to EEA countries using authorised trade channels. Some EAEPC member companies have been in business for 20 years and are amongst the top-10 pharmaceutical suppliers to their national markets.

EAEPC's primary aims are to safeguard the free movement of medicines within the EEA's Internal Market - a principle first laid down in Article 28 (formerly Article 30) of the European Community's founding Treaty of Rome and reaffirmed in subsequent Treaties - and to counteract any attempts to restrict the freedom of choice for the consumer through trading patterns in breach of EU competition rules (Articles 81 EC & 82 EC).

The Association believes that free trade will lead to improvements in health standards through the provision of innovative medicines at lower cost, benefiting statutory healthcare systems, other third-party payers, and the public as both patients and taxpayers, as well as assisting the EU to achieve its objective of a single market.

PARALLEL TRADE: THE BASICS

What is Parallel Trade?

Parallel trade occurs when products are purchased in a country where they are cheaper and transported for resale to other countries where they are more expensive, in competition with the same product sold by the manufacturer or its local licensee. Parallel trade increases the effectiveness of the market and consumers enjoy lower prices as a result. It helps to restrain costs in markets that are not very price sensitive.

Parallel trade will exist wherever there are price differentials. It has been ongoing worldwide since goods were first traded and is found across Europe today with a wide range of branded products, including such diverse items as motor cars/motor cycles, computers, cameras, pianos, compact disks, clothing, food and ski equipment (table 1).

Table 1: Extent of parallel trade within the EU

footwear and leather goods	<5%
musical recordings	overall 5-10%, some releases up to 20%
motor cars	estimates up to 5%
consumer electronics	around 5%
domestic appliances	<5%
cosmetics and perfumes	around 13% for upper end of market
clothing	5-10%
soft drinks	0-15%
confectionery	<10%
alcoholic drinks	<5%

Source: NERA & SJ Berwin, 1999[1]

For parallel trade to be possible, four preconditions must be met:

- there must be unrestricted free trade between the countries involved;

- there must be substantial differences between the prices of identical goods in these countries;
- the costs of transport in relation to the cost of goods must be low;
- the distribution of goods must be entirely separate from their manufacture.

All these conditions are found in the case of prescription medicines in the EEA. Yet, in the context of the penetration by parallel trade with other goods, the overall level with medicines is unremarkable. Various estimates by independent economic consultants[2,3] on the share of the prescription pharmaceutical market in the EU taken by parallel-traded products from 1990 through to 2000 have consistently arrived at a figure of 2%. EFPIA estimates put the 2002 penetration at 4%..

Why Do Price Differences with Medicines Occur?

Pricing of prescription medicines and controlling access to reimbursement via social health insurance schemes are purely national responsibilities throughout Europe. Today and for the foreseeable future, these tasks remain in the hands of individual member states, subject only to the condition that the methods they employ are transparent and to do not discriminate by country of origin.

Willingness and ability to pay, medical and prescribing practices, the balance of supply-side versus demand-side cost containment interventions, and even value judgements in healthcare differ between countries, and therefore so do prices. Further important factors are inflation differences and currency fluctuations outside the euro-zone.

An exacerbating issue is a proactive policy of price differentiation undertaken by many international pharmaceutical manufacturers. As commercial enterprises, companies naturally aim to obtain the highest price each national market will bear, and so discriminate between countries to reflect differences in the ability to pay. Price differentiation is known to yield higher profits than uniform pricing. Companies also control the sequence of launches across Europe so as to limit the opportunities for the authorities to depress these prices in major markets through application of international price referencing.

A number of surveys, some repeated year-on-year, have shown considerable inter-state price differences for the same or very similar product. Such differences are found regardless whether comparisons are made at the price the manufacturer sells the medicine to wholesalers, or at the cost that social health insurance has to meet, which includes margins for the wholesaler and the pharmacy, plus, in most countries, value-added tax.

Is it Legal?

Yes, parallel trade is completely legal. A core objective of the Treaty of Rome is the creation of a single, Internal Market through which goods, services, people and capital – the 'four freedoms' – can freely pass. Article 28 of the EC Treaty provides that:

> *'Quantitative restrictions on imports and all measures having equivalent effect shall be prohibited between member states.'*

A direct consequence of free movement is the classic Cassis de Dijon doctrine of the European Court of Justice (ECJ)[4], that a product lawfully placed on the market of one member state must be allowed to circulate freely throughout the EU. This principle was later extended to the three European Free Trade Area countries – Iceland, Liechtenstein and Norway – that together with the present 15 EU member states makes up the EEA.

Pharmaceutical parallel trade in Europe is strictly limited - in terms both of where the products are sourced and where they are finally sold - to within the EEA. Therefore the term 'parallel import', in a European context anyway, is now redundant. Trade between EEA member states is no longer classified as imports or exports, rather it merely represents the free movement of goods within a single European marketplace having no internal borders.

The products that are traded may be patented, or marked with the originator's trade mark or brand name. Such intellectual property rights attached to goods are regarded as having been exhausted. The principle of exhaustion of rights (sometimes referred to as 'the first sale doctrine') is that once a product is legally placed on the market in a country within the EEA by the owner of the rights, or with the owner's consent, the owner cannot use these rights to hinder the further sale of the product elsewhere within the EEA, except in very exceptional circumstances.

Pharmaceutical parallel trade has been supported by the European Commission since its outset and by an unbroken series of almost 30 ECJ judgements[5].

How Does it Work?

Parallel traders buy medicines from well-established, authorised pharmaceutical wholesalers in countries where the products are cheaper. If the parallel trader has obtained a specific authorisation from the government in the country of destination for the product concerned, it can be resold there to wholesalers or direct to pharmacies, in parallel with the same medicine sold by the manufacturer's subsidiary or its licensee.

Parallel traders do not manufacture any medicines themselves, but merely adapt the labelling – and perhaps the packaging – to meet local requirements under government supervision according to national law. This adaptation process includes removing the original patient package inserts and replacing them with others giving the same information in the local language.

Parallel traders do not deal directly with the public. All transactions are done through authorised trade channels, and the pharmacist – who effectively is in the position to buy the same product at two different prices - dispenses it to the patient in the normal way.

Parallel traders take pride in being reliable, responsible and professional business partners for wholesalers and for pharmacists in community and hospital practice. Great importance is attached to consistently making available a broad range of products, in all package sizes and strengths, and to ensure that only the most up-to-date product information is supplied. In some cases, additional features beneficial to patients, such as Braille labelling, is added by parallel traders.

The products that enter into parallel trade are surplus to local needs. Wholesalers in the supplying states are naturally obliged to meet domestic demand first; if they didn't, given the level of competition between wholesalers for pharmacy customers, they would not remain in business long. Most countries also impose, through national law or a voluntary code of conduct, a so-called 'public service obligation'. This requires wholesalers to guarantee to keep an adequate range of medicines in stock and to deliver over the whole of their normal area of operation all supplies requested within a very short time period.

What are the Economics?

It is impossible to generalise as to the level of price differential between member states sufficient to trigger parallel trade. To a trader, a small margin on a best-selling product may be equally acceptable to a larger margin on a low volume product. There are also other important considerations, especially availability and maintenance of supply. Parallel trade is constrained much more by supply than by demand.

The gross margin for the parallel trader does not, of course, represent profit. He has first to meet costs associated with regulatory compliance, purchasing, transport, warehousing, insurance, repackaging, quality assurance, distribution and promotion.

As with any other supplier, the parallel trader also has to cover the costs of the distribution chain and provide it with an appropriate level of profit. The margin structure of pharmacists in many member states is based on a linear scale. This provides a perverse financial disincentive to dispensing lower-cost products, and the impact of this has to be taken into account by parallel traders when negotiating terms with the trade.

Patients throughout Europe expect to take a doctor's prescription for any one (or more) of literally thousands of products into their local community pharmacy and receive it (or them) with minimal delay. Modern medicines can be very costly and no pharmacy could either afford the funds or find the space to keep in stock the entire range. The wholesale network or the parallel trader's own distribution system acts as the vital intermediary, but maintaining multiple daily deliveries all year round to tens of thousands of pharmacies is itself associated with high costs.

Finally, a large part of the price advantage that the parallel trader has achieved through prudent purchasing must be passed on to whosoever pays the bill – normally, the social health insurance system or national health service. The price charged for a parallel-traded product is always less than that for the domestic version. If this were not the case, the entire *raison d'etre* of parallel trade would cease to exist, as would the trade itself.

Just What the Physician Ordered

It is accepted that a part of the medicines market in every member state – a part that makes a disproportionately large and growing contribution to overall costs – consists of branded preparations under patent, where there is either no therapeutic alternative at all or only limited interchangeability in respect of particular patients. Different active ingredients within the same therapeutic category often affect individuals in different ways. Moreover, doctors, if persuaded by the merits of a branded product, are reluctant to switch on cost grounds alone to even a closely similar variant because of the risk of lower efficacy, poorer tolerability or allergy. Patients, too, prefer the familiarity of their usual brand.

A patent confers a monopoly and, by definition, a monopoly denies the right for the forces of competition to effectively work for the benefit of consumers. Parallel trade is the only form of competition to any specific medicine during the life of its patent.

Parallel trade offers a real solution to the funding problem that all European healthcare systems increasingly face. It provides, along with guaranteed cost savings, the original products from innovative research-driven manufacturers, not substitutes or copies. It also minimises the implementation of other, more interventionist or market-distorting cost-containment measures.

Which Countries are Involved?

There are many decades of experience with incoming parallel trade in the Netherlands, the United Kingdom and Germany. Since the early 1990s, Denmark followed by most of the other Nordic countries and Ireland have been added to the list, with a small number of parallel-traded products appearing most recently on the markets of Austria, Belgium, Italy, Spain and Greece. As regards supplying states, no one source is dominant, either as a whole or where any individual product is concerned.

No official figures on the trade are gathered and conjectures about its size in different member states vary widely. Estimates of the extent that parallel trade has penetrated national pharmaceutical markets, obtained from mainly manufacturer sources, are shown in table 2.

Table 2: Approximate parallel trade retail pharmaceutical market penetration by value, 2002

country	% share	source
Denmark	10.2	LIF[6]
Germany	7.1	IMS
Netherlands	13.3	SFK[7]
Norway	6.3	LMI[8]
Sweden	9.3 (2001 figure)	LIF[9]
United Kingdom	16.5	IMS

Some of the tougher recent cost-containment measures have been imposed in the traditional free markets of Denmark, Germany, the Netherlands and the UK. At the same time, some former low-price countries, like France, Italy and Spain, are now awarding higher prices than previously, due to the authorities referencing against prices in other countries and because of 'European price corridor' strategies by multinational companies.

The result is that some prices in a 'low-price' country are higher than those for the same product in a 'high-price' country. Prices are also relatively fluid, being affected by exchange rate variations and by subsequent price movements.

What is certain is that parallel trade with medicines is no longer a simple south-north process, or even one-way. Almost all EEA countries are involved, as the product source or the product destination; indeed, many countries simultaneously act, with different products, as both source and destination. Attempts by some manufacturers to stifle the

trade by applying supply quotas to wholesalers have, paradoxically, lead to its spread across Europe. Whereas five years ago a parallel trader in Germany, for example, might have sourced a particular brand from a single country, today the figure can be eight or more source countries.

Parallel trade consequently boosts intra-Community trade. Indeed, the European Commission views it as decisive vehicle for the completion of the EU Internal Market in medicines[10]:

> *'Parallel trade acts an important driving force for market integration where there are important differences in prices between Member States'.*

PARALLEL TRADE: THE SAFEGUARDS

As befits their special position with the maintenance of human health, all medicines – including parallel-traded ones – are strictly regulated in Europe by either national authorities or by the European Agency for the Evaluation of Medicinal Products (EMEA).

A number of EU Directives and Regulations have been adopted over the years with the aim of removing barriers to trade in medicines while ensuring that public health was not endangered. None has dealt specifically with parallel trade. It was left instead to the European Court to play a key role in establishing and regulating this sector.

De Peijper Judgement

The most important test case to establish the regulatory position arose in the Netherlands in the early 1970s. A Dutch parallel trader, Adriaan de Peijper of Centrafarm, was prosecuted for importing a medicinal product from a wholesaler in the UK without the approval of the Dutch authorities, and without possessing either the product marketing approval documents or the batch records. De Peijper argued that he was unable to adduce such evidence because the manufacturer would not give him access to the necessary data. The product was authorised in both the Netherlands and the UK, and the Dutch court referred the matter to the ECJ.

The Court found in favour of the plaintiff; asking him to produce the records demanded by the Dutch authorities was held restrictive[11]:

> *'National rules or practices which make it possible for a manufacturer of the pharmaceutical product in question and his duly appointed representative, simply by refusing to produce the documents relating to the medicinal preparation in general or to a specific batch of that preparation, to enjoy a monopoly of the importing and marketing of that product, must be regarded as being unnecessarily restrictive.'*

The Court felt that as the relevant documentation was already held by one set of authorities, they should co-operate in making these available on a reciprocal basis, and that member states should develop a presumption of conformity. If the parallel-traded and the domestic versions were slightly different it was up to the authorities to investigate whether this was therapeutically significant.

The only measures which a national regulatory authority were justified in taking as regards parallel trade, the Court said, were those intended to verify that such products were identical with the version already marketed in that country by the domestic trade mark owner, or that the difference had no therapeutic effect.

> *'Public health authorities should be encouraged 'not to place parallel imports at a disadvantage, since the effective protection of health and the like of humans also demands that medicinal preparations should be sold at reasonable prices.'*[11]

This was to guard against unnecessary over-regulation as the products had all been previously approved by the regulatory authorities. Parallel trade makes modern, innovative medicines more affordable, while an unaffordable medicine is neither safe nor efficacious.

Commission Communication

Following the *de Peijper* judgement, the European Commission produced a Communication outlining the basic principles for an abbreviated form of marketing authorisation for parallel-traded medicines[12].

The Commission recommended that the information supplied to the national authorities by the parallel trader should just be sufficient to ensure that the product concerned is effectively covered by an existing authorisation in the member state of destination.

In relation to the product sold by the domestic holder of the full marketing authorisation, the parallel-traded version must therefore:

- contain the same active ingredient(s);
- be administered to patients through the same route;
- have the same therapeutic effects; and
- have a common origin (ie made by, or under licence to, the same company, or a member of the same group of companies)

Detailed information is obtained from the authorising authority in the country of origin to allow full comparison with the domestic version. The parallel trader is required to provide as a minimum:

- the product name and where it is sourced;
- the name and address of the holder of the full marketing authorisation, both in the member state of origin and in the member state of destination;
- the name and address of the parallel trader;
- the product's marketing authorisation number in the source country;
- the product's summary of product characteristics;
- specimens or mock-ups of the product in the form in which it will be sold in the member state of destination; and
- the appropriate fee.

A 'reasonable period' (a maximum of 45 days was suggested) after receipt of such information should be adequate to assess it, the Commission said. In practice, the assessment period facing parallel traders in several countries is often very much longer.

All EEA countries – with the notable exception of France - that are actual or potential destinations for parallel trade now have national rules based on the Commission Communication in place. Every parallel-traded product is required to have its abbreviated marketing authorisation number issued by the national authority and the name of the owner of that authorisation clearly labelled on the pack. If the manufacturer makes any change to the product or its labelling, parallel traders have to quarantine any stock they hold until they obtain regulatory approval for the necessary variation. Pharmacists who supply unauthorised products are open to disciplinary action.

EMEA Approvals

A compliance check is used by the EMEA on the request of a parallel trader for high-tech or biotech medicines that have already received centralised, pan-European marketing approval by the Agency[13]. Such products are, by definition, identical in every respect across the EU, with the Community marketing authorisation covering all linguistic versions of the label and package insert. As a result no further regulatory approval is necessary before parallel distribution takes place.

What Other Regulations Apply?

As one of the conditions for their abbreviated marketing authorisations, parallel traders are required to keep records of the origin, quantity and batch numbers of all products they sell, as well as to retain a sample from every issued lot. An authentic reference sample is also kept for every presentation against which every incoming batch is checked.

If as is usual they are involved in modifying the outer packaging to enable the product to enter the local supply chain parallel importers need a manufacturing authorisation, with all the usual obligations this entails (e.g. employment of an EU Qualified Person, maintenance of Good Manufacturing Practice standards, periodic government inspection). Under manufacturer liability provisions, parallel traders in several countries are required to maintain substantial insurance cover, yet this has never once been needed.

In most countries, it is also a requirement for parallel traders to hold a wholesale dealing authorisation, as well as a manufacturing authorisation, if pharmacies are supplied direct. Granting of such an authorisation is conditional upon compliance with a number of EU-set requirements and Good Distribution Practice guidelines, including:

- maintaining suitable premises for the storage of medicines;
- employment of an EU Responsible Person;
- restrictions upon the sources and supply of such products;
- maintenance of the cold chain for temperature-sensitive products;
- establishment of approved product recall procedures;
- record keeping requirements, in addition to maintaining measures to ensure an audit trail for product traceability

PARALLEL TRADE: THE SAVINGS

Parallel trade can only be realised in case of demand and demand would not exist if the parallel trader did not pass on a large part of the price differential to the payer. Across Europe, payers for prescription drugs are primarily national social health insurance

schemes/national health services, though, except with the very young, the elderly, the unemployed and the chronically-ill, there is also usually an element of patient co-payment.

Direct savings accrue in every member state with incoming parallel trade. The European Commission, in its 2003 Communication following the G10 process, described these savings as 'significant'. This is because national governments and/or their national health providers have introduced measures to incentivise the use of and guarantee savings from parallel trade. How these measures apply and how the savings are split between the statutory healthcare system and patient vary by country.

> *' The UK reimbursement system with fixed reimbursement fees and its clawback system* de facto *provides an incentive for intermediaries and pharmacies to purchase cheaper parallel-traded drugs. It has also been shown that other Member States give more specific incentives to parallel trade, in order to achieve cost savings for the healthcare budget. Denmark, Germany and Sweden serve as an example.'*[14]

An independent study by health economists at the UK's University of York estimated that direct savings accruing to payers and patients from pharmaceutical parallel trade in 2002 in the UK, Germany, Sweden, Netherlands and Denmark totalled the equivalent of $734 million (at current exchange rates)[15]. This figure does not include hospitals, the private sector, or other countries with incoming parallel trade like Norway, Finland, Ireland and Austria.

In addition to direct savings in all countries that realise incoming parallel trade, there is also general price erosion, benefiting all buyers. This is because parallel trade brings an important competitive element to bear, especially in the notoriously price uncompetitive patent-protected segment, the part of the market that generics cannot reach.

> *'...parallel trade...that is the nearest to price competition in drugs that Europe gets.'* Kenneth Clarke (former UK Health Secretary), UniChem conference, Mauritius, 2002

> *'For a manufacturer to enjoy a monopoly of the importing and marketing of the product must be regarded as unnecessarily restrictive.'* [12]

> *'Patented medicines enjoy patent protection for at least 20 years. In cases where only a few alternatives are available, parallel trade will offer the only source of competition.'* [15]

The availability of parallel-traded products, or even just the threat of this, can result in lower prices for domestic equivalents than would otherwise be the case. Market prices are reduced and/or price rises forgone, and greater discounts or improved terms are offered to distributors in an attempt to buy their loyalty.

> *'Parallel trade also generates indirect savings by creating competition, whereas otherwise there is none, and thus forcing pharmaceutical manufacturers to reduce the prices of domestically sourced products. These indirect savings are difficult to quantify but they could be larger than direct savings.'*

Governments which cap reimbursement for multisource products are also able to set lower reimbursement ceilings when parallel-traded versions are available.

What are the Benefits to the Patient?

Patients as taxpayers or as members of health insurance funds have a clear interest in seeing their hard-earned contributions well spent by the statutory healthcare system.

> *'Ultimately, all patients pay for the national health system. Public health systems are financed by contributions or by general taxes. Any savings made by these schemes via the purchase of cheaper parallel-traded drugs indirectly benefit the schemes' members.'* [15]

In many European countries (eg Belgium, Denmark, Finland, France, Greece, Luxembourg, Norway, Portugal, Spain, Sweden), the majority of patients pay a share of the cost of prescribed medicines they consume, so use of cheaper parallel-traded products will mean lower out-of-pocket demands.

> *'Patients benefit directly from parallel trade either when they have to pay the full amount of the purchase price themselves or when reimbursement is only partial and is expressed as a percentage of the actual purchase price (in contrast with a flat fee).'* [15]

Some member states employ forms of reference pricing (similar to 'maximum allowable cost' in the US), in which interchangeable products are grouped with the amount reimbursed by the statutory healthcare system capped at some predetermined amount per group. If a parallel-traded product is dispensed the patient may avoid paying any excess payment that would otherwise be due.

With the growing use of so-called 'lifestyle drugs' (eg treatments for erectile dysfunction, smoking cessation aids, hair restoratives, slimming agents) as well as oral contraceptives – products that are not widely if at all reimbursed - the consumer makes a direct saving from the cash purchase of a parallel-traded medicine on private prescription.

PARALLEL TRADE MYTHS & REALITY

Against an obvious background of commercial interests, it is the aim of some international pharmaceutical manufacturers to keep the market share of parallel- traded products as low as possible by obstructing inter-state movement. Initiatives taken include:

- supply quota-fixing measures
- price corridor strategies
- dual pricing strategies
- market segmentation practices
    - variable pack size
    - variable brand name
    - variable form of administration
    - different packaging
- selective distribution
- targeting with legal actions

Such attempts are invariably in vain, for, as the Competition Directorate-General of the European Commission has said[16]:

> *'On several occasions the Court of Justice has ruled that parallel imports should not be blocked, irrespective of the factors that determine price differences. Hence, in the pharmaceutical sector, the Commission has correctly applied the competition rules to agreement or conduct which restrict parallel trade in drugs.'*

The EAEPC believes that criticism and resistance from some quarters is based on a misunderstanding of the actual facts. This section aims to dispel some of the erroneous folklore that has developed around the topic.

Myth: 'The dogma of free movement within the internal market is incompatible with price-fixing by national governments'

Fact: The ECJ has stated quite clearly that existing inter-state price differences with medicines cannot justify a derogation from the principle of free movement, even if such differences result from price controls imposed by member states[17].

Despite this ruling, manufacturers continue to argue that a correctly working market entails not just the free movement of products, but also the freedom to set prices. This viewpoint ignores today's reality:

- Only a minority of member states still exert direct price control on new prescription medicines at the level of the factory gate. Instead, the preferred approach, adopted across the entire EEA in various country-specific ways, is to limit access to the public reimbursement system or curtail payments made under it.

- Even where actual price control still exists, the authorities no longer price by inflexible formulae, and allow instead a true negotiation, by which a company's asking price for its key brands is increasingly accepted, sometimes in return for offsets elsewhere.

  '...given the fact that companies actually negotiate the prices with the Spanish government and manage to achieve price increases by invoking one or more of the justifications set forth in the relevant Royal Decree, it is too simplistic to regard pharmaceutical companies as price takers because the national competent authorities set maximum prices.'[14]

Payers are primarily concerned with keeping the growth in the total cost of the drugs bill under control and give considerable commercial freedom to companies to set individual product prices as long as overall budgetary limits are respected. Various types of 'deals' concluded by multinational firms so as to achieve comparable prices for their new potential blockbusters with those in other countries have resulted. These may include, for example, provision of the results of a cost-effectiveness study, volume sales caps, prescribing or advertising restrictions, delayed price cuts, or immediate price cuts and/or reimbursement delistings with other, unrelated but ageing products in its portfolio.

Other arrangements, agreed by national associations on behalf of their members, make provision for cash paybacks by industry as a whole if the growth in the drugs budget exceeds pre-set limits. These allow prices higher than otherwise on individual products to be agreed in an environment of cost containment. Such schemes are in place in Belgium, France, Portugal and Spain, and formerly applied in Italy.

Myth: 'Patients will be frightened and confused by foreign language packs'

Fact: Labelling of parallel-traded medicines is fully in accordance with EU and country-specific legislation. This includes provision of a label and a patient package insert in the local language, whose texts have been approved by the national regulatory authority.

In some cases, one or more self-adhesive over-labels will be applied to the original cartons, though in other circumstances the parallel trader will totally replace the carton by a new one giving the required information only in the local language. This latter situation might occur, for example, when the manufacturer markets the product with different pack sizes in different countries, where the amount of information to be provided on the label is extensive, or to enhance patient compliance.

Any repackaging done by the parallel trader is performed under strict GMP conditions and affects only the outer container; the actual dosage form is entirely untouched. Almost all solid dosage forms in Europe are blister or foil wrapped before inclusion by their manufacturer in patient packs; dispensing from bulk is very rare.

The ECJ has laid down the circumstances under which repackaging can be undertaken[18]:

- the product inside the packaging must not be affected;
- the new packaging must clearly state who repackaged the product and the name of the manufacturer;
- the reputation of the trade mark or its owner must not be damaged; and
- the trade mark owner must be given adequate prior notice before the repackaged product is put on sale and, on demand, be supplied with a specimen of the repackaged product.

Many parallel-traded dosage forms are identical in appearance with the domestic version. In other cases, as also happens quite frequently with generic medicines, the shape and colour may vary. In a very few cases the additives are different. This may require explanation by the pharmacist to the patient and checks for intolerance. Some patients may not be suitable to receive parallel-traded products. As the expert on medicines, the pharmacist is well qualified to conduct screening, and to give the necessary advice and reassurance.

The considerable market shares, of well over 50%, achieved and maintained by certain individual parallel-traded products in certain countries, provide clear proof of their high level of acceptance by patients.

Myth: 'Doctors would prefer their patients to receive locally-made rather than foreign products'

Fact: Today, in the majority of EU member states, the source of production of most medicines is in other member states. To save costs, companies have consolidated

manufacturing into a handful of sites to serve the entire continent. Several are situated outside the EU. Most specialise as 'centres of excellence' for particular types of dosage forms. In such cases, 'parallel imports' compete with 'direct imports' The motivation for the manufacturer is the same as for the parallel trader – to exploit lower costs.

Myth: 'Manufacturers will withhold new introductions from countries that supply parallel trade'

Fact: There is no evidence of this. It seems unlikely, as the main supplying countries are typically high-volume users of medicines and hence attractive markets for industry.

Myth: 'Parallel trade will deter the search for new cures'

Fact: There is no link between parallel trade and investment in R&D

European patients are best served not only by having access to the lowest possible prices for today's first-choice treatments but also by assuring that a stream of new innovations continues to emerge from research and development pipelines to tackle unmet medical needs. Diversion of sales from one European country to another with parallel trade has not, however, led to the research-based industry cutting back on R&D. In fact, just the opposite; spend on pharmaceutical R&D in Europe grew more than three-fold from 1985 to 1999[19].

With the market share of parallel trade in its peak year of 2002 amounting to only 4% EU-wide, this cannot influence investment in R&D.

> *'There does not appear to be any causal link between the losses due to parallel trade and GlaxoWellcome's R&D investments. Moreover, these losses are too insignificant to affect these investments to a considerable extent. Finally, it must be stressed that the R&D budget of pharmaceutical companies, while important, only represents around 15% of their total budget. Losses stemming from parallel trade could just as well be deducted from the companies other budget items, such as marketing costs.*
>
> *...Any savings they might hypothetically make by preventing parallel trade would therefore not automatically lead to higher R&D investments. It is conceivable that these savings might merely be added to the companies' profits . '*[14]

An independent consultant[20] has put total direct losses to manufacturers from parallel trade across Europe at about Euro 500 million per year, roughly the same as one company's costs in discovering, developing and launching a single new active ingredient, he noted. Manufacturers also incur considerable self-inflicted costs (e.g. lower sales volume, loss of customer goodwill, legal costs) in their attempts to prevent parallel trade.

There is no evidence that capital investment or competitiveness is affected either. Europe's pharmaceutical trade surplus with the rest of the world increased fourfold between 1985 and 1999[19].

Myth: 'It acts as a channel for counterfeit, pirated or substandard products'.

Fact: Parallel traded medicines are the products of the original manufacturers, often from the very same plant that produces the domestic versions. They are either exactly identical, or with very small differences in colour or inert excipients, differences which the regulatory authorities verify have no therapeutic consequences. If a manufacturer criticises a parallel-traded product it amounts to criticism of its own product.

Handling, transportation and storage of medicines by parallel traders are strictly in accordance with the conditions given in the product's marketing authorisation, and this includes adhering to any cold chain or narcotic requirements.

Counterfeiting is a totally different subject to parallel trade. There is, in fact, very little evidence that counterfeit medicines are traded by any means in Europe. A 1999 survey published by the European Commission found the proportion actually on the market was, after the US, the lowest in the world[21]. In 2001, the Medicines Control Agency described the level of pharmaceutical counterfeiting in the UK as 'virtually undetectable'[22]. One of the main reasons is that the system works effectively in a closed loop: Authorised manufacturers sell only authorised product to authorised wholesalers, who sell only to authorised pharmacies, hospitals and dispensing doctors. Parallel traders use the same distribution channels used by domestic products.

As far as can be ascertained there has never been a single, proven case of a counterfeit medicine leaving the parallel trade supply chain in Europe. Certainly, none has been reported in the two largest markets for incoming parallel trade – the UK and Germany; in the case of the latter, the government has recently verified this fact[23].

Parallel traders take the strictest precautions. For a start, they source only from authorised, reputable wholesalers/traders in other EEA countries with whom they have had business dealings for many years. All incoming batches are compared against authentic reference samples, and multiple checks against photos of authentic products, package texts and leaflets are made at different stages of the process. In addition to the quality assurance procedures agreed between the trader's local medicines inspectorate and its Qualified Person, voluntary ones are often instigated, eg UV detection of holograms on some packs from Greece, and re-assay of vaccines in Germany by the Paul Erlich Institute.

It is not unknown for parallel traders during their routine checks to detect defects in products and to report these to the manufacturer and regulatory authority concerned. As the only checks made in practice on a medicine after it leaves the manufacturer are those conducted by parallel traders, the likelihood of a patient receiving a counterfeit product is actually less not more with parallel trade.

Myth: 'Parallel trade will damage Europe's industrial base'

Fact: For many years, leading manufacturers have predicted they will be damaged or even eliminated, not only by parallel trade, but by the likes of price controls, heavy-handed regulation and by generic competition, but the sector has not merely survived it has flourished.

> *'Conclusive information on the economic effect of this (parallel) trade on the British pharmaceutical industry is not available, given the uncertainty surrounding*

such factors as the profits made on sales to the country which is the source of imports and other discounts offered by manufacturers in the United Kingdom."[24]

As well as offering competition to the domestic trade mark owner, the parallel trade sector is itself highly competitive, with up to 30 active players per country, each offering different terms. Together they provide employment to thousands of staff. Management is highly qualified, with extensive experience often gained in large pharmaceutical companies or in community pharmacy.

Many firms also have a strong platform to participate in the development of generic medicines, a sector that - with the active encouragement of several national governments - is forecast to grow strongly over the next decade, enhancing price competition with patent-expired molecules to the benefit of payers and patients. To further extend the continuum, some parallel traders have evolved into fully-fledged pharmaceutical companies, with a portfolio that includes original products and investment in R&D.

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REFERENCES

1. NERA and SJ Berwin & Co: The Economic Consequences of the Choice of Regime of Exhaustion in the Area of Trademarks, Report for DG XV of European Commission, London, 1999

2. Burstall M and Senior I: Undermining Innovation: Parallel Trade in Prescription Medicines, IEA Health and Welfare Unit, London, 1992

3. Senior I: Parallel Importance, Pharmaceutical Marketing, September 2000, pp 44-46

4. Cassis de Dijon ECJ case, 1979, ECR 649

5. Macarthur D, Drawing the lines in parallel trade, Scrip Magazine, July/August 2002, pp 20-22

6. Lægemiddel Industri Foreningen (LIF), the Danish Association of the Pharmaceutical Industry

7. Stichting Farmaceutische Kengetallen (SFK): Facts and Figures 2002

8. Legemiddelindustriforeningen (LMI), the Norwegian Association of Pharmaceutical Manufacturers: Farmastat

9. Läkemedelsindustriföreningen (LIF), the Swedish Association of the Pharmaceutical Industry

10.Commission Communication on the Single Market in Pharmaceuticals, 25 November 1998

11. Officer van Justite vs de Peijper, ECJ case C-104/75, 20 May 1976, ECR 613

12. Commission Communication on Parallel Imports of Proprietary Medicinal Products for which Marketing Authorisations have already been granted, C115/5, Official Journal of 6 May 1982

13.Procedure for Notifications of Parallel Distribution of Centrally-authorised Medicinal Products, March 1999, EMEA, London

14. Commission Decision of 8 May 2001 relating to a proceeding pursuant to Article 81 of the EC Treaty, IV/36.957/F3 Glaxo Wellcome (notification); IV/36.997/F3 Aseprofar & Fedifar (complaint); IV/37.121/F3 Spain Pharma (complaint); IV/37.138/F3 BAI (complaint); IV/37.380/F3 EAEPC (complaint)

15. West P & Mahon J, Benefits to Payers and Patients from Parallel Trade, York Health Economics Consortium, May 2003 (www.yhec.co.uk).

16. XXVth Report on Competition Policy, European Commission, COM [96]126 final

17. Merck vs Primecrown, joined ECJ cases C-267/95 & C-268/95

18. Joined ECJ cases C-427/93 (Bristol-Myers Squibb vs Paranova), C-429/93 (Boehringer Ingelheim vs Paranova) and C-436/93 (Bayer vs Paranova)

19. The Pharmaceutical Industry in Figures, EFPIA, Brussels, 2001 Edition

20. Senior I, speaking at an open forum 'Parallel Trade in European Pharmaceuticals', 6 September 2000, Vision in Business Conferences, London

21. Communication on Counterfeiting and Piracy in the Single Market, 30 November 2000, European Commission, Brussels

22. Dr Gordon Munro of Medicines Control Agency, quoted in 'Inspection and Enforcement under the Medicines Act, Pharmaceutical Journal, 20 January 2001, pp 85-88

23. Deutsche Apotheker Zeitung, 6 November 2003, p 20

24. Written reply to UK Parliament by Under Secretary for Health, David Lammy, 4 November 2002

GLOSSARY OF ABBREVIATIONS

EAEPC	European Association of Euro-Pharmaceutical Companies
EC	European Community
ECJ	European Court of Justice
EEA	European Economic Area
EMEA	European Agency for the Evaluation of Medicinal Products
EU	European Union
GMP	good manufacturing practice
R&D	research and development