OPINION

'Marching-In' on Remdesivir: Wrong, Pointless and Bad for Patients

BY PETER KOLCHINSKY

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A coalition of state attorneys general has asked for the Department of Health and Human Services to let other companies manufacture and sell Gilead's COVID-19 treatment remdesivir, in order to expand supply and reduce the drug's cost.

These AGs misunderstand the drug's manufacturing process, ignore the economics behind its development, and demonstrate ignorance of the disease itself. They are willfully blind to the value that remdesivir provides to individual patients and to the U.S. health care system more broadly. And in asking for this "march-in" right, the AGs are also attempting to apply a law, 1980's Bayh-Dole Act, that in fact isn't applicable to the remdesivir situation.

Gilead's antiviral has been shown in clinical trials to benefit hospitalized COVID-19 patients and received an emergency use authorization from the Food and Drug Administration in May 2020. The AGs in the letter, led by California Democrat Xavier Becerra and Louisiana Republican Jeff Landry, say that Gilead is "unable to assure a supply of remdesivir sufficient to alleviate the health and safety needs of the country amid this pandemic," and that its remdesivir supply is "dangerously limited."

Let's start with how many patients will need it. In their letter to HHS, the attorneys general point out that Gilead has said it will make 2 million courses of remdesivir treatment by the end of 2020, and make a reasonable estimate that 85 percent, or 1.7 million courses, would be used to treat U.S. patients. They then note Gilead would be unable to supply enough remdesivir to treat all of the 4.6 million cases of COVID-19 in the United States at the time of the letter.

Of course, many of those U.S. COVID-19 cases occurred months ago, before remdesivir's EUA. Even if they were all active cases today, the vast majority of people who contract COVID-19 aren't hospitalized. And while remdesivir is only indicated for hospitalized patients, it is not actually appropriate for all hospitalized patients (National Institutes of Health guidelines prioritize low-flow oxygen patients). Thus only a small fraction of the 4.6 million U.S. COVID-19 patients would benefit from remdesivir, as it's currently used.

It's true that Gilead isn't yet making enough remdesivir to treat that fraction of patients. But the company ramped up manufacturing months ago and will have enough to meet global demand, including all relevant U.S. patients, by October. So would allowing another manufacturer to jump in at this stage help boost supply between now and then? Not even close.

Manufacturing remdesivir isn't trivial. If the HHS secretary granted march-in rights today, and lined up a capable manufacturer tomorrow, that supply would still not be available until well into 2021. Gilead has also been able to improve its manufacturing processes and condense its manufacturing timeline to as short as six months. A manufacturer starting from scratch would likely need almost a year to amass an adequate supply. This isn't even hypothetical: Gilead has already granted free licenses to generic drugmakers in Asia and Africa to make enough.

The AGs also assert that remdesivir is too expensive. They point to a study suggesting that the drug could be made at a cost-per-treatment of less than a dollar a day. But that study has been dismissed and discredited by health economists as flawed and inaccurate for flouting intellectual property rights, minimizing the cost of R&D, and ignoring the savings remdesivir generates by enabling people to leave the hospital sooner.

The AGs also advance a false narrative that the federal government, and not Gilead, has paid for the lion's share of remdesivir's development. Indeed, the government provided about \$76 million in total direct support to some of Gilead's academic collaborators for their research on antivirals across several disease areas. Of that, government grants totaling about \$19 million were specifically earmarked toward coronavirus research.

But this amounts to less than 2 percent of Gilead's expected total investment in remdesivir in 2020 alone. Every bit helps, to be sure, but Gilead itself has taken on the vast majority of the risk of getting remdesivir to patients. (Meanwhile, insurance companies are raking in record profits on the backs of U.S. citizens and patients, and not risking a thing.)

Contrary to the AGs contention, there is no "market failure" for remdesivir – only the extraordinary effort of a company fighting a pandemic.

Invoking Bayh-Dole will not result in more remdesivir available to Americans in the next year. But attempting to invoke it reveals just how misguided these particular AGs are about right vs. wrong in medicine, health insurance, and the needs of patients.

And while expressing concern for the uninsured, not once did these AGs call for insurance reforms to lower out-of-pocket costs for remdesivir, or for expanding insurance to all families. The reality is that uninsured families in America would not be able to afford the costs of hospitalization for COVID-19 even if remdesivir were free and came with \$1,000 attached to it. That's the real injustice.

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