

Gilead Sciences: hepatitis C pricing, HIV promotion, and the path to long-acting prevention

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1. Executive assessment and company identity

Gilead Sciences is a research-based biopharmaceutical company whose current business spans HIV, viral hepatitis, oncology, and other therapeutic areas. Its August 2026 financial release describes a substantial HIV treatment and prevention business alongside liver-disease medicines and cancer therapies. This report concentrates on three documented access questions: the launch-era affordability of its hepatitis C treatments, a resolved U.S. investigation of HIV speaker programs, and the evolving international delivery of lenacapavir for HIV prevention. These are distinct products, periods, and policy mechanisms. A conclusion about one does not automatically apply to the others.¹

The central assessment is that a medicine's scientific contribution and its accessibility require separate evidence. A treatment can represent a major therapeutic advance while its initial price and the number of eligible people create immediate pressure on public budgets. Conversely, a royalty-free license and a low announced procurement price can help establish an access pathway without demonstrating that every eligible person has received the medicine. This distinction is particularly important when comparing a short hepatitis C treatment course with a continuing HIV-prevention program: they address different clinical needs, have different delivery requirements, and cannot be ranked by nominal prices alone.

For hepatitis C, the principal public evidence is a 2015 bipartisan Senate Finance Committee investigation. It examined Gilead's pricing decisions and the consequences for public programs. Its conclusions are legislative findings, not a criminal conviction or a court determination that the launch price was unlawful.² For HIV promotion, a 2025 civil settlement included factual admissions concerning speaker-program conduct. That record supports a stronger statement about admitted behavior, but it is not a general judgment that Gilead's HIV medicines lacked clinical value.^{10,11}

The contemporary access story also includes material positive developments. Gilead granted generic manufacturers licenses for lenacapavir in specified countries; procurement partners subsequently reported initial deliveries and patient starts. Important elements remain conditional or prospective, including generic supply planned for 2027 and a multiyear expansion target.^{6,7,8,9}

This is a newly prepared public-source assessment. It does not reconstruct an unavailable earlier Pharma Foundation report, quantify the Foundation's historical work, or supply evidence for an individual's past contribution. Its purpose is to make documented corporate decisions, legal outcomes, and access measures understandable without treating commitments as completed outcomes or treating every price as a patient's bill.

2. Historical context: from hepatitis C launch prices to prevention licensing

The Senate's December 2015 account traced the commercial introduction of Sovaldi and then Harvoni. It identified a U.S. wholesale price of \$84,000 for a Sovaldi course and \$94,500 for Harvoni at launch. These were historical product prices examined in a particular investigation, not verified September 2026 pharmacy prices. The inquiry drew on internal company material and public-program information to examine how pricing decisions affected access during the early expansion of hepatitis C treatment.²

The committee's executive summary recognized the treatments' importance compared with the older treatment environment, including people who had waited for better options. It nevertheless concluded that maximizing revenue, rather than research-and-development spending or a required acquisition return, was central to the pricing process it examined. That conclusion belongs to the committee and its documentary analysis; it should not be relabeled as an independently replicated economic finding by this report.³

Gilead's own 2015 annual-report narrative emphasized a different part of the record: clinical progress, payer discounts, patient assistance, and expanded treatment. The company reported that more than 770,000 people worldwide had initiated treatment with its hepatitis C products since their 2013 introduction. It also described substantial discounts to U.S. public and private payers and negotiations with authorities outside the United States. These are company-reported historical statements; the narrative is not a direct response resolving every conclusion of the Senate investigation.⁴

A later timeline involves HIV prevention rather than hepatitis C treatment:

Date	Documented development	Necessary qualification
October 2024	Six manufacturers received lenacapavir licenses covering 120 countries	Geographic licensing scope, not completed delivery
June 2025	FDA labeling established Yeztugo's U.S. prevention indication	Eligibility and HIV-testing requirements apply
September 2025	Partners announced a planned generic price and 2027 supply pathway	Dependent on regulatory approval and implementation
April-May 2026	Partners reported deliveries, country introductions, and patient starts	Dated rollout snapshots, not universal access

The licenses preceded prevention approval and therefore represented preparation for a future market. By contrast, the June 2025 FDA label and the 2026 rollout updates concern later regulatory and implementation stages.^{5,6,8,9} Preserving that sequence prevents a common error: describing a licensing announcement as though it established immediate availability in every covered country. It also provides a fair basis for assessing progress as subsequent evidence becomes available.

3. Principal evidence: affordability barriers and admitted promotional practices

The hepatitis C inquiry's most important access finding concerned the interaction between price and public-program capacity. Its executive summary reported that at least 27 state Medicaid programs restricted treatment to people with the most advanced disease. The committee connected these restrictions to the budget consequences of the prices it examined. The finding concerns the early launch period, and this report does not assume that those restrictions remain in force today.³

Analytically, the distinction between long-run value and short-run affordability explains why the finding matters. A program can expect future health benefits from treatment while still facing a current-year appropriation that cannot cover every eligible person at the prevailing net cost. A value argument alone does not identify the financing arrangement that solves that timing problem. Equally, a restriction count does not establish that price was the sole cause of every individual's treatment delay: diagnosis, care capacity, eligibility processes, and patient circumstances can also matter. The documented policy response is evidence of a barrier, not a complete patient-level causal model.

A separate 2025 case addressed how prescriptions were promoted. The U.S. Attorney's Office for the Southern District of New York announced a \$202 million civil settlement approved on April 28, 2025. The government's allegations concerned speaker programs used to induce prescribing of Gilead HIV medicines. Unlike a settlement with an express blanket denial of the relevant facts, this resolution included extensive factual admissions about program practices and compliance failures.¹⁰

The filed stipulation describes more than 17,300 speaker programs, payments exceeding \$23.7 million to speakers, and examples of repeated attendance at programs on the same topic. Gilead admitted specified facts about how programs operated and how compliance controls failed to identify or prevent improper inducements. The covered speaker-program period ran from 2011 through November 17, 2017, while the release of certain false-claims liability extended to associated claims through May 17, 2018.¹¹

These facts support scrutiny of the relationship between educational events, prescribing incentives, and public reimbursement. They do not supply a measured increase in the price of a prescription, prove that every attended event was unlawful, or show that all associated treatment was unnecessary. Nor should the \$202 million resolution be described as a criminal fine. Keeping the legal mechanism precise helps a reader understand what the record establishes: a resolved civil enforcement matter with admissions concerning identified promotional conduct, separate from the Senate's assessment of hepatitis C pricing.

4. Pricing and access: comparing the right units

The publicly reported figures below describe different types of prices and outcomes. They are presented together to clarify their meanings, not to create a numerical ranking of medicines.

Figure	Product, place, and date	What the figure measures
\$84,000	Sovaldi, United States, launch-era Senate record	Wholesale price for a treatment course
\$94,500	Harvoni, United States, launch-era Senate record	Launch price for a treatment course
US\$40 per person per year	Planned generic lenacapavir, licensed markets, anticipated 2027	Announced injection cost under a partner agreement
No more than US\$17	Same planned generic pathway	Additional initial oral course
More than 11,000 people	Early African lenacapavir rollout, by April 2026	Reported PrEP initiations
Three million people	Global Fund/U.S. commitment, through 2028	Multiyear expansion ambition

The first two figures come from the Senate's historical account; they do not represent net manufacturer receipts after all concessions.² The next two come from a September 2025 agreement announced by Unitaid, CHAI, Wits RHI, and Dr. Reddy's. Generic availability was anticipated for 2027 following regulatory approval. The statement specifically distinguished the annual injection price from the initial oral course.⁸ The last two figures come from separate implementation and commitment announcements, with different dates and coverage.^{7,9}

The planned US\$40 figure therefore should not be advertised as the complete annual cost of delivering prevention. Testing, clinical assessment, administration, follow-up, logistics, and travel can require additional resources. The FDA label requires HIV testing before initiation and subsequent injections and warns about resistance if infection is undiagnosed. Those requirements are a reminder that affordable medicine procurement is one input to an effective clinical service.⁵

Likewise, a wholesale course price cannot reveal what a particular insured person paid. Rebates, negotiated discounts, benefit design, and assistance can separate list prices from payer costs and patient out-of-pocket spending. The historical Gilead narrative documents the existence of discounts and assistance, but it does not disclose a universal net price applicable to every payer.⁴

No percentage reduction is calculated between the hepatitis C prices and the lenacapavir figure. Such a comparison would join different diseases, units, years, products, and markets. No conversion of sales revenue into people reached is attempted either. A defensible access comparison would first specify the population, eligible indication, time period, completed service, and payer perspective; it would then collect comparable observations within that definition.

5. Outcomes, company position, and the latest documented status

The clearest contemporary access development is an operational pathway involving licensing, interim supply, procurement, and country delivery. Gilead's October 2024 announcement described nonexclusive, royalty-free agreements with six generic manufacturers for 120 primarily low- and lower-middle-income countries. It also described a company commitment to provide supply without profit until manufacturers could fully support demand. That is an announced supply commitment, not an independent audit of costs or proof that the licensing territory includes every country with unmet need.⁶

The Global Fund reported on April 14, 2026 that it and the United States were expanding their ambition to reach three million people through 2028. At that date, initial deliveries had reached nine African countries and rollouts had started in six. These were concrete implementation steps, but the three-million figure remained an ambition for the full period.⁷

CHAI's May 15 update provides a later, differently defined snapshot. It reported that, by April, eight African countries had introduced lenacapavir and more than 11,000 people had started it. It also projected more than 600,000 starts during 2026 across ten early adopters. That projection is not a count achieved by publication, and neither snapshot should be presented as a verified September total.⁹ Apparent differences between country counts can result from reporting dates and distinctions between shipment, introduction, and clinical initiation; the terms should remain visible rather than be collapsed into one headline number.

Gilead's August 2026 earnings update confirms that the prevention business is commercial and developing. It separately identifies an application for a potential once-weekly oral Yeztugo option, with an FDA target action date of February 2, 2027. That proposed regimen was under review in the cited update. It should not be confused with the already approved injectable prevention option or with oral initiation requirements in the existing label.^{1,5}

The historical enforcement matter also has a definite outcome. The 2025 speaker-program settlement resolved covered civil claims, included admissions, and established a monetary obligation. Its existence should remain part of the company's record without being recycled as an allegation about present-day programs unsupported by new evidence.^{10,11}

The overall position is consequently mixed and specific: substantial therapeutic and implementation developments coexist with a documented history of affordability concerns and admitted promotional-control failures. The appropriate next question is whether current programs produce sustained, equitable access, measured through actual service delivery and retention rather than announcements alone.

6. Implications, research method, and limitations

This report uses public primary sources checked on September 9, 2026: Senate materials, a federal settlement and government announcement, an FDA label, company disclosures, and implementation statements from procurement and access organizations. Sources serve different evidentiary purposes. The company is authoritative for what it announces and reports, the court-filed agreement for admitted facts and settlement terms, the FDA for the referenced approved labeling, and program partners for the implementation observations they publish. None of those roles makes every source an independent evaluation of patient outcomes.

The analysis connects these records through a limited proposition: access depends on both the terms of sale and the machinery that turns a medicine into a delivered service. For hepatitis C, a practical research update would examine dated state coverage rules, treatment rates, and net spending in the same population. For HIV prevention, it would distinguish a license, a registration, an order, a shipment, a first administration, and continued use. Those are successive stages with different failure points. The stage actually measured is essential; the broad word “access” cannot establish all of them.

A future data table should record product and formulation, geography, currency, price basis, unit, observation date, and source. Where a price excludes an initiation course or service costs, that exclusion belongs alongside the figure. Country-level implementation records should similarly preserve the reference date and distinguish achieved counts from forecasts. This report does not create a modeled dataset or estimate savings from incomparable published figures.

Several limitations matter. Confidential payer rebates, patient-level insurance records, complete worldwide eligibility rules, and current country-by-country initiation counts were not available in the reviewed material. The historical Senate investigation was not independently replicated from its underlying document production. The report does not independently audit Gilead's global treatment counts, the cost of no-profit supply, or partner projections. A source's latest checked publication is not necessarily the latest event in every jurisdiction.

Finally, legal and clinical conclusions remain bounded. The Senate pricing analysis is not a conviction; the speaker-program settlement includes specified admissions but does not establish that all prescribing was improper; and an FDA indication is not individualized advice to use a medicine. More complete outcome data could strengthen the assessment within these distinctions. For Pharma Foundation readers, that approach offers a useful accountability standard: describe the decision, identify the evidence and its date, state the result actually demonstrated, and make remaining uncertainties visible.

References

1. Gilead Sciences. *Gilead Sciences Announces Second Quarter 2026 Financial Results*. 4 August 2026. [Open source](#)
2. U.S. Senate Committee on Finance. *Wyden-Grassley Sovaldi Investigation Finds Revenue-Driven Pricing Strategy Behind \$84,000 Hepatitis Drug*. 1 December 2015. [Open source](#)
3. U.S. Senate Committee on Finance. *Executive Summary*. 1 December 2015. [Open source](#)
4. Gilead Sciences. *Gilead Annual Report 2015*. 2016. [Open source](#)
5. U.S. Food and Drug Administration. *YEZTUGO (lenacapavir) prescribing information*. June 2025. [Open source](#)
6. Gilead Sciences. *Gilead Signs Royalty-Free Voluntary Licensing Agreements With Six Generic Manufacturers to Increase Access to Lenacapavir for HIV Prevention in High-Incidence, Resource-Limited Countries*. 2 October 2024. [Open source](#)
7. The Global Fund. *Global Fund and U.S. Expand Commitment to Long-Acting HIV Prevention as Country Rollout of Lenacapavir Accelerates*. 14 April 2026. [Open source](#)
8. Clinton Health Access Initiative. *Unitaid, CHAI, and Wits RHI enter into a landmark agreement with Dr. Reddy's to make HIV prevention tool lenacapavir affordable in LMICs*. 24 September 2025. [Open source](#)
9. Clinton Health Access Initiative. *Lenacapavir and long-acting HIV PrEP: flash market update and spotlights across early adopters*. 15 May 2026. [Open source](#)
10. U.S. Attorney's Office, Southern District of New York. *U.S. Attorney Announces \$202 Million Settlement With Gilead Sciences For Using Speaker Programs To Pay Kickbacks To Doctors To Induce Them To Prescribe Gilead's Drugs*. 29 April 2025. [Open source](#)
11. U.S. District Court, Southern District of New York. *Stipulation and Order of Settlement and Dismissal, United States ex rel. Bellman v. Gilead Sciences, Inc., 16 Civ. 6228*. Approved 28 April 2025. [Open source](#)