



January 24, 2007

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**Re: Review of Canada's Access to Medicines Regime**

Dear Mr. Clark and Ms. Zirger:

I am writing in support of the attached submission by *Canada's Research-Based Pharmaceutical Companies (Rx&D)* related to the *Canada's Access to Medicines Regime (CAMR)*, and to add some additional thoughts from GlaxoSmithKline's perspective.

I am very proud of the role that GSK's Canadian operations play in the fight against disease in the developing world. Our manufacturing facility in Mississauga, Ontario has the worldwide manufacturing mandates for Malarone® tablets (to treat malaria), Mepron® suspension (which treats pneumonia and other opportunistic infections associated with HIV), and a number of HIV oral liquid products. Approximately 80 percent of our Mississauga plant's production is exported to more than 120 countries worldwide, including many developing countries.

Our company continues to support the humanitarian goals of the CAMR. GSK is committed to playing a full part in addressing the healthcare challenges of the developing world by taking an innovative, responsible, and, above all, sustainable approach. Our core business activity of developing and launching new medicines and vaccines significantly improves health care in the developing world.

GSK does not believe changes to the current Access to Medicines Regime are warranted at this time, as the attached submission from Rx&D addresses in detail. We wish to highlight the fact that the CAMR system has not yet been truly tested. In fact, to our knowledge there has been only one attempt to use it.

With the innovative industry offering both not for profit pricing and voluntary licences along with the increasing production of generic firms in the developing world, the question is no longer one of availability of medicines to treat HIV/AIDS. The industry has developed a more strategic approach in the past number of years. Rather than looking at the developing world simply as a recipient of aid or donations, GSK and industry have established new partnerships and business models to truly meet the health challenges faced by developing countries. We believe that this is a large part of the reason why no compulsory licenses have been sought under the CAMR.

## **GSK'S EXPERIENCE WITH THE CAMR TO DATE**

It is worth noting that, in the one instance where there was a preliminary attempt to use the CAMR, media reports indicated that it would have resulted in approximately 150,000 doses of antiretrovirals reaching the developing world. GSK, by contrast, shipped in excess of 126 million tablets of preferentially-priced antiretrovirals used in the treatment of HIV (Combivir® and 3TC®) to the developing world in 2005 alone.

Nevertheless, the facts of this sole attempt to use the CAMR are as follows:

The C-9 legislation was enacted in May 2004 but it was not until May 2006 that the Canadian generic company Apotex applied for a voluntary licence from three patentees, including GSK. Our company responded promptly, indicating its willingness to grant a licence to Apotex, seeking clarification on key questions related to anti-diversion and patient safety. Apotex did not respond to GSK's request for further information. GSK again wrote to Apotex in early September 2006, seeking its re-engagement. Apotex's legal counsel responded on September 7, 2006, indicating that the letter was received and that a response was forthcoming. As of this writing, GSK has yet to receive a response.

Actual experience to date with the CAMR licensing system is, therefore, very limited. Consequently, our view is that the system has not yet been thoroughly tested, and that it is premature to speak of the system's "complexity" or that the system is "broken".

## **GSK IN THE DEVELOPING WORLD: MAKING A DIFFERENCE**

GSK believes that focusing solely on the features of the CAMR misses the broader concerns and issues with respect to the healthcare challenges of the developing world. These challenges are varying and complex and, as a result, so is our approach.

GSK makes a vital contribution to developing country healthcare through action in four areas:

GSK's antiretrovirals and antimalarials, vaccines are available at **not-for-profit prices** in approximately 100 countries. GSK has supplied over 126 million tablets of Combivir® and 3TC® to the developing world at preferential prices in 2005 alone. We also offer our vaccines at highly preferential/discounted prices; some 90% of all the vaccines we supply go to the developing world.

In addition, GSK's **research and development efforts** also target diseases particularly affecting the developing world through a dedicated research facility in Spain. GSK has numerous R&D programs for both treatments and vaccines for HIV/AIDS, TB and malaria. In 2003, we launched *Lapdap* the first antimalarial to be developed through a Public Private Partnership and we are currently developing the world's most advanced malaria vaccine which we hope to submit for regulatory approval as early as 2010.

In addition, GSK funds **community-led initiatives** in over 100 countries around the world. In the developing world, GSK's activities span four major developing world diseases lymphatic filariasis (LF), HIV/AIDS, malaria and diarrhoeal disease. Since 1998, GSK has provided free of charge over 500 million albendazole treatments reaching over 100 million people in its endeavor to eliminate LF. In total GSK's global community investment activity was valued at almost \$900 million Canadian in 2005.

Finally, we have a series of **innovative partnerships and solutions** designed to address the challenges of the developing world. GSK has granted 8 voluntary licences to African generic companies to enable them to produce and supply versions of our leading ARVs across sub-Saharan Africa. GSK is also helping to build clinical expertise in Africa by supporting 28 HIV/AIDS collaborative studies in developing countries, including 23 in Africa. These studies involve more than 18,000 patients.

## **LOOKING FORWARD**

The World Health Organization and other health experts have clearly identified human resources, delivery and infrastructure as key health care challenges in the developing world today. With this in mind, as Canada reviews its support for activities in the developing world, we would urge you to look more broadly at developing world needs, beyond simply having Canadian generic firms export product.

For example, we suggest that Canadian aid to developing countries focus on areas where Canadian investment/expertise can bring the greatest value. Some examples include increasing the number of doctors and nurses in regions with greatest health need; offering training and re-training programs for health providers; helping to establish health clinics in rural areas; and helping to set up regional education programs to promote sanitation, reproductive and women's health, and disease prevention. The lack of funding for treatment programmes remains a challenge. Despite welcome new resources coming through via initiatives such as the Global Fund, funding remains inadequate. Any additional support the Canadian government could provide in this area would therefore be worth considering.

Canada should also ensure that its policies are appropriately coordinated with existing initiatives by other OECD countries, and identify opportunities to complement investments by OECD governments or companies like GSK. Authorities in developing countries should also be encouraged to effectively enforce measures to prevent diversion of medical supplies.

Canadian expertise and generosity can make a difference in many of these areas, and we encourage the government to think broadly and strategically on these questions..

In conclusion, I submit that efforts to modify the CAMR will not truly address the needs at hand. Our medicines *are* reaching the developing world, and our company is making a difference on the ground. Canadian and International effort should instead now be focussed on the areas we have set out above.

I am proud of our efforts to help meet the health needs of the developing world and look forward to doing more. GSK is happy and willing to share its growing expertise in this area.

Yours truly,

A handwritten signature in black ink, appearing to read 'Paul N. Lucas', written over the text 'Yours truly,'.

Paul N. Lucas  
President & CEO

Attachments:  
Rx&D Submission  
GSK's Corporate Responsibility report

c.c.: The Honourable Maxime Bernier, Minister of Industry  
The Honourable Tony Clement, Minister of Health



2005

# GSK Corporate Responsibility Report



# Introduction

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# 1

## Introduction

Welcome to GSK's Corporate Responsibility Report 2005. This report explains our approach to the wide range of social, ethical and environmental issues associated with our business and reports our performance in 2005. The full web-based report is available on [www.gsk.com](http://www.gsk.com)

GSK is a research-based pharmaceutical company, with operations in 119 countries. We make prescription medicines, vaccines, over-the-counter medicines, and consumer healthcare products. Our business accounts for 6.3% of the world's pharmaceutical market. We have strong positions in several therapeutic areas including anti-infectives, asthma, cancer, cardiovascular, depression, diabetes, HIV/AIDS and urology. For an overview of our business, see our Annual Report.

### OUR CONTRIBUTION TO SOCIETY

In the last 80 years, medicines and vaccines have transformed millions of lives. They have helped to increase life expectancy and lowered death rates from conditions such as heart disease, stroke and cancer. Medicines enable many people with chronic diseases to enjoy good health and lead full lives. In developed countries, healthcare advances mean most people are no longer at risk from diseases such as polio and TB that were major threats less than a century ago.

But continued research and development of new medicines is vital. There are still many serious illnesses for which there are few treatments or where treatments may be improved.

Discovering and developing new medicines is expensive – the average cost is around £450 million and it takes an average of 15 years. Society now relies on the pharmaceutical industry to fund most of this research, indeed the majority of medicines used around the world have been developed by the pharmaceutical industry.

GSK invested £3.1 billion in R&D in 2005 and employs over 15,000 people. We have 149 prescription medicines and vaccines in clinical development.

We believe that our business makes a valuable contribution to society by developing and marketing medicines which improve people's lives. However we recognise that the research, development, manufacture and sale of medicines raise ethical issues for some stakeholders. We listen to these concerns and address them where we can.

This report explains our approach to the significant corporate responsibility issues for our business, including:

- **Access to medicines** – how we make our medicines accessible to poor patients in developed and developing countries
- **Research and development** – how we maintain high ethical standards in our research and the publication of research results
- **Sales and marketing** – how we maintain high ethical standards in the sales and marketing of our products

It also covers our employment practices and approach to human rights, our environmental performance and our community investment.

### ABOUT THIS REPORT

This report covers our corporate responsibility activity and performance during 2005. It updates our last corporate responsibility report published in March 2004. Data relate to the calendar year 2005 (except where stated).

The environmental data is collected from all of our 81 pharmaceutical and consumer manufacturing sites, 5 of our 8 biologicals manufacturing sites and 19 of 21 pharmaceutical and consumer R&D sites as well as all 7 distribution centres, all 6 major office locations and 7 of the smaller office and sales locations. We include data for sites that were in operation for all or part of the year. Notes attached to the charts explain the scope and data collection process for each parameter in more detail. Unless specified as being per unit of sales, figures are absolute numbers, i.e. total consumption of energy, water etc. Data in the environment, health and safety sections of this report are externally verified.

## Introduction continued

The scope of other data relates to our worldwide operations except where indicated.

We use external guidelines and frameworks to inform our reporting where relevant. We do not base our report on the Global Reporting Initiative guidelines but we have included a GRI Index on our website to show which elements of the guidelines we cover and to aid comparison with other company reports.

A number of changes have been made to this year's report in response to feedback received during 2005. We have added a summary to give readers an overview of our approach to CR and the key issues for our business. Last year we organized the report according to our ten CR Principles. This year we are still reporting progress against our principles but we have reorganized some sections to make the report easier to navigate.

Information on our marketing practices, previously contained in Products and Customers, has been incorporated into the Ethical Conduct section. Information previously contained in the Leadership and Advocacy section has been embedded through out the report, in particular in Government and External Affairs, Public Private Partnerships and Major Public Health Initiatives. For more information on our stakeholder engagement process see Stakeholder Engagement.



## CEO and Chairman's letter

**Corporate responsibility is fundamental to delivering our business goals. While the interests of shareholders remain paramount we also need to respond to stakeholder expectations by helping to address society's healthcare challenges.**

We accept this challenge. Solving problems such as healthcare provision in the developing world is not a job for one company alone, however we do have an important contribution to make. Our access to medicine programmes for HIV/AIDS and our work with the World Health Organization to eradicate Lymphatic Filariasis (LF) are evidence of the efforts we are making. In 2005 we shipped 126 million preferentially priced Combivir and Eпивir tablets to developing countries for treatment of HIV/AIDS and donated 136 million albendazole tablets for the prevention of LF. Through our public private partnerships we are developing the first pipeline of new tuberculosis treatments in 40 years and testing new vaccines and treatments against malaria, a disease which takes a devastating toll on the people of Africa.

Corporate responsibility encompasses how we address and manage issues that arise from our business activities. Good performance on corporate responsibility supports our business strategy because it protects and enhances our relationships and reputation with doctors, governments and patients.

GSK's core business – the research and production of medicines – makes a valuable contribution to society. For many people our medicines are, quite literally, life-saving. But our satisfaction in what we do does not mean we can ignore issues associated with the research, manufacture and sale of medicines – from the publication of research results and marketing practices of pharmaceutical sales representatives, to the use of animals in research and the environmental impacts of our manufacturing processes.

We are confident we have the right policies and programmes in place so that we operate to the highest standards. This report provides an update on the progress we have made against our ten corporate responsibility principles during 2005. Particular highlights include our new policies on the authorship of research articles, consumer advertising and patient advocacy, and our Clinical Trial Register that now contains results from over 2,000 GSK sponsored clinical trials.

We seek views from a wide range of stakeholders and respond to their suggestions where possible. This report contains new information in a number of areas in response to feedback we have received (see Stakeholder Engagement). We hope this report provides the information you are seeking about corporate responsibility at GSK and we welcome your feedback.



**Sir Christopher Gent**  
Chairman



**JP Garnier**  
Chief Executive Officer

## Managing corporate responsibility

Corporate responsibility supports our business strategy by preparing us to meet future expectations, protecting our reputation and helping us to reduce business risk. So it is important that management of CR issues is integrated into our day-to-day operations.

Our approach to CR is informed by frequent discussions with a range of stakeholders, including employees, shareholders, patients, doctors, governments and NGOs. For information on our engagement process and the feedback we have received, see Stakeholder Engagement and Government and External Affairs.

### WHY CORPORATE RESPONSIBILITY IS IMPORTANT TO GSK

To achieve its business goals, GSK focuses on a number of business drivers:

- build the best product pipeline in the industry to the benefit of patients, consumers and society
- continuously improve performance through commercial and operational excellence
- improve access to medicines through a range of extensive programmes, both in the developed and developing world
- be the best place for the best people to do their best work

Corporate responsibility encompasses how we achieve our goals and implement our business drivers. It means operating in a way that reflects our values. CR supports business success by reducing business risks and protecting our reputation.

The way we conduct our business affects our relationship with the patients and consumers who use our products, the doctors who prescribe our medicines and the governments that regulate our industry. Our reputation with these people and the trust they place in our products is critical to our business.

By demonstrating to stakeholders that we meet high ethical standards in all aspects of our work, and that we are committed to helping address healthcare challenges, we can maintain their support and retain our 'licence to operate'. Our reputation, the standards we operate to and our employment practices also impact our ability to attract, retain and motivate the best people.

For more on our business strategy see our Annual Report.

### CR GOVERNANCE

GSK's Corporate Responsibility Committee consists of non-executive directors and provides a Board-level forum for reviewing external issues with the potential to impact on GSK's business and reputation. It provides high-level guidance on our approach to all CR issues. Members of the corporate executive team, including the CEO, also attend CRC meetings.

The Committee meets four times a year to review our policies and progress on our CR principles. Policies and activities relating to four of the principles – access to medicines, standards of ethical conduct, research and innovation and global community partnerships – are reviewed annually. Other principles are discussed regularly, at least once every three years. The Committee's findings are reported to the Board.

During 2005 the Committee met four times and reviewed our activity in a number of areas including:

- Access to medicines
- Animal testing
- Clinical trials in developing countries
- Community partnerships
- Corporate responsibility reporting including final sign-off of the CR report
- Reputation management

Management of significant business risks is coordinated by the Risk and Oversight Compliance Council (ROCC). The ROCC also considers reputational and corporate responsibility risks.

For more background information on the CRC and ROCC, see Risk management and compliance on [gsk.com](http://gsk.com).

## Managing corporate responsibility continued

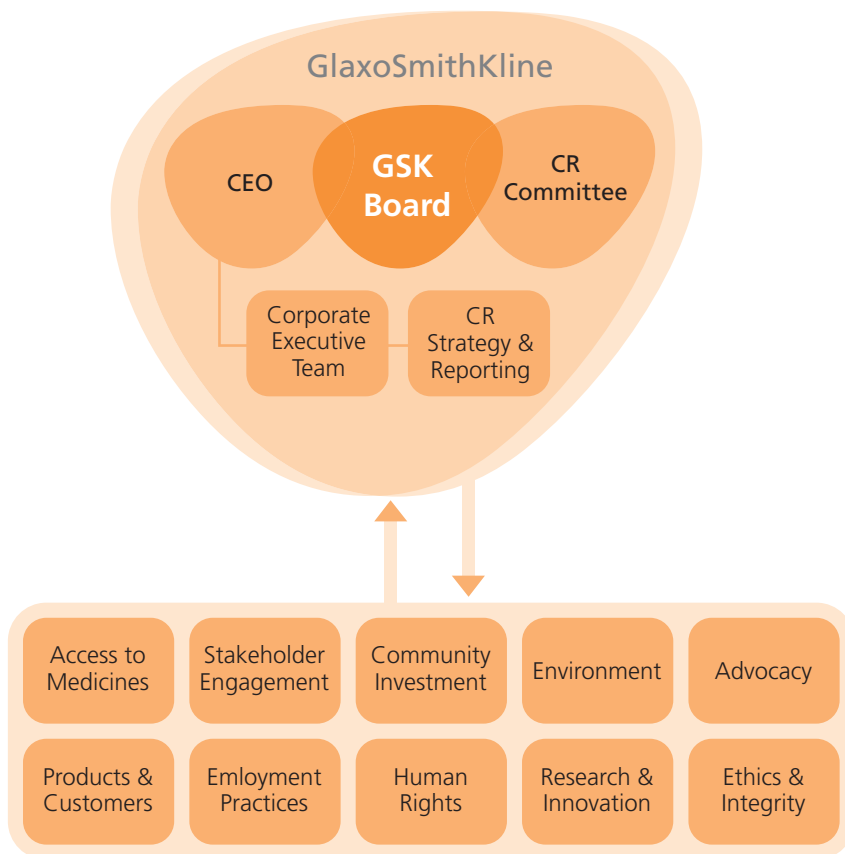
### Management structure

We believe that day-to-day management of CR issues and performance is done most effectively within our business operations, where experts on all our CR issues work.

Coordination is provided by a cross-functional team, made up of representatives from key business areas. These representatives are senior managers and have direct access to the appropriate Executive Team member. Their role is to oversee development, implementation and communication of CR policy across GSK. This ensures a comprehensive and consistent approach is taken throughout the organisation.

We also have a small CR team that co-ordinates policy development, reporting, and communication with socially responsible investment analysts.

For details of our Environment Health and Safety management see EHS Management.



### GSK's CR Committee



**Sir Christopher Gent**  
(Chairman of CR Committee)

Sir Christopher is the former Chief Executive Officer of Vodafone Group Plc. He is a non-executive director of Lehman Brothers Holdings Inc; a director of the International Advisory Board of Hakluyt & Co; and is a Senior Adviser at Bain and Co.



**Sir Ian Prosser**

Sir Ian was formerly a non-executive Director of SmithKline Beecham plc. He was Chairman and Chief Executive of Bass plc (latterly InterContinental Hotels) and Chairman of the World Travel and Tourism Council. He is non-executive Deputy Chairman of BP plc and a non-executive director of Sara Lee Corporation. He is also a member of the CBI President's Committee.



**Dr Lucy Shapiro**

Dr Shapiro is Ludwig Professor of Cancer Research in the Department of Developmental Biology and Director of the Beckman Center for Molecular and Genetic Medicine at the Stanford University School of Medicine. She holds a PhD in molecular biology from Albert Einstein College of Medicine.

## Managing corporate responsibility continued

### OUR CR PRINCIPLES

Our Corporate Responsibility Statement and Principles (below) identify our key corporate responsibility issues and provide guidance for employees on the standards to which the company is committed.

#### Corporate Responsibility Statement and Principles

The mission of our business – to improve the quality of human life to enable people to do more, feel better and live longer – focuses on the needs of patients. We will achieve this mission through our products and activities, while enhancing the contribution we make to society, sustaining economic performance and operating in an environmentally responsible manner.

#### Employment practices

We will treat our employees with respect and dignity, encourage diversity and ensure fair treatment through all phases of employment. We will provide a safe and healthy working environment, support employees to perform to their full potential and to take responsibility for the performance and reputation of the business.

#### Human rights

We are committed to upholding the UN Universal Declaration of Human Rights, the OECD guidelines for MNEs and the core labour standards set out by the International Labour Organisation. We expect the same standards of our suppliers, contractors and business partners working on GSK's behalf.

#### Access to medicines

We will continue to research and develop medicines to treat diseases of the developing world. We will find sustainable ways to improve access to medicines for disadvantaged people, and will seek partnerships to support this activity.

#### Leadership and advocacy

We will establish our own challenging standards in corporate responsibility, appropriate to the complexities and specific needs of our business, building on external guidelines and experience. We will share best practice and seek to influence others, while remaining competitive in order to sustain our business.

#### Community investment

We will make a positive contribution to the communities in which we operate, and will invest in health and education programmes and partnerships that aim to bring sustainable improvements to under-served people in the developed and developing world.

#### Engagement with stakeholders

We want to understand the concerns of those with an interest in corporate responsibility issues. We will engage with a range of stakeholders and will communicate openly about how we are addressing CR issues, in ways that aim to meet the needs of different groups while allowing us to pursue legitimate business goals.

#### Standards of ethical conduct

We expect employees to meet high ethical standards in all aspects of our business, by conducting our activities with honesty and integrity, adhering to our CR principles, and complying with applicable laws and regulations.

#### Research and innovation

In undertaking our research and in innovating:

- we may explore and apply new technologies. We will constructively engage stakeholders on any concerns that may arise;
- we will ensure that our products are subject to rigorous scientific evaluation and testing for safety, effectiveness and quality;
- we will comply with or exceed all regulations and legal standards applicable to the research and development of our products.

#### Products and customers

We will promote our products in line with high ethical, medical and scientific standards and will comply with all applicable laws and regulations.

#### Caring for the environment

We will operate in an environmentally responsible manner through systematic management of our environmental impacts, measurement of our performance and setting challenging performance targets. We will improve the efficiency of all our activities to minimise material and energy use and waste generated. We aim to find opportunities to use renewable materials and to recycle our waste.

## Managing corporate responsibility continued

### STAKEHOLDER ENGAGEMENT

Engaging with the different groups that have an interest in the way we operate is an important part of responsible business practice. Our stakeholders include employees, investors, patients, doctors, governments, NGOs, multilateral organisations, local communities, suppliers and the scientific community. By listening to them and being open about our views and actions we can build trust and address their concerns.

Most of this discussion takes place in the normal course of business. For example our scientists meet regularly with academics, researchers and other pharmaceutical companies. Through our access to medicine and community investment programmes we collaborate with NGOs, multilateral agencies, governments and community groups. More information is available on stakeholder interaction in the following sections: Access to Medicines, Animal Research, Employees, Suppliers, and Government and External Affairs.

In 2005 we established a panel of external stakeholders to provide ongoing advice and comment on our EHS performance. The panel is facilitated by The Environment Council, an independent NGO. See EHS Management.

We also seek stakeholder feedback to inform our approach to managing and reporting on CR issues. In 2005 this included:

- Engagement with socially responsible investors (SRI). During 2005 we had more than 30 meetings with SRI analysts and discussed issues including access to medicines, animal rights, supply chain, sales and marketing ethics and clinical trials. Fifteen SRI analysts attended our annual corporate responsibility (CR) briefing and met with 12 senior GSK managers.
- A survey of 51 corporate responsibility opinion leaders in Europe, the UK and the US. Participants included academics, CR organisations, customers, government agencies, investors, the media, multilateral agencies and NGOs.
- A survey of GSK employees. This assessed employee awareness of CR issues and sought their views on the key CR issues for GSK.

This section contains a summary of the feedback we received through these channels and details of how we are responding.

### Stakeholder feedback

This section summarises feedback on our corporate responsibility (CR) performance and reporting from CR opinion leaders, SRI investors and employees.

#### CR opinion leader survey

The CR opinion leader survey sought views from 51 people on our CR performance and reporting through telephone interviews. The survey provided in-depth qualitative feedback but was not designed to produce statistics. This is the second year we have commissioned this survey. Nineteen of the participants in 2005 also took part in the 2004 survey. The survey was conducted by an external organisation.

#### Findings

Overall, participants rated GSK's CR performance more highly than in 2004..

A significant number also wanted to understand more about how our approach to corporate responsibility is integrated with business strategy and management. In addition they identified six priority issues for GSK:

- Access to medicines
- Marketing ethics and advertising
- Research and development of new drugs
- Clinical trial ethics and publication of trial results
- Drug pricing
- Environmental impacts

**Access to medicines** – We received positive feedback on our access to medicine programmes in developing countries, including preferential pricing and research into diseases of the developing world. Several stakeholders wanted GSK to adopt a tiered pricing system for middle income countries and extend access programmes in developed countries.

**Marketing ethics and advertising** – Respondents felt our reporting was weakest on marketing ethics. Participants wanted us to be more open about our marketing practices and show how ethical dilemmas are addressed.

**Research** – There was praise for our Clinical Trial Register. More information was wanted on research ethics, our relationships with the medical profession and how research areas are chosen

**Drug pricing** – Participants, particularly in the US, wanted to know how prices are set. There was criticism of profits made by pharmaceutical companies.

## Managing corporate responsibility continued

**Environment** – Participants welcomed the breadth of our programmes and quantitative targets. They wanted more on our environment strategy and materials efficiency programmes and for GSK to set a more ambitious CO2 target and implement programmes to address pharmaceuticals in the environment.

### CR Reporting

Participants were asked to comment on our 2004 CR Report. They liked its comprehensive coverage and

increased transparency but felt it did not show which CR issues GSK considers most important to its business or convey how our approach to CR supports our overall business strategy.

The majority thought GSK's reporting would be improved by providing more detail on how stakeholder engagement influences our approach to CR, bringing more external voices into the report, being more open about challenges, and increasing the number of performance indicators.

### Feedback from investors

GSK received the following ratings from investors and rating agencies:

| Organisation  | Rating   |
|---|--|
| Association of British Insurers                           | GSK was given a 'full' rating for its disclosure of Board responsibilities and policies relating to social, ethical and environmental issues. This is the highest possible rating.   |
| Dow Jones Sustainability Index                            | GSK was included in the DJSI World Index. We came 2nd in the sector with a score of 82% (up from 76% in 2004).   |
| FTSE4Good index   | GSK was included in the FTSE4Good Index.   |
| EIRIS   | GSK was rated 'Good' in the EIRIS draft report on Access to Medicines. Only one other company achieved this top rating.  |
| Global 100 Most Sustainable Companies – Corporate Knights | GSK was included in the Global 100 Most Sustainable Companies, based on research by Innovest Strategic Value Advisors. GSK is one of only three pharmaceutical companies listed  |
| Morley Fund Management                                    | GSK's rating improved from A3 to A2 due to greater disclosure and management of key impact areas such as R&D into developing world diseases, access to medicines, ethical issues in R&D, human rights, EHS, and business ethics. |
| Oekom Research  | GSK was rated best in sector by Oekom's Corporate Responsibility Rating. We received a B rating, an improvement from B- in 2002.   |
| Sarasin Bank  | GSK was rated one of the three best performers in the industry based on analysis of company CR reports.  |
| Covalence   | GSK was ranked as the top company across all sectors in Covalence's ethical ranking of the world's biggest companies.  |



## Managing corporate responsibility continued

### Feedback from employees

An online CR survey was sent to 980 randomly selected GSK employees to assess awareness of our CR performance and reporting. In total, 375 took part mainly from the UK and US, a 38% response rate. The findings showed that:

- 70% had heard of the term corporate responsibility or corporate social responsibility
- 27% were aware that GSK produces a corporate responsibility report. Of these, most had heard about the report from the myGSK global news site or gsk.com
- Respondents felt that the CR issues of most importance to GSK are: ethical business conduct (88%), access to medicines (50%), health and safety (48%), the environment (25%)
- 70% were aware of GSK's ethics programmes. For access to medicines this was 68%, health and safety 66%, R&D processes 57%, employment practices 47%, sales and marketing practices 46%, community partnerships 43%, environment 33%.

We are looking at ways to increase employee awareness of our approach to CR and CR reporting. An internal communications programme is being undertaken and we will conduct a follow-up survey in 2006 to measure its impact.

### How we are responding

We reviewed our Corporate Responsibility Report in the light of stakeholder feedback and have addressed many of the points they made. This includes providing a better explanation of how corporate responsibility (CR) relates to our business strategy and more discussion of the challenges and dilemmas we have encountered.

Additional content has been provided this year in the following areas:

- Our approach to public policy and political lobbying. We are publishing our positions on key policy issues as well as our membership of trade associations and political donations in 2005.
- More on our marketing ethics policies and how we implement them, including data on the number of employees disciplined or dismissed for unethical conduct.
- Our approach to advertising to consumers.
- Our approach on payments to healthcare practitioners conducting GSK clinical trials.

- GSK's approach to the authorship of research articles in medical journals in response to concerns about 'ghost-writing'.
- Our relationship with patient advocacy groups. We are publishing a list of all the patient groups which received financial support from GSK in 2005.
- Our approach to preferential pricing in middle income countries and why we do not operate a tiered pricing system.
- Information about our pilot project to assess the benefits of extending preferential pricing to more products.
- More information on how we manage human rights standards in our supply chain.
- More information on our environment strategy and efforts to improve materials efficiency.

Sometimes we receive feedback and suggestions from stakeholders that we disagree with or are unable to accommodate without damaging the interests of the company and its shareholders. Where possible we explain the reasons for this, for example the need to use animals in research.

It is not possible to provide quantitative data or meaningful indicators for all areas of our CR performance. We will continue to review the performance indicators that we publish and build on them where possible.

We will continue to engage with stakeholders to understand their views of our approach to CR.

### GOVERNMENT AND EXTERNAL AFFAIRS

The pharmaceutical industry is highly regulated and these regulations can have a significant impact on our business. It is therefore important that we engage in debate on legislation and seek to influence policy decisions that affect GSK. In fact, as a major multinational corporation we are often approached by governments to give our views, along with other stakeholders such as NGOs.

Our size and global reach give us access to governments and policy makers. We recognise that we need to use this access responsibly to benefit patients and our business. Our public policy work is governed by our External Affairs Code of Conduct, and backed up by factual research and analysis. GSK's External Affairs teams monitor changes and proposed reforms to legislation and meet regularly with government officials to explain our views on a range of public policy issues.

## Managing corporate responsibility continued

Lobbying on issues affecting the whole pharmaceutical industry is sometimes conducted through trade associations. We may also hire professional lobbyists to support our public policy work.

GSK believes that, where legally and culturally appropriate, political donations are a legitimate way of supporting the political process. We have a Political Donations Policy that governs our activity in this area. Information on donations is given both in this report and in the Annual Report and Accounts.

In addition, we have policies governing our interactions with other important stakeholders such as patient advocacy groups.

This section describes:

- Our membership of trade organisations
- US lobbying expenditure in 2005
- Political donations
- Our position on key issues
- Our approach to patient advocacy and the patient groups we supported in 2005.

GSK was one of eight companies given a 'systematic' rating by SustainAbility and WWF in their survey of how 100 leading companies report on their lobbying practices. This was the highest rating awarded. A company received a 'systematic' rating if "Coverage of lobbying indicates that systems exist to actively manage and disclose lobbying and public policy activities. The company likely discusses policy positions on several material issues in some depth. However, approach to lobbying is still not fully integrated with company values, business principles and core business decision-making."

More background information on our approach to public policy is available in the External affairs section of [gsk.com](http://gsk.com).

### Membership of trade associations

GSK is a member of trade organisations including:

- Association of the British Pharmaceutical Industry (ABPI)
- Biotechnology Industry Organization (BIO)
- European Federation of Pharmaceutical Industries (EFPIA)
- Intellectual Property Owners Association (IPO)
- Japan Pharmaceutical Association
- LIF (The Swedish Association of the Pharmaceutical Industry)

- Organization For International Investment (OFII)
- Pharmaceutical Research and Manufacturers of America (PhRMA)

### US lobbying expenditures

GSK spent \$4,860,000 on federal lobbying activities in the US during 2005. This information is reported to the US Congress in accordance with the Lobbying Disclosure Act of 1995. This figure includes the salaries and cost of benefits for all employees registered to lobby the US government, as well as the cost of hiring any outside lobbying consultants, the cost associated with the support of lobbying contacts, such as planning activities, research and other background that is necessary. In addition the figure includes the cost of our running the GSK Washington DC government affairs office; support staff, the portion of trade association fees associated with federal lobbying and other costs of our activities in dealing with the US Federal government.

We do not collect data on lobbying expenditure, separately from other expenses in other countries.

### Political donations

GSK makes political donations with corporate funds where such donations are authorized by law and are culturally appropriate. In 2005 we contributed £320,000 to political organisations in the US and Canada. The majority of donations are made in the US. All donations are covered by the GSK policy on political donations.

GSK does not make donations to political parties or other political organisations in the European Union. See our Annual Report for more information.

### Contributions in the United States

In the US, candidates are financed primarily by contributions from companies, individuals, NGOs and other parties. The rules concerning contributions are complex – for more information on the exact process please go to [\[link to appropriate legislation\]](#). However it is important to note that corporate funds cannot be used to support candidates for federal office.

GSK corporate funds are only given to candidates at state level, in those states where such contributions are allowed by state law. These contributions are an accepted and important way for companies to engage in the political debate. In 2005, we donated \$548,000 (approximately £301,000) to candidates for state-held offices in the US.

GSK contributions are not made on the basis of political party. GSK supports candidates who seek an environment that appropriately rewards high-risk, high-investment industries and believes in free market principles and



## Managing corporate responsibility continued

intellectual property rights. All states make information about political donations publicly available.

Corporate contributions to national political parties and candidates running for federal office are prohibited by US law. In accordance with the Federal Election Campaign Act, there is a GSK Political Action Committee (PAC) that facilitates voluntary political contributions by eligible employees. The PAC is not controlled by GSK but by our participating employees, who have the legal right to set up a PAC and make contributions to candidates and political parties at the federal and state levels. The GSK PAC is run by employees and all contributions are voluntary. PAC contributions are subject to strict limitations. For example, the GSK PAC may not contribute in excess of \$5,000 to a candidate for federal office per election.

PAC contributions are determined by a governing board of PAC-participating GSK employees from across the company. As required by law, PAC contributions are reported to the Federal Elections Commission (FEC), the agency that oversees federal election activities. In 2005, the first half of the two-year federal election cycle, the GSK employees' PAC contributed \$514,000 in total to 379 candidates for state and federal offices.

### Contributions in Canada

In 2005, GSK donated \$CAD 42,000 (approximately £19,000) in Canada to political candidates in those provinces where it is legal.

### Contributions in Other Countries

No contributions were made in other countries during 2005.

### Our position on key issues

There is a wide range of issues that affect the industry and it is important that we have clear positions to contribute to the debate.

There is some criticism that companies are not transparent about their positions on key issues. GSK considers that, by definition, when we lobby on an issue then it becomes public and we prepare all position statements assuming that this will be the case. While we publish position statements on many key issues on our website, it would be impractical and inefficient to do this with every issue on which we have a view. We are however, happy to discuss our position on any issue with legitimate parties.

The issues covered on the website change as and when new issues or updated statements are prepared. The current position statements can be found at [www.gsk.com/](http://www.gsk.com/). The current issues covered include:

- Clinical trials in developing countries
- Counterfeit medicines
- Developing world challenges and access to medicines
- Importation of medicines
- Intellectual property and the TRIPS agreement
- Product diversion
- Preparations for a flu pandemic

### Patient advocacy

Patient advocacy groups provide their members with support and information on how to live with their condition, represent patient views and advocate on issues affecting patients' interests. They are an important stakeholder for GSK and we engage with them as part of our aim to be a patient-focused company.

GSK is committed to ensuring that the company works ethically with patient groups, and that the groups' independence and credibility are not compromised. A global set of principles supports this focus:

### GSK principles for working with patient groups

1. The independence of patient associations, of their political judgement and of their activities shall be assured.
2. In all co-operative matters, transparency is vital.
3. Any joint policies undertaken between patients associations and GlaxoSmithKline shall be based on mutual respect and trust.
4. GlaxoSmithKline shall refrain from using undue influence to promote its specific medicines or services.
5. When working with patient associations GlaxoSmithKline will always comply with local laws/governance.

Throughout 2005 the company focused on communicating these principles externally to patient groups as well as, within internal training programmes, to ensure that GSK employees act appropriately with patient groups.

## Managing corporate responsibility continued

Patient Advocacy Leaders' Summits (PALS) are one of the ways we engage with patient groups. In 2005 there were regional summits across North America, in individual European countries and for the first time, there was a pan-European summit in Brussels. These meetings give patient groups the opportunity to learn more about GSK, and tell the company how it can better support their work. There are typically a range of workshops for attendees, including sessions on media-training and sharing best practice. The patient group representatives are also able to discuss and debate key issues relating to patient advocacy and healthcare policy. Attendees represented a wide range of patient groups including those dedicated to cancer, diabetes, HIV/AIDS, respiratory diseases, mental health and epilepsy.

The GSK European patient group advisory board was formed in 2005. It considers how the voice of patients can be strengthened across Europe. It is also a sounding-board that allows GSK to have a forum to consult patient groups on the future policy direction of the company, as well as a forum for the groups to raise policy issues that are important to them. The board has an independent chair from the European Cervical Cancer Association, and is made up of representatives from a series of European groups.

In the USA and in Europe GSK is playing a leading role, within the pharmaceutical industry and amongst healthcare stakeholders, to ensure that patient groups maintain their independence.

In the UK GSK's advocacy work is governed by the Association of the British Pharmaceutical Industry (ABPI) Code of Practice which was revised in 2006. The new code states that there must be a written agreement with all patient groups that companies work with, and that there must be a list of all patient groups receiving financial support from companies. The GSK list is available on our website.

# Access to medicines

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## Access to medicines

Millions of poor people in both developed and developing countries cannot obtain the medicines they need. This is part of a broader problem of access to healthcare which remains a significant challenge in many parts of the world. The primary responsibility for addressing this problem rests with governments, but all stakeholders, including the pharmaceutical industry, have important contributions to make.

This section describes how GSK is supporting efforts to improve access. It covers our:

- Contribution to the developing world through research, preferential pricing, partnerships and voluntary licences, and community investment in important public health initiatives;
- Pricing arrangements and discount cards for middle-income countries;
- Patient Assistance Programs and discount cards to help uninsured patients in the US.

We believe that our response is not only the right thing to do but makes good business sense. Companies that adapt their business practices to address such challenges will be the leaders of the future. In the competitive market for talented people this also helps us to attract and retain the best people.

Overall we need to make adequate returns on our business activities to enable us to invest in the R&D to bring new medicines and vaccines to patients. It is this innovation that underpins the sustainability of the company.

By finding innovative ways to help poor people in developed and developing countries access our medicines, we are addressing ethical, reputational and commercial imperatives. For these reasons access to medicines is a strategic business driver of GSK.

We also support under-served communities worldwide through donations, funding and practical support, see Community investment.

### DEVELOPING WORLD

There is a healthcare crisis in many parts of the developing world. Millions of people do not have access to adequate food and clean water. Sometimes the political will is lacking, and even when it is evident, governments often do not have the resources to fund the clinics and staff needed to deliver even basic healthcare. The AIDS pandemic has made these problems worse, creating a generation of orphans and depriving communities of their greatest asset – fit, healthy and productive people.

Tackling this crisis is a complex challenge. Poverty is the fundamental cause and a huge barrier to progress. Significant political will and extra funding are needed from new national and international sources to aid development and build healthcare infrastructure. We welcome the additional resources promised by the G8 during 2005.

We believe that it is the responsibility of governments and intergovernmental agencies, supplemented by the work of many NGOs, to deliver the healthcare needed in these countries. However, the pharmaceutical industry can play a significant role in supporting their efforts.

We make an important contribution through:

- Research and development into diseases disproportionately affecting developing countries. We believe GSK is currently the only company researching both new vaccines and treatments for HIV/AIDS, TB and malaria – the World Health Organization's three priority diseases. Much of this research is conducted through public private partnerships.
- Preferential pricing, specially reduced prices for antiretrovirals (ARVs), anti-malarials and vaccines. In 2005, we shipped a combined total of 126 million preferentially-priced *Combivir* and *Epivir* tablets for the treatment of HIV/AIDS to the developing world;
- Granting voluntary licences. GSK has granted seven voluntary licences for the manufacture and supply of generic versions of our leading ARVs for treating HIV/AIDS in Africa;

## Access to medicines continued

- Community investment in public health initiatives and partnerships that foster effective healthcare including major programmes to tackle lymphatic filariasis, malaria, HIV/AIDS and diarrhoeal disease.

### Research and development

The research and development (R&D) of new drugs and vaccines is an essential element in improving health in the developing world. There are still no effective treatments for some widespread and life-threatening diseases. Many existing treatments for diseases such as malaria are becoming less effective due to drug resistance.

Many diseases disproportionately affect the developing world. But lack of resources means there is often no viable commercial market for new treatments. Public private partnerships (PPPs) are helping to address this problem.

GSK collaborates with several PPPs including the Medicines for Malaria Venture (MMV), the Global Alliance for TB Drug Development (GATB), the Aeras Global TB Vaccine Foundation (Aeras), the Malaria Vaccine Initiative (MVI) and the International AIDS Vaccine Initiative (IAVI).

GSK has created a dedicated group in our pharmaceutical R&D organisation, to focus on diseases of the developing world (DDW). This includes a dedicated drug discovery centre at our Tres Cantos R&D site in Spain and clinical development experts in the UK and US. DDW projects are prioritised according to their social and public health benefits rather than their commercial returns. A similar group exists in our vaccines organisation based in Belgium.

Unlike many diseases that disproportionately affect the developing world, HIV/AIDS is different because it affects both developed and developing countries, so there is a commercial market for new treatments. This encourages investment in the required R&D. GSK is an industry leader in research into HIV/AIDS treatment.

In total GSK has 13 clinical programmes for medicines and vaccines against eight diseases<sup>1</sup> particularly relevant to the developing world. Seven of these projects are for diseases that disproportionately affect developing countries.

### Public private partnerships

GSK wants to continue investing in research to tackle diseases that blight the developing world. However, there is a dilemma. Pharmaceutical companies must be profitable to sustain their business and to continue to develop new medicines. This business model does not work in cases where there is no prospect of a commercial return. Unfortunately, because of the lack of resources in endemic countries, there is limited profit to be made from new treatments for many diseases that disproportionately affect developing countries.

The public private partnership (PPP) model, in which business and the public sector work together, offers a solution to this problem.

In a PPP, companies such as GSK provide the R&D, technology, manufacturing and distribution expertise. Academic institutions may also be involved providing research and disease area knowledge. Public sector partners, such as governments, or organisations such as the Gates Foundation, help fund the development and delivery costs and ensure that medicines get to the people who need them. Funds are usually channelled through organisations such as the Medicines for Malaria

Venture (MMV) or the Malaria Vaccine Initiative (MVI). Importantly, any new treatments resulting from these research efforts are made accessible to the developing world at an affordable price.

Initial drug discovery for diseases of the developing world (DDW) takes place at our dedicated DDW Discovery Centre at Tres Cantos. GSK provides the facilities and meets all the costs of running the site. There are 100 scientists employed by GSK at Tres Cantos half of whom are subsidised by our partner organisations – the Medicines for Malaria Venture (MMV) and the Global Alliance for TB Drug Development (GATB). Research programmes are overseen by joint steering committees with representatives from GSK and our partner organisations.

As compounds move into clinical development, GSK provides the clinical, regulatory and manufacturing expertise and resources through our global R&D and supply network. Partner organisations help fund the cost of running clinical trials and address issues of access and distribution. This reduces the costs of development and gets new products to patients faster.

## Access to medicines continued

### Development Pipeline at end of 2005 for diseases relevant to the developing world\*

| Focus    | Pre-clinical Activity | Phase I                             | Phase II                               | Phase III   | Marketed  |
|----------|-----------------------|-------------------------------------|--|---|---|
| HIV      | ✓                     |                                     | Protease Inhibitor (brecanavir)        |   | <i>Retrovir, Epivir, Combivir, Ziagen, Trizivir, Agenerase, Epzicom/ Kivexa, Lexiva/Telzir</i>  |
| Vaccines | ✓                     | HIV<br>TB                           | Malaria<br>Hepatitis E<br>Dengue Fever | <i>Streptorix</i> (S. pneumoniae paediatric)<br><i>Cervarix</i> (cervical cancer)<br>N. meningitis combinations | <i>Rotarix</i> – (Rotavirus)<br><i>Havrix</i> – (Hepatitis A)<br><i>Engerix-B</i> – (Hepatitis B)<br><i>Twinrix</i> – (Hep A&B)<br><i>Infanrix/Tritanrix</i> – DTP family (Diphtheria, Tetanus, Pertussis)<br><i>Boostrix</i> (Diphtheria, tetanus, Pertussis acellular)<br>Polio Sabin – (Polio)<br><i>Priorix</i> – (Measles, Mumps and Rubella)<br><i>Typherix</i> – (Typhoid)<br><i>Hepatyrix</i> – (Typhoid, Hepatitis A)<br><i>Varilrix</i> – (Varicella)<br><i>Hiberix</i> – (Haemophilus influenzae type b)<br><i>Mencevax ACW</i> – (meningitis) |
| Malaria  | ✓                     | N-tert butyl isoquine (GSK369796)** |  | tafenoquine CDA (chlorproguanil dapsone + artesunate)   | <i>Lapdap, Halfan, Malarone</i>   |
| TB       | ✓                     |                                     |  |   |   |
| Other    |                       |                                     |  | sitamaquine (visceral leishmaniasis)  | <i>Zentel</i> (de-worming agent)<br><i>Pentostam</i> (visceral leishmaniasis)<br><i>Banocide</i> (Lymphatic Filariasis – GSK India)   |

\*more detailed information on our product pipeline can be found in the Annual Report

\*\*isoquine should enter phase 1 in 2006

### Progress in 2005

#### Malaria

In 2004, phase IIb clinical trials of our malaria vaccine for children, that has been in development for 15 years, showed unprecedented results. In 2005, new data published in the leading medical journal, the Lancet, showed that the vaccine remained efficacious over 18 months. Several more years of clinical investigation will be needed before this vaccine is ready for use but these results indicate it has the potential to help save millions of children's lives. To support this activity, in October the Bill & Melinda Gates Foundation announced a grant to the PATH Malaria Vaccine Initiative (MVI) to extend the public private partnership between MVI and GSK Biologicals. Most of the new grant will directly support clinical trials in Africa. From its own funds, GSK will at least match the \$21.4 million it receives from MVI, to help defray some of the clinical development costs.

We are working with the Medicines for Malaria Venture (MMV), the World Health Organisation (WHO) and academic partners to develop CDA, an affordable fixed-dose artemisinin combination treatment for malaria in Africa, based on GSK's existing anti-malarial, *Lapdap*. In November 2005 we announced clinical results indicating that CDA is likely to be effective against drug resistant *P falciparum* malaria as found in Africa. CDA has now progressed into phase III trials. Dr Chris Hentschel, CEO of MMV commented, "These results suggest that CDA could become a major weapon in the fight against drug-resistant malaria. Moving into phase III trials marks a key step in the development of this promising antimalarial."

## Access to medicines continued

During 2005 GSK and the University of California, San Francisco received MMV's Project of the Year award for our falcipain project, investigating a new class of compounds for use against malaria. We are now conducting further research to identify candidate compounds for development in 2006. GSK also received the Project of the Year award in 2004 for our pyridones project. This is the first time that a company has won in successive years.

Following extensive development work in 2005, we hope to identify a suitable candidate for our pyridones project in the first half of 2006 and commence Phase I trials in humans in 2007.

Significant chemical and pharmaceutical development was undertaken on our candidate GSK369796 (n-tert butyl isoquine) for malaria and we plan to start clinical studies in humans in 2006. During 2005 we progressed our clinical development programme for tafenoquine, a new antimalarial being developed in partnership with the US government's Walter Reed Army Institute of Research.

Additionally, we have a number of other targets with potential potency against malaria that we are working on at our Tres Cantos site or with our collaborators.

### HIV/AIDS

In November 2005, GSK and the Institut Pasteur announced a new European collaboration to develop an AIDS vaccine by fusing genes from the human immunodeficiency virus (HIV) onto an existing measles vaccine. GSK will license the measles vaccine vector technology from Institut Pasteur and the two entities will jointly develop the AIDS vaccine. The project is being supported by a €5.5 million (£3.7 million) grant from the European Union and will include development of a production process for the experimental vaccine as well as two clinical studies. The first study will evaluate the safety profile of the vaccine candidate. The second will examine safety and whether the vaccine produces an immune response against HIV in volunteers with pre-existing immunity to measles. The clinical studies will begin in the third year of the five year collaboration.

Earlier in 2005, we also launched a public private partnership with the International AIDS Vaccine Initiative (IAVI) to develop an AIDS vaccine using nonhuman primate adenovirus vector technology. The collaboration – the first-ever in AIDS vaccine research between IAVI and a major vaccine company – will facilitate research into vaccines against types of HIV that circulate predominantly in Africa. Under the agreement, IAVI will contribute technical expertise and funding, and GSK and IAVI researchers will form a joint research team.

GSK Biologicals also has an in-house AIDS vaccine development project using the company's proprietary adjuvant technology. A successful AIDS vaccine might need to combine several of these approaches.

We had mixed results in our antiretrovirals research in 2005. In December we announced positive results from a study evaluating the safety, tolerability and antiviral activity of our investigational protease inhibitor, brecanavir. Brecanavir is now expected to enter phase III development in 2006. If approved, it may be useful in treating patients infected with strains of HIV that have become resistant to multiple protease inhibitors.

In October we terminated the clinical trial of aplaviroc, our CCR5 antagonist, due to concerns over liver toxicity. We are reviewing the safety data and following-up with all patients.

The red tablet versions of our HIV/AIDS medicines *Combivir* and *Epivir*, developed to avoid diversion, became the first medicines of any kind to be granted a positive scientific opinion by the European Medicines Agency (EMA) Committee for Medicinal Products for Human Use. This opinion was granted under Article 58 of EU Regulation 726/2004 which allows the EMA to give a scientific opinion on medicines intended for use outside the EU. The EMA can now grant a Certificate of Pharmaceutical Product to facilitate registration of these ARVs in developing countries.

Liquid formulations of HIV medicines are currently the only way to treat very young children. However they are not always easy to use in a developing world setting and the WHO and UNICEF have stated that access to solid formulations would facilitate the treatment of older children. We are currently assessing the development of ARV tablets with a score line which can be more easily broken into smaller doses. This will help physicians and carers administer the right dose efficiently and safely to children. We organised and hosted a meeting in September 2005 with representatives from the EMA, the FDA, Médecins Sans Frontières, UNICEF and the WHO to discuss the development of scored tablets for children. Our partners showed a great interest in this project and understood the challenges behind this development. We are now consolidating available information into a document for further discussion with regulators during the first half of 2006.

GSK has entered into a material transfer agreement with the International Partnership for Microbicides (IPM) under which GSK will select and provide proprietary anti-HIV compounds to be tested for possible use as microbicides to prevent transmission of HIV.



## Access to medicines continued

We are supporting clinical trials sponsored by external organisations – such as the WHO, the UK's Medical Research Council and US National Institutes of Health (NIH) – through our HIV-collaborative research programme for resource-poor settings. Twenty-four trials, including 18 in Africa, are currently underway mainly focusing on public health issues. Some 12,500 patients currently form, or will form, part of our HIV collaborative studies in the developing world.

### *Tuberculosis (TB)*

TB kills 2 million people a year and is a leading cause of death amongst people with AIDS in the developing world. But no new drugs against TB have been discovered in more than 40 years.

During 2005 GSK announced a joint drug discovery partnership with the Global Alliance for TB Drug Development (GATB), the leading public private partnership working on TB treatments. GATB aims to accelerate the discovery and development of affordable drugs that will shorten treatment and be effective against multi-drug-resistant strains of TB. All compounds will be screened to ensure they can be taken with HIV treatments, since people living with AIDS are often susceptible to TB infection. GATB will support 25 full-time scientists working exclusively on the TB drug programme at Tres Cantos. GSK will contribute a matching number of staff and all remaining overhead costs. Under this partnership, GSK is screening a number of compounds for possible use as new classes of drugs with potency against TB. Any medicines discovered will be made as affordable and accessible as possible to those most in need.

GSK continues to provide funds to the Faculty of Health Sciences at Stellenbosch University, South Africa for TB research projects. These projects aim to identify markers that can predict whether patients will respond quickly to treatment or if TB is likely to recur.

In October 2005, GSK and the Aeras Global TB Vaccine Foundation announced a new public-private partnership to develop GSK's TB candidate vaccine which has shown promising results in early-stage clinical trials. GSK and Aeras plan to conduct additional trials in Europe involving adults previously infected with TB or vaccinated with Bacillus Calmette-Guérin (BCG). Studies will then begin in Africa and other locations to test the safety and efficacy of the vaccine candidate in populations highly affected by TB.

### *Rotavirus*

Our vaccine, *Rotarix*, for the prevention of rotavirus induced gastroenteritis, was launched in Mexico in January 2005 and has now been approved in 15 countries in Latin America. By early 2006, four countries – Brazil, Panama, Venezuela and El Salvador – had decided to vaccinate all new-born babies. We have distributed 1.4 million doses in Latin America, enough for 700,000 babies.

Rotavirus infection is the leading cause of severe diarrhoea and vomiting (gastroenteritis) in children under two and kills around 600,000 children each year – one child every minute - mostly in developing countries. *Rotarix* was tested in the largest phase III clinical trial ever performed for a vaccine, involving over 60,000 children. Since its first launch, *Rotarix* has been licensed in several additional countries worldwide. We continue to seek regulatory approval for the vaccine in other developing countries.

### *Cervical cancer*

Clinical trials data presented at the Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) on our candidate cervical cancer vaccine, *Cervarix*, showed very encouraging results. Cervical cancer is the most common cause of cancer deaths in women in the developing world. Current published data suggest that the vaccine could reduce by 70% a woman's lifetime risk of developing cervical cancer. We plan to apply for registration of the vaccine in the US and Europe as well as our International region during 2006.

### *Leishmaniasis*

During 2005 we continued intensive development of sitamaquine, a new oral treatment for visceral leishmaniasis. This disease affects half a million people a year in the developing world and is usually fatal if untreated. GSK is providing all the funding for this project. A new treatment for visceral leishmaniasis is urgently needed, since current medicines are either impractical or becoming ineffective due to drug resistance. Sitamaquine has shown good efficacy in pilot phase II trials. A further phase IIb study will start in 2006 to investigate a shorter treatment course and positive results will enable phase III studies in 2007.

<sup>1</sup>HIV/AIDS, malaria, leishmaniasis, dengue fever, hepatitis E, N. meningitis, cervical cancer and pneumonia



## Access to medicines continued

### PREFERENTIAL PRICING

Poverty, lack of political will and insufficient medical infrastructure (hospitals, clinics and health workers) are the biggest barriers to accessing healthcare in developing countries.

The affordability of medicines is also important and there are two elements to this. First is the ability of governments or patients to pay for medicines. Solving this problem will require governments and inter-governmental agencies to make significant additional financial resources available.

The second element is the price at which medicines are sold, an area GSK can help to address. We are making key medicines available to developing countries at more affordable prices. This is a major commitment that we call 'preferential pricing' which includes not-for-profit prices for the world's poorest countries, and discounted prices for wealthier developing countries. Other factors in the supply chain such as taxes, tariffs and distributor mark-ups can also have a significant impact on the price of medicines. These factors are out of our control and should be addressed by governments.

All our HIV/AIDS and malaria treatments are available at not-for-profit prices to public sector customers and not-for-profit organisations in all the Least Developed Countries and sub-Saharan Africa, as well as countries with eligible Global Fund and PEPFAR projects. This means that our not-for-profit prices are offered in over 100 countries. Our not-for-profit prices are sustainable – we do not make a profit on them, but we do cover our manufacturing and distribution costs. Therefore we can continue to supply them in the long-term.

Our not-for-profit prices are comparable with generics. *Combivir*, our leading ARV, is available at \$0.65 a day including delivery costs. The latest (June 2005) pricing report by Médecins Sans Frontières<sup>1</sup> shows that the average cost of generic equivalents is \$0.64 a day and the lowest priced generic equivalent costs \$0.50 a day – the generic prices do not include shipping costs and insurance, which are included in our prices.

We negotiate public sector prices with middle-income developing countries on a case-by-case basis, see above.

GSK vaccines are also available at preferential prices. Here we work with multinational organisations such as UNICEF, the World Health Organization and the Pan American Health Organisation, governments and non-governmental organisations, to provide appropriate and affordable vaccines for the developing world. This includes basic polio vaccines as well as specially developed combination vaccines that target several diseases. In 2005, of the 1.2 billion vaccines we shipped, around 90% went to the developing world.

### Progress in 2005

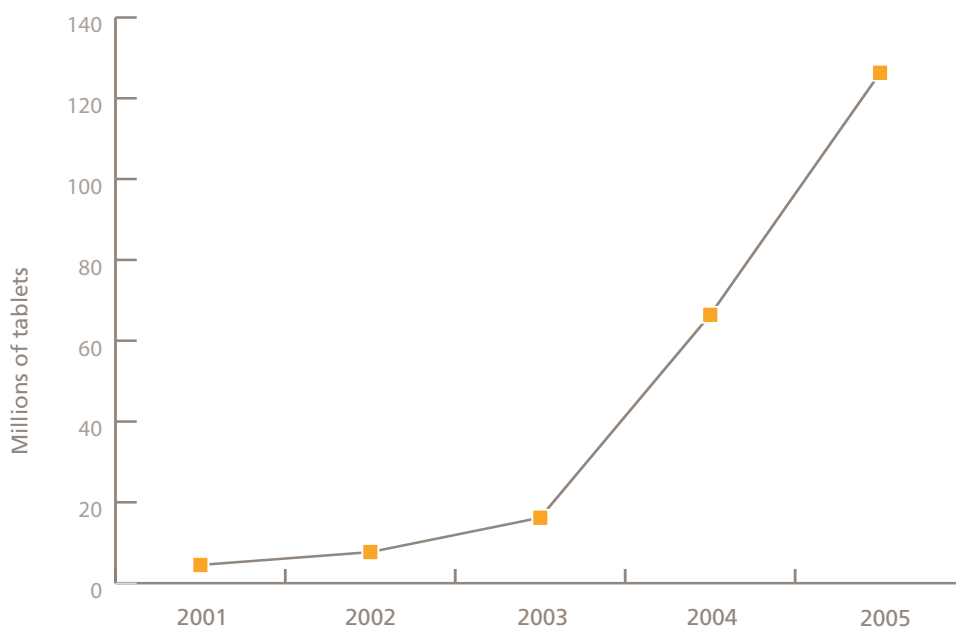
In 2005 we shipped 45 million preferentially-priced *Combivir* tablets, with the majority of these going to Africa. This is a 40 % increase on last year and more than in the previous two years combined. Shipments of *Epivir* grew by 135% to 81m tablets. The number of arrangements we have in place for the supply of preferentially priced ARVs did not change significantly during the year.

Overall shipments are relatively low considering the scale of the HIV/AIDS epidemic but the growth is encouraging. More doctors, hospitals and clinics are needed to treat more patients and ensure better uptake of preferentially priced medicines.

<sup>1</sup> <http://www.accessmed-msf.org/prod/publications.asp?scntid=28620051846504&contenttype=PARA&>

## Access to medicines continued

Shipments of preferentially priced Combivir and Efavir (excluding diverted stock)



Shipments of preferentially priced Combivir and Efavir (excluding diverted stock) - millions of tablets

| Shipments    | Y2001      | Y2002      | Y2003       | Y2004       | Y2005        |
|--------------|------------|------------|-------------|-------------|--------------|
| Combivir     | 3.5        | 6.0        | 11.0        | 32.0        | 45.0         |
| Efavir       | 1.0        | 1.7        | 5.2         | 34.4        | 81.3         |
| <b>Total</b> | <b>4.5</b> | <b>7.7</b> | <b>16.2</b> | <b>66.4</b> | <b>126.3</b> |

## Access to medicines continued

It is difficult to estimate the number of patients treated as a result of our preferential pricing agreements, since GSK does not control healthcare provision. A report from the UN-led Accelerating Access Initiative (AAI), suggests that by September 2005 more than 582,000 people living with HIV/AIDS in developing countries were receiving treatment with at least one antiretroviral supplied by the seven pharmaceutical companies in the AAI (compared with 221,000 people on treatment in 2004). This includes 341,000 patients in Africa. Much remains to be done, but this growth is encouraging.

### *Middle income countries*

We can only afford to supply products at low prices in the world's poorest countries if we can still make an adequate return on them in wealthier markets. Nevertheless, we recognise that many middle-income countries also need assistance.

We negotiate preferential pricing arrangements with middle-income countries on a case-by-case basis. We believe this is the best approach since the disease burden, and resources available to address it vary significantly from country to country. These arrangements combine a viable and sustainable commercial return for GSK with increased affordability for the healthcare systems concerned.

For several more developed countries we are also introducing discount cards for senior citizens, see developed world below.

### *Anti-diversion measures*

Product diversion, where not-for-profit medicines are illegally shipped back for sale in wealthier countries, undermines our ability to provide not-for-profit prices and denies treatment to the intended patients in poorer countries. We have introduced different packaging and tablet colours for many of our not-for-profit medicines to help prevent product diversion. Special tri-lingual 'access packs' are now approved for *Combivir*, *Epivir* and *Trizivir* in over 50 countries, and we have received regulatory approval for the red *Epivir* and *Combivir* tablets in over 25 countries. GSK has nine ARVs registered under the EU's Anti-Diversion Regulation. We are the only company to have registered products under this regulation.

### *Extending preferential pricing*

We set up five pilot projects in collaboration with NGOs in Tanzania, Uganda, Nigeria, Zambia and Malawi to assess the impact of extending preferential pricing to a wider range of products, such as antibiotics and asthma treatments.

### Eligibility for not-for-profit prices

Our not-for-profit prices are targeted at those countries where the need is greatest and the available resources are most lacking. These are the Least Developed Countries (LDCs) and all of sub-Saharan Africa (SSA) – a total of 64 countries. In addition, all private employers in sub-Saharan Africa who provide care and treatment to their uninsured staff can purchase our ARVs at not-for-profit prices. The not-for-profit prices are also offered to all Country Co-ordinating Mechanism (CCM) projects<sup>2</sup> fully funded by the Global Fund and projects funded by the US President's Emergency Plan for AIDS Relief (PEPFAR), in their 15 focus countries. In total our not-for-profit prices are therefore offered in over 100 countries.

In our target countries we also seek not-for-profit arrangements to facilitate access for core public employees such as teachers, nurses, police and fire-fighters who are not covered by private health insurance schemes.

We negotiate prices with the private health sector on a case-by-case basis. We depend on revenues from sales to the private market to maintain a local presence and much-needed infrastructure in developing countries. Without this local capacity we would be unable to provide essential services such as training healthcare workers to use our products, product support, safety monitoring and registration and launch of new products.

A list of products covered by not-for-profit prices and eligible countries is available on our website.

As expected we found that pricing is just one of a number of factors that affect the accessibility of medicines. Lack of healthcare capacity and infrastructure were more fundamental barriers. However, making our products available at more affordable prices did expand usage. There also appeared to be a preference for our products over similarly priced generics. We are evaluating the findings from the pilots and will use them to inform a strategic review of our business in sub-Saharan Africa.

<sup>2</sup>The vast majority of Global Fund projects are Country Co-ordinating Mechanism (CCM) projects

## Access to medicines continued

### VOLUNTARY LICENSING

We want to play an active role in addressing the healthcare crisis in developing countries. We believe preferential pricing arrangements are the best way to do this, because we are able to ensure delivery of a safe, quality product at an affordable price for as long as it is needed. This is where we focus our efforts. But in some situations voluntary licences may also help to increase the supply of medicines.

Voluntary licences (VL) enable local manufacturers to produce and sell generic versions of our products. In November 2005 we signed a licencing agreement with Universal Corporation of Kenya. In total we have now signed seven licencing agreements for our antiretrovirals (ARVs) in Africa, where HIV/AIDS is having a devastating impact. This includes two VLs in Kenya and five in South Africa, the first of which was granted to Aspen Pharmacare in October 2001. Some cover just parts of Africa and others all of sub-Saharan Africa.

A decision to grant a VL depends on a number of factors including the severity of the HIV/AIDS epidemic in that country, local healthcare provision and the economic and manufacturing environment. VLs are not a universal solution to HIV/AIDS but a specific response to a particular set of circumstances.

We discuss VLs with potential partners on a case-by-case basis. Selecting the most appropriate licensee is key. We need to be sure that the manufacturer will be able to provide a long-term supply of good-quality medicines and will implement safeguards to prevent the diversion of medicines to wealthier markets.

Voluntary licence holders can combine the active ingredients they have licensed from us with other licensed active ingredients to produce fixed dose combinations. They can also use the US Food and Drug Administration's fast track approval process for ARVs to accelerate the availability of generic ARVs for PEPFAR (US President's Emergency Plan for AIDS Relief) program for programmes in Africa.

There has been much discussion about the use of compulsory licences, under which intellectual property rights are taken away from rights holders. Compulsory licenses are one of the flexibilities in the World Trade Organisation's TRIPs agreement on intellectual property, which can be used for humanitarian purposes. GSK believes that widespread use of compulsory licences will undermine the intellectual property framework and be counter-productive in the long term. R&D into new treatments, especially where commercial markets exist, such as for HIV/AIDS, depends on protection for intellectual property.

### INVESTMENT IN PUBLIC HEALTH INITIATIVES

GSK supports public and community health initiatives in developing countries through donations of preventative medicines, and financial and practical support.

We focus this charitable support on efforts to tackle three major diseases – lymphatic filariasis (LF or elephantiasis), HIV/AIDS and malaria – as well as our PHASE education programme to reduce diarrhoea-related disease. We partner with non-profit organisations to progress these efforts.

For more information on our community investment programmes in 2005, see Community Investment.

#### Progress during 2005

##### Eliminating Lymphatic Filariasis (LF)

GSK is a founding partner in the Global Alliance to Eliminate LF ([www.filaria.org](http://www.filaria.org)). LF is a disfiguring disease prevalent in tropical countries and one of the world's leading causes of permanent disability.

The Global Alliance is a partnership between pharmaceutical companies, the World Health Organization, Ministries of Health, NGOs and community organisations, aiming to totally eliminate LF by 2020.

We have committed to provide as many doses of albendazole, our anti-parasitic drug used to prevent transmission of LF, as are needed to treat the one billion people at risk in 80 countries. In 2005, we opened a new albendazole manufacturing facility in Cape Town, South Africa. This will give us the capability to support LF elimination efforts in all at-risk countries.

In 2005, we donated 136 million albendazole treatments, worth £14.3 million (\$25.8 million) valued at wholesale prices, to 36 countries. Two new countries joined the programme in 2005. We have donated over 400 million treatments since 1998, reaching over 100 million people.

We also gave almost £1 million (\$1.8 million) in grants during 2005 to support the Global Alliance to Eliminate LF. A team of GSK employees helps the Global Alliance in its advocacy, research, community mobilisation and education initiatives.

In December 2005, GSK's programme to eliminate LF won the top honour for Corporate Social Responsibility at the inaugural annual Scrip Awards, which recognise performance excellence in the global pharmaceutical and biotech industries.

## Access to medicines continued

### Positive Action on HIV/AIDS

We recognise the need to support the communities most affected by HIV/AIDS and have a longstanding commitment as part of our community investment. Set up in 1992, Positive Action aims to strengthen the capacity of community based organisations providing HIV/AIDS healthcare services and to increase the number of people coming forward for testing and treatment by reducing stigma and discrimination. It recognises that involving people affected by HIV/AIDS is key to controlling the HIV pandemic.

We launched new Positive Action programmes in India, Kenya and Mexico during 2005, and we now have 20 Positive Action programmes running in 30 countries.

Positive Action is supporting the Reach India project which aims to make HIV/AIDS prevention, financial and business education available to millions of poor women in rural India. GSK is giving \$500,000 (£275,000) that will be used to develop the capacity of community organisations and self-help groups to reach women in rural areas. In its first three years, this is expected to benefit 500,000 women and 2.5 million family members. Reach India is a project of Freedom from Hunger supported by Catholic Relief Services and Positive Action.

In Kenya GSK is giving £1 million (\$1.8 million) over three years to integrate HIV/AIDS treatment and support services into 60 general healthcare clinics.<sup>3</sup> This will enable patients to avoid the stigma of visiting an HIV clinic. Fewer than 10% of Kenyans know their HIV status. Fear of stigmatisation is a significant barrier to people seeking testing, diagnosis and treatment services. Positive Action will also focus on training for healthcare professionals and the creation of patient self-help groups to increase awareness and support patients in sticking to their treatment regimes. The programme is a collaboration between GSK, AMREF (the African Medical and Research Foundation), Elizabeth Glaser Pediatric AIDS Foundation and the National Empowerment Network of People Living with HIV and AIDS in Kenya.

In Mexico we launched a three-year project with the International HIV/AIDS Alliance, and its Mexican partner, Colectivo Sol. The project aims to improve quality of life for people with HIV/AIDS, reduce stigma and discrimination, and help people protect themselves against HIV/AIDS through education and awareness raising.

For information on our arrangements to supply HIV/AIDS medicines at preferential prices to developing countries, see preferential pricing above.

<sup>3</sup>Source: Kenya Demographic and Health Survey 2003  
<http://www.measuredhs.com/hivdata/>

### GSK's African Malaria Partnership

Our African Malaria Partnership supports education and behaviour change programmes in eight African countries, through partnerships with Freedom from Hunger, AMREF and Plan International.

GSK has invested \$1.5 million in the African Malaria Partnership over three years. This is expected to benefit two million people by 2006, by encouraging effective prevention and prompt treatment, particularly among children and pregnant women.

In 2005, we gave a further \$1.5 million (£824,000) three-year grant to a new partner, the Malaria Consortium (a UK NGO), to launch *Mobilising for Malaria*. This initiative aims to focus attention on malaria and generate political commitment and sustained funding to combat the disease. It will generate media coverage, increase the number of NGOs and community organisations engaged in tackling malaria, and give more African communities the knowledge and tools they need to prevent transmission of malaria.

### Personal Hygiene & Sanitation Education (PHASE)

Every year more than two million people die of diarrhoea-related disease, mostly children in developing countries. These deaths can often be easily prevented through better hand washing and sanitation.

PHASE is helping to reduce diarrhoea-related disease by encouraging school children to wash their hands. GSK established PHASE in 1998 and has invested £1.5 million (\$2.7 million) in the programme. PHASE is run in partnership with AMREF and Plan International – as well as Ministries of Health and Education.

The programme has had impressive results. For example, a study by AMREF in Kenya showed that after four years, 88% of children from participating schools washed their hands after using the toilet compared with 46% from non-participating schools.

PHASE was extended to Bangladesh during 2005 and now operates in six countries. Bangladesh is the first Asian country to take part in PHASE. In its first year, the programme will be implemented in 64 schools, reaching 20,000 children. GSK is working with a new partner in Bangladesh – Save the Children USA. PHASE will be integrated into Save the Children's existing School Health and Nutrition Programme to ensure the project's long-term sustainability after GSK funding finishes.

GSK has convened a PHASE steering committee with representatives from our partner organisations to help expand the programme into more countries.



## Access to medicines continued

### DEVELOPED WORLD

Access to medicines is not just an issue for the developing world. Even in developed countries some patients cannot afford the medicines they need. This is a particular problem in the US where many people do not have health insurance. GSK has developed Patient Assistance Programs and discount cards in the US to help patients without insurance.

We are also introducing discount cards in several middle-income countries to enable qualifying patients to obtain prescription medicines at a discount price.

### Programmes in the US

Patient Assistance Programs provide prescription medicines to low-income, uninsured patients free or at minimal cost. GSK operates several programmes, including *Commitment to Access* which covers cancer treatments and *Bridges to Access* which covers other medicines for outpatients. Patients are registered through one phone call from a patient advocate and receive medicine at their local pharmacy or by mail order. In 2005, 565,000 patients received GSK medicines worth \$463.8 million through these programmes, compared with \$372.5 million in 2004. The value of the medicines is calculated using the wholesale acquisition cost (WAC).

GSK was the first pharmaceutical company in the US to offer a card providing savings on medicines to low-income senior citizens and disabled people. Known as the *Orange Card* this enabled these people to buy GSK outpatient prescription medicines at a discount of up to 40%. In 2005, 205,672 *Orange Card* holders received 49,084 prescriptions, saving \$5 million (based on WAC).

In 2002, GSK and six other pharmaceutical companies established the *Together Rx* card which provided discounts on over 155 prescription medicines for low-income senior citizens who are eligible for Medicare. In 2005, 347,835 people received 463,901 GSK prescriptions through this programme, saving \$7.5 million (based on WAC).

Our access programmes in the US will change significantly in 2006 with the launch of a new Medicare prescription drug coverage programme. The *Orange Card* and *Together Rx* programmes finished on 31 December 2005 as those patients are now eligible for the new Medicare programme. We will report on the roll-out of these changes next year.

In January 2005, GSK and nine other pharmaceutical companies created a new card to improve access to medicines for other uninsured Americans, not just seniors. The *Together Rx Access* card provides savings of 25-40% on more than 275 medicines. Approximately 36 million people, around 80% of uninsured people in the US, are eligible to enrol. The participating companies enrolled 353,113 people in 2005, who received 647,227 prescriptions worth \$10.1 million (based on WAC). GSK assisted 10,947 of these patients, with 31,617 prescriptions, worth \$2.9 million.

### Orange Cards in middle income countries

In 2004 GSK introduced *Orange Cards* providing discounts on certain GSK prescription medicines for eligible patients in Bulgaria, Lithuania and Ukraine. The nature of the discounts varies between countries, depending on the needs of the patient and the way in which the healthcare system operates.

Our *Orange Card* in the Ukraine gives all asthma and chronic obstructive pulmonary disease patients who are under 25 or over 50, an average discount of 19% on GSK's Seretide asthma medicine. Asthma patients of any age who suffer disabilities or who are affected by the Chernobyl nuclear disaster are also eligible. Eligibility is assessed by the patient's doctor and patients can receive the medicine at participating pharmacies. A hotline number has been set up to help patients find their nearest pharmacy. In 2005, 3,500 patients enrolled and received discounts worth \$176,000.

In Lithuania, our *Orange Card* gives senior citizens an average discount of 40% on the patient co-payment on all GSK prescription medicines. So far more than 12,000 patients have applied for an *Orange Card* and 155 pharmacies are registered to participate. In 2005, 3,000 patients received discounts worth £20,000 (\$36,400). In December we widened the group who are eligible for the *Orange Card* to include disabled people.

A GSK *Orange Card* was also introduced in Bulgaria in May 2004 for low-income patients with chronic diseases such as asthma, chronic obstructive pulmonary disease and diabetes. Card holders receive an average 35% discount on four GSK prescription medicines. In 2005, 36,000 patients received discounts worth over Euro 1.4 million (\$1.75 million)

## Access to medicines continued

### Summary of GSK discount programmes

| Country   | GSK Programme  | Number of Patients                     | Value of Benefit to Patients |
|-----------|--|--|------------------------------|
| US        | Patient Assistance Programs – Free or minimal cost medicines for low-income, uninsured patients.       | 565,000 received prescriptions         | \$464 million                |
| US        | <i>Orange Card</i> – Discounts for low-income senior citizens and disabled people.                     | 205,672 received prescriptions         | \$4.992 million              |
| US        | <i>Together Rx</i> – Discounts for low-income senior citizens. Joint industry programme.               | 347,835 received prescriptions         | \$7.561 million              |
| US        | <i>Together Rx Access</i> – Discounts for all low-income uninsured patients. Joint industry programme. | 10,947 received prescriptions          | \$2.912million               |
| Bulgaria  | <i>Orange Card</i> – Discounts for low-income patients with chronic diseases.                          | 36,000 patients received prescriptions | \$1.75 million               |
| Lithuania | <i>Orange Card</i> – Discounts for senior citizens and disabled people                                 | 12,000 enrolled                        | \$36,400                     |
| Ukraine   | <i>Orange Card</i> – Discounts on asthma medicine for patients under 25 or over 50.                    | 3,500 enrolled                         | \$176 000                    |

### CASE STUDY

#### A prescription for combating global diseases

Malaria kills over one million people a year, mostly children in developing countries. Beyond the human toll, malaria costs Africa at least \$12 billion a year in lost growth and accounts for around 40% of public health spending.

Until recently there was little research devoted to malaria and other developing world diseases. Developing countries often don't have the money to pay for new medicines so there is little incentive for companies to develop them.

In the last five years, public private partnerships (PPPs) have transformed the research landscape for malaria and other developing world diseases. GSK is involved in several such partnerships. In a PPP, public sector organisations including governments and private foundations, such as the Bill & Melinda Gates Foundation, help fund research and may also help developing countries purchase new products once they are registered.

The Medicines for Malaria Venture (MMV) now manages the largest portfolio of malaria drug research in history with 21 projects at different stages of development. GSK is one of several partners in MMV along with academic institutions, biotech firms and other pharmaceutical companies.

One of our MMV projects is CDA, an affordable fixed-dose combination treatment for malaria in Africa. CDA is based on GSK's *Lapdap*, itself one of the first new malaria treatments developed through a PPP. In 2005, clinical trials showed that CDA may be effective against drug resistant malaria.

A similar partnership, the Malaria Vaccine Initiative is accelerating the development of a malaria vaccine. GSK clinical trials in 2004 and 2005 showed that the vaccine, *Mosquirix*, is efficacious in children aged 1-5 over an 18 month period. This is the first time a vaccine has been proved efficacious against a parasitic disease in humans. These results demonstrate the feasibility of developing an efficacious vaccine against malaria that could significantly contribute to reduce the intolerable global burden of this disease.

# Research

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## Research

**Research and development (R&D) of new medicines and vaccines is at the core of our business, and makes a significant contribution to society.**

**New medicines and vaccines have brought huge benefits to the health and quality of life of millions of people over the last 100 years. But continued R&D remains as important as ever. There are still many serious, debilitating and life threatening illnesses for which there are no effective treatments or where treatments could be significantly improved.**

In 2005 we invested £3.1 billion (\$5.6 billion) and employed over 15,000 people in R&D. Our goal is to build the best product pipeline in the industry. Our research aims to meet unmet medical needs. Our pipeline includes compounds with the potential to make a major contribution to healthcare in developing countries (see Access to medicines). Although this work is essential, there is often little or no return on investment for new treatments in this area. We seek partners to help fund these projects.

Throughout the R&D process we seek the views of patients to inform our research. Focusing on patient needs drives innovation which brings commercial success.

We recognise that biomedical and pharmaceutical research raises ethical concerns – from the use of new technologies to the objective reporting of clinical trial results. We are committed to attaining high ethical and scientific standards in all our R&D work. This section explains our approach to:

- Animal research, and our efforts to reduce, refine and replace animal testing.
- The conduct of clinical trials. How we ensure GSK-sponsored clinical trials are carried out to the same ethical standards irrespective of where they are conducted.
- Training and auditing for clinical trials. How we train GSK employees involved in clinical trials and how we check that trials are carried out to Good Clinical Practice (GCP) standards.
- Clinical trial information and results. How we publicly disclose trial information and results through journal articles, the GSK Clinical Trial Register and other public databases.

Background information on our approach to new technologies is available on our website.

### ANIMAL RESEARCH

Animal research is essential to understand disease and to evaluate the safety and effectiveness of new medicines and vaccines before they are given to people.

Regulations require new medicines to be tested on animals before being tested on humans for safety reasons. Some vaccines have to be tested on animals each time a new batch is produced. We estimate that animal research accounts for around 5% of all GSK research expenditure.

GSK has 14 animal research laboratories in Europe, Japan, Singapore and the US. Some research (around 7% of our total animal research) is conducted by external contractors on our behalf. This percentage has remained relatively constant over the last three years.

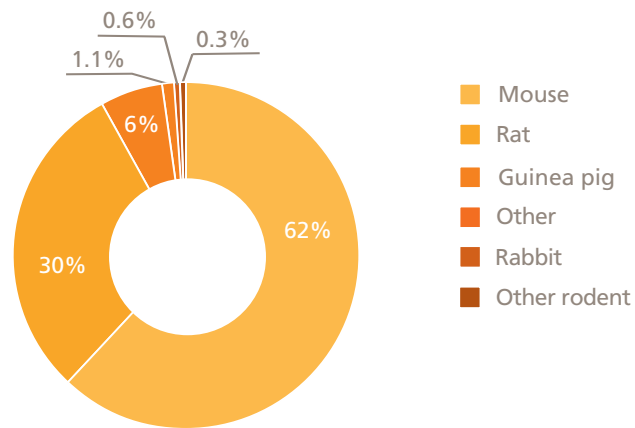
Over 98% of the animals used by GSK are rodents (such as rats, mice, guinea pigs) and rabbits. The remaining 2% includes fish, ferrets, pigs, dogs, cats and primates.

Our goal is to use animals only when scientifically necessary, and then to use as few animals as possible and minimise their distress. Our animal research laboratories are subject to strict internal and legal controls. GSK is committed to the 3Rs – reduction, refinement and replacement – and to achieving the highest standards of animal welfare. We run award programmes to encourage implementation of the 3Rs, share best practice with others in our industry and communicate our approach to interested parties.

This approach is having an impact. Despite a significant increase in R&D activity since 1994 the number of animals used by GSK in our laboratories is broadly similar to that of eleven years ago.

## Research continued

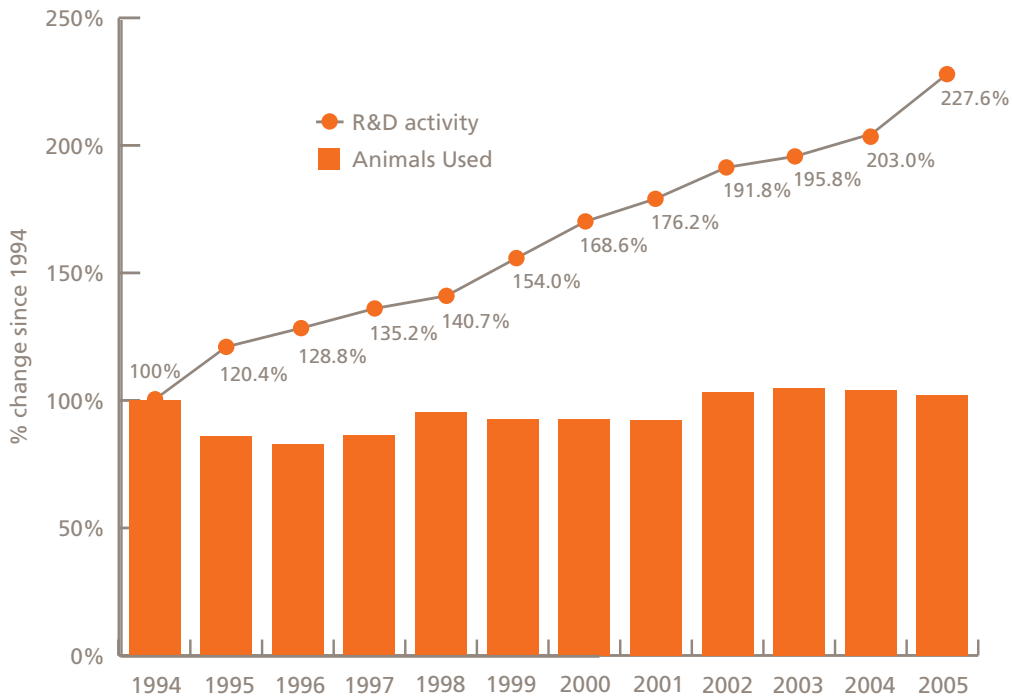
Animals used by GSK in 2005



| Animals used by GSK in 2005 |        |
|-----------------------------|--------|
| Animal                      | % Used |
| Mouse                       | 62.0%  |
| Rat                         | 30.0%  |
| Guinea pig                  | 6.0%   |
| Other                       | 1.1%   |
| Rabbit                      | 0.6%   |
| Other rodent                | 0.3%   |

## Research continued

Change in R&D activity compared to change in number of animals used in GSK research laboratories (figures normalised to 1994 levels)\*



Change in R&D activity compared to change in number of animals used in GSK research laboratories\*

| Year | Animals Used | R&D Activity |
|------|--------------|--------------|
| 1994 | 100.0%       | 100.0%       |
| 1995 | 85.9%        | 120.4%       |
| 1996 | 83.1%        | 128.8%       |
| 1997 | 86.5%        | 135.2%       |
| 1998 | 95.5%        | 140.7%       |
| 1999 | 92.5%        | 154.0%       |
| 2000 | 92.8%        | 168.6%       |
| 2001 | 92.4%        | 176.2%       |
| 2002 | 103.3%       | 191.8%       |
| 2003 | 105.0%       | 195.8%       |
| 2004 | 103.9%       | 203.0%       |
| 2005 | 102.3%       | 227.6%       |

\* Around 7% of our total animal research is conducted by external contractors on our behalf. This percentage has remained relatively constant over the last three years.

## Research continued

### The three Rs

The 3Rs commit us to: reducing the number of animals used in each study; refining studies to minimise pain and maximise the information obtained from each animal; and replacing animal studies with alternative methods wherever possible.

Recent GSK advances in research techniques supporting the 3Rs and animal welfare:

1. Redesigning animal studies and refining testing methods so that more outputs (e.g. biomarkers similar to those measured in blood tests in human clinical trials) can be obtained from the same animal, while it is alive. This reduces the total number of animals needed to obtain this data.
2. Use of radio-telemetry technology that enables continuous measurements to be made (e.g. for blood pressure, heart rate, and temperature), without disturbing or restraining the animal.
3. Observation of the night-time activity of marmoset monkeys which resulted in improvements to their nest boxes for resting and sleeping.

See our website for more background information on implementation of the 3Rs at GSK.

### Training and awareness

We provide extensive training on the 3Rs to staff who are involved in the care and use of animals, and we have a number of initiatives to increase awareness of animal welfare. For example, we produce quarterly bulletins which review recently published journal and news items on these subjects. A UK-based 3Rs committee made up of GSK scientists, statisticians, senior managers, animal technicians and veterinarians encourages a 3Rs culture at GSK through seminars and production and promotion of 'Recommended Practice' guidelines for scientific procedures and animal welfare.

Our Animal Welfare Awards encourage employees to find alternatives to animal research. The awards, presented by GSK's R&D Chairman, recognise employees who have made outstanding advances in implementing the 3Rs. In 2005 awards were made for further development in the use of advanced medical imaging systems to minimise animal use.

A GSK animal technician was awarded the 2004 Andrew Blake Tribute Award by Seriously Ill for Medical Research – the UK national patients' group in support of humane animal research – for a paper on 'Improvements in the housing, husbandry and welfare of ferrets at GSK'.

### Sharing best practice

GSK participated in a study by the UK Associate Parliamentary Group for Animal Welfare on 'The use of animals in vaccine testing for humans'. Information on our work to develop new tests for vaccines, such as the replacement of primates with mice in testing for oral polio vaccines, is included in the final report published in March 2005, see <http://www.apgaw.org/userimages/Vaccinetesting.pdf>.

The annual GSK Laboratory Animal Welfare Prize recognises external researchers or laboratories developing the best new techniques for implementing the 3Rs. From 2006, we will increase the prize to £10,000 and it will be awarded through the new UK National Centre for the 3Rs.

Together with industry partners in the Association of the British Pharmaceutical Industry, we are funding a new three-year post at the National Centre for the 3Rs to encourage sharing of industry best practice.

### Regulation and internal controls

Our laboratories comply with strict national laws, guidelines and codes of conduct on animal welfare. Regulators carry out regular unannounced inspections of our sites to check standards of animal care.

To ensure appropriate use of animals, all proposed animal tests must be reviewed by our Ethical Review Committee. GSK laboratories, and any external laboratories conducting research on our behalf, must follow our Code of Practice on animal research which includes best practice standards for animal care and use. We reviewed and updated our Code of Practice and Policies in 2005.

'Best practice' is defined as a combination of what is currently known from the scientific literature, from published recommendations, and from the knowledge of experts within and outside GSK. Independent accreditation by the Association for the Accreditation and Assessment of Laboratory Animal Care (AAALAC) International is one way laboratories can demonstrate that they meet best practice.

Ten of our laboratories are accredited by AAALAC including all our animal laboratories in Belgium, Italy, Spain, the UK and US. At present the vast majority of the animals used by GSK are in AAALAC accredited facilities. We aim to achieve AAALAC accreditation for all our laboratories conducting animal research.

### Communicating our approach

Animal testing is clearly a very sensitive issue and some people hold strong views on it. We believe it is important

## Research continued

to explain the need for animal research and to be open about what we do.

GSK took part in a two-year detailed ethical review by the Nuffield Council on Bioethics on 'The ethics of research involving animals', published in 2005. This concluded that animals can be useful models for studying specific aspects of human biology and disease and the likely effects of chemicals and medicines in humans. However, the usefulness of animal models has to be judged on a case-by-case basis for each type of research or testing.

The report recommended that more information be made available on the goals and welfare implications of animal research and alternative scientific methods to enable interested parties to judge whether specific types of research are justifiable. It emphasised the importance of using alternatives to animal research and the development of new alternative methods. It condemned the use of violence and intimidation by those opposed to animal research. GSK endorses the report's findings.

Our laboratories host visits from schools, colleges, animal welfare organisations and others. In 2005, we also made over 25 visits to UK schools and about 10 visits to US schools and community groups to discuss issues around animal research. We engage regularly with animal welfare organisations, our investors and other interested parties, as well as contributing to the debate in the media.

In an article on animal research and the impact of animal rights extremism the Financial Times noted that "GlaxoSmithKline has led the UK pharmaceutical industry in a cautious move towards more openness about its use of animals" (20 October 2005).

We accept the legitimate right to lawfully protest against animal research as a part of a free society but condemn the use of violence and intimidation by those opposed to animal use.

### CONDUCT OF CLINICAL TRIALS

The safety and effectiveness of new medicines must be evaluated in human clinical trials before they can be approved for marketing. Regulators will only give approval if trials demonstrate that a product is safe and effective and that its benefits outweigh any risks from potential side effects.

A new product will typically be tested through three stages of clinical trials. These involve both healthy individuals and patients with the relevant disease. In 2005 there were 149 projects in clinical development.

All clinical trials, wherever they are carried out, are conducted according to the Good Clinical Practice (GCP) guidelines developed by the International Conference on Harmonisation (ICH) and the principles contained in the World Medical Association Declaration of Helsinki on the 'Ethical Principles for Medical Research Involving Human Subjects' (2004). The ICH guidelines provide an internationally accepted ethical and scientific quality standard for designing, conducting, recording and reporting trials. They cover issues such as the selection and training of trial investigators, gaining informed consent from trial participants, monitoring and quality assurance.

We have policies to ensure that medical practitioners running GSK-sponsored clinical trials are selected and recompensed appropriately. Our policy on Payments to Healthcare Practitioners and Institutions Conducting GSK-Sponsored or GSK-Supported Clinical Studies states that clinical trial investigators must be selected solely on their qualifications to conduct clinical research. Their history of using GSK products must not be taken into account. Payments to practitioners reflect fair market value for the work performed and no payments are offered or made that could influence their judgement on whether to enrol or maintain a participant in a clinical study

### Standards for clinical trials

Trial protocols (the plan for how a clinical trial will be conducted) are reviewed by external regulatory agencies in the relevant countries when required and all protocols are considered by relevant ethical review committees whose remit covers the sites where studies will take place.

An ethics review committee is composed of lay people, medical professionals and scientists. They assess whether a trial is justified and whether it is designed and will be conducted according to appropriate ethical standards. Ethics committees have the power to reject or stop a clinical trial.

Safety data are routinely collected throughout development programmes and are reported to regulators in line with applicable regulations as well as being reviewed by GSK on an ongoing basis for any safety signals. The GSK Global Safety Board is responsible both for approval of pivotal protocols and internal assessment of any issues related to patient safety that arise during the development programme. We audit clinical trials to ensure they are conducted to the appropriate standards, see Training and Auditing for Clinical Trials.

## Research continued

### Clinical trials outside Western Europe and North America

GSK conducts clinical trials to answer scientific questions and to meet regulatory requirements. We seek to conduct clinical trials where:

- The population is relevant to the scientific question and where the results can be generalised to broader populations.
- High quality data can be obtained.
- Costs can be minimised.

Most clinical trials take place in Western Europe and North America. Trials in developing countries are also conducted to evaluate new medicines for many different diseases. These include diseases that were previously considered as only prevalent in the developed world, but which are now common in developing countries. We are therefore looking to increase the number of patients we recruit into trials in Central and Eastern Europe, Asia, South America and South Africa. In addition, GSK has an ongoing commitment to invest in research and development that targets diseases which disproportionately affect developing countries (e.g., malaria). Clinical trials in developing countries are usually required to develop these investigational compounds. It is important to note that clinical trials of investigational medicines are not conducted in countries when it is known at the outset that there is no intent to pursue registration and make the medicine available for use in that country.

### Development of medicines

GSK is starting to perform more trials in regions such as Central and Eastern Europe, South Africa, Latin America and parts of Asia. There are several reasons for this:

- Healthcare infrastructure and clinical trial capabilities in these regions have improved significantly in recent years. For example, many physicians, now working in developing countries, have been trained and educated to global standards. Therefore, clinical trials can now be more readily conducted and effectively monitored in these countries.
- Changes in living standards mean diseases previously common only in the developed world (e.g., hypertension and diabetes) are now becoming prevalent in developing countries. Including patients from many ethnic backgrounds enables us to develop medicines in a truly global fashion and helps us to evaluate whether new treatments are suitable for different ethnic groups.

- As the number and scale of trials taking place in North America and Western Europe increases it is more difficult to find experienced investigators who are able to start trials and recruit suitable patients quickly. Fewer patients are enrolled into trials in other countries so it is easier to find participants. This speeds up the research process and helps ensure new medicines get to patients more quickly.
- Patients in these countries have often used fewer medicines than those in North America and Western Europe. This makes them good candidates for a clinical trial because it is easier to assess the effect of the medicine being tested.
- Regulators around the world now require significant amounts of clinical data to approve a medicine. This impacts both the pool of available patients in North America and Western Europe and increases the costs associated with conducting clinical trials in these countries. Recruitment costs per patient in countries outside North America and Western Europe are lower, thereby allowing pharmaceutical companies to meet regulatory requirements and financial demands.

### Relevant populations

GSK is committed to investing in R&D for diseases disproportionately affecting developing countries, see Access to Medicines. These compounds must usually be tested through clinical trials in developing countries where the disease is prevalent and the medicine is relevant for the local population. For example, the incidence of malaria in the developed world is very low. This means we can only conduct scientifically robust clinical trials for new malaria treatments in developing countries.

There are concerns that trials in these regions may not be carried out to the same high standards as those in Western Europe and North America. GSK-sponsored clinical trials are conducted to the same ethical standards irrespective of the location. All studies meet international and national regulatory and legislative requirements and are conducted in accordance with principles of Good Clinical Practice (GCP) and the principles contained in the World Medical Association Declaration of Helsinki on the 'Ethical Principles for Medical Research Involving Human Subjects' (2004).

In some of the least-developed countries additional measures are often needed. For example, in cultures other than those in Western society, while still complying with ethical and legal requirements, additional steps are taken to match the objectives of informed consent to local culture. For example local leaders and/or family members may need to be involved.



## Research continued

### Post-trial treatment

We are sometimes asked what happens to a patient's treatment at the end of a trial.

It is important to realise that GSK is not, in general, responsible for the provision of nationally licensed medicines (treatments already approved for use) after a trial. For this reason, GSK-sponsored clinical trials in chronic conditions will not be carried out unless we are assured at the outset that the national healthcare system is able to provide, and is responsible for, the continued care of trial participants, after the trial. Importantly where patients are initiated on nationally licensed medicines during a trial in a chronic disease, we need to be assured that, where there are no suitable alternatives, these medicines will be made available after the trial to those patients who derived a measurable medical benefit.

GSK also recognises that there may be circumstances when there is a compelling medical rationale for patients who have derived a measurable medical benefit from an investigational compound (a medicine that has not yet been approved) during a clinical trial to continue to receive that compound. For example, if the illness being treated is life threatening or seriously debilitating and there are no other treatments available or there are significant risks in switching patients to alternative treatments. When this is the case, post-trial treatment with the investigational compound is provided with appropriate oversight, for example in a clinical trial setting. GSK commits to provide the investigational compound for as long as necessary or until the compound is approved and licensed in that country.

### TRAINING AND AUDITING FOR CLINICAL TRIALS

We provide training to ensure that clinical trials are performed to high ethical and quality standards. We audit the conduct of clinical trials to ensure they are carried out according to Good Clinical Practice (GCP) guidelines.

All employees involved in designing, conducting and monitoring GSK-sponsored trials are trained in GCP. Training is mandatory and employees must have completed the required training before starting or changing jobs. In 2005 there were 13,085 training activities related to GCP. Each 'training activity' represents a successful completion of an e-learning module or instructor-led course related to GCP by one of our employees or complementary workers.

We keep detailed training records which are routinely requested by regulatory authorities when undertaking an inspection to assess the competence of employees undertaking clinical trials.

GSK's internal audit department conducts audits of GSK systems and processes involved in the conduct of trials, as well as auditing clinical research organisations and investigators performing clinical research on our behalf. In 2005, 170 audits were conducted:

- 106 audits of investigator sites conducting GSK-sponsored trials. This represents approximately 5% of investigator sites participating in pivotal clinical trials (pivotal clinical trials are those trials that provide the primary data on which regulatory approval is based).
- 13 audits of internal GSK systems and processes used in managing clinical trials/data.
- 32 audits of clinical research organisations carrying out clinical trials on GSK's behalf.
- 9 audits of GSK Medical Departments based in specific countries.
- 10 audits conducted in response to suspected irregularities.

In 2005, these audits resulted in 127 findings that needed further investigation and 3 investigators were reported to regulatory agencies.

Audit results are reported quarterly to the R&D Risk Management & Compliance Board, and annually to the GSK Audit Committee. Any concerns or issues identified during audits are fully investigated and appropriate action taken. This may include retraining or, in severe cases, dismissal for the individuals concerned as well as development of new training programmes or procedures to prevent a reoccurrence. Trial data may also be re-analysed.

Inspections of investigators, clinical research organisations, independent ethics committees (IECs)/Institutional Review Boards (IRBs) and sponsors of clinical trials are also carried out by regulatory authorities to ensure the safety of trial participants, the quality of data, and that trials are conducted according to GCP. During 2005 there were more than 50 such inspections of GSK and investigators used by GSK to conduct clinical studies.

## Research continued

### CLINICAL TRIAL INFORMATION AND RESULTS

We make the results of our clinical trials widely available to healthcare practitioners and others who use or evaluate the use of our medicines. We also publicly disclose information on ongoing trials.

#### Ongoing clinical trials

Publicly available internet-based registration of ongoing clinical trials can provide a stimulus for increased participation in clinical research. It also provides an important reference point so interested parties can track the subsequent disclosure of clinical trial results.

GSK is legally required to post summary protocol information for ongoing studies of treatments for serious or life-threatening diseases conducted under a US Investigational New Drug Application on the National Institutes of Health website ([www.ClinicalTrials.gov](http://www.ClinicalTrials.gov)). During 2005, we made an additional commitment to post protocol summaries of all patient clinical trials, irrespective of the countries involved, initiated on or after 1 November 2004 or ongoing as of 1 July 2005 to [clinicaltrials.gov](http://clinicaltrials.gov). At the end of 2005 there were 159 protocol summaries of actively recruiting clinical trials on [ClinicalTrials.gov](http://ClinicalTrials.gov).

Our postings meet the requirements of the International Committee of Medical Journal editors. For non-phase III trials, our policy is to delay registration of certain data elements on an exceptional basis when they are competitively sensitive.

#### Clinical trial results

Pharmaceutical companies are legally required to disclose all relevant data from clinical trials to the appropriate regulatory authorities when seeking approval for a new product.

After approval, sponsors have a continuing obligation to provide regulatory authorities with updated safety information from clinical trials. This ensures regulators can accurately assess the safety and effectiveness of new medicines and monitor their safety. Safety and efficacy information is provided to doctors through prescribing information which is approved by regulators.

In addition there is a need to use other ways to appropriately communicate the results of our clinical trials to healthcare practitioners and others who use or evaluate the use of our medicines.

GSK follows the PhRMA Principles on the Conduct of Clinical Trials and the Communication of Clinical Trial Results and is committed to timely communication of results for all products approved for marketing.

Wherever possible we publish our trial results in peer-reviewed scientific and medical journals, or in conference abstracts and proceedings. These are used by research and healthcare communities to obtain the latest information on treatments.

GSK cannot guarantee publication by these methods since this is at the discretion of journal editors and conference organisers. For this reason, we launched the GSK online Clinical Trial Register in 2004, to supplement prescribing information and publications in the scientific literature. The register contains results and protocol information from GSK-sponsored trials of marketed medicines. It also provides references to publications that have appeared in medical journals. Anyone can use the internet to access the register.

There have been concerns about ghost writing of journal articles, where doctors put their names to articles written by pharmaceutical companies. GSK's approach is that authorship and acknowledgements for articles must be consistent with journal guidelines and must be determined based on the level of contribution to study design, data acquisition, analysis and interpretation, and writing or revising the manuscript. The named senior author for a paper must actively participate in the drafting process and lead the content development of manuscripts. The senior author works closely with co-authors and retains final approval authority for the manuscript. Any GSK staff or contractors who contribute to the development of manuscripts for external authors must be named in the article.

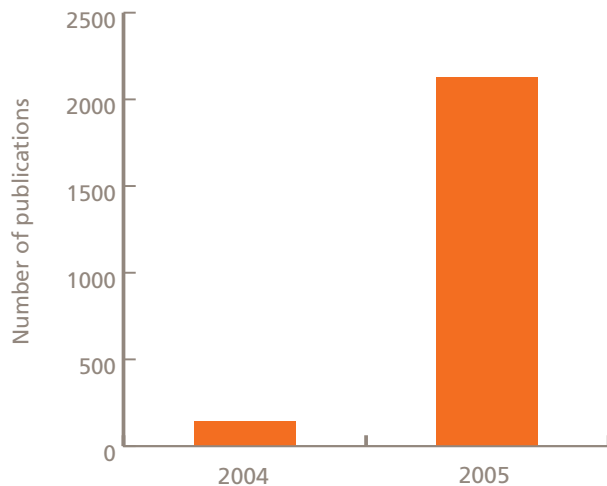
#### Activity in 2005

At the end of 2005 there were 2,125 clinical trial summaries on the GSK Clinical Trial Register (<http://ctr.gsk.co.uk/welcome.asp>). This includes over 98% of the clinical trials of our major marketed products which have been completed since the merger of GSK or were completed before the merger and are likely to inform medical judgement. We are continuing to populate the register with clinical trials that relate to other marketed medicines and this will be completed during 2006.



## Research continued

Number of publications of GSK clinical trials on the GSK Clinical Trial Register (cumulative total)



Number of publications of GSK clinical trials on the GSK Clinical Trial Register (cumulative total)

| Year | Publications |
|------|--------------|
| 2004 | 143          |
| 2005 | 2,125        |

Our objective is to publish trial results for all new products within 10 months of the product reaching the market and to publish the results of trials completed after a product is approved for marketing within one year of trial completion.

An independent assessment of documentation processes and procedures used by GSK in populating the Clinical Trial Register (<http://ctr.gsk.co.uk/welcome.asp>) has been conducted by an external organisation. We will continue to engage the services of this organisation to ensure that

GSK complies with the corporate policies and procedures that it has established to fulfill our commitment to make information from our clinical research activities available to the public. In addition we are actively involved in sharing our views and experiences on clinical trial registration through an advisory board process established by the World Health Organization which is establishing an International Clinical Trials Registry Platform (<http://www.who.int/ictrp/en/>).

## Research continued

### CASE STUDY

#### Diabetes research at GSK

*Avandia*, for the treatment of type 2 diabetes, is one of GSK's top selling medicines. *Avandia* was launched in 1999 but it is the outcome of research that began some 20 years earlier.

Type 2 diabetes has two causes – an inability to produce enough insulin; and insulin resistance, an inability to respond to insulin that is available. It causes a rise in blood sugar which can have devastating consequences for the patient including blindness, heart attacks and strokes.

Beecham, a GSK legacy company, began researching type 2 diabetes in the 1970s. At that time there were two types of oral sugar-lowering drugs available. These worked by stimulating the body to produce more insulin or by helping the liver to control blood sugar levels. But the treatments were not successful for everybody. Furthermore, no diabetes treatment remains effective in one patient forever. As the disease progresses, patients must combine a number of different drugs.

Beecham focused its research on treatments that used a new mechanism – combating insulin resistance – an area that little was known about. It took about six years of research before a promising compound was identified. By 1990 the team had developed a novel

and potent compound that was first tested in human clinical trials in 1993.

With complex diseases such as type 2 diabetes, the failure rate in research is high. Despite significant investment in R&D by the pharmaceutical industry, no new drugs were introduced for more than 40 years before insulin sensitisers, such as *Avandia*, became available. *Avandia* has now been used by more than seven million people worldwide, helping them to control their disease and improve their quality of life.

Diabetes research at GSK has not stopped. We are investing more than £175 million in several large outcome studies to assess the effect of *Avandia* on the long-term complications of diabetes and to see whether it can be used to prevent at-risk people from developing the disease. Two new combination treatments, *Avandamet* and *Avandaryl*, have been launched that combine *Avandia* with other diabetes treatments. This makes it easier for patients to maintain their treatment regime. GSK has another novel diabetes drugs in clinical trials and an ongoing research programme at our metabolic research centre in North Carolina.

The rapid increase in obesity, a major cause of type 2 diabetes, and the appearance of the disease in children, makes this research more important than ever.

# Ethical conduct

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## Ethical conduct

GSK is fully committed to ensuring that our business practices meet high standards of ethics and legal compliance and that our employees behave with honesty and integrity.

It is important that we get this right. The way we conduct our business affects the patients and consumers who use our products, the doctors who prescribe our medicines, the governments that regulate our industry, and our reputation. Our reputation with these stakeholders is critical to our business. Our reputation also affects our ability to attract, retain and motivate the best people. Meeting high ethical standards enables us to maintain the support of these stakeholders and retain our 'licence to operate'.

This section explains our approach to business and marketing ethics and our performance in 2005. It covers:

- GSK's Code of Conduct and management certification on business ethics.
- Our approach to marketing ethics, including our marketing codes of practice and updated policy on direct-to-consumer advertising.
- Training and awareness programmes to reinforce the importance of ethical conduct and to ensure that employees understand what standards of behaviour are required.
- Monitoring and compliance systems, including the role of our Corporate Ethics and Compliance department, channels for receiving reports of alleged cases of misconduct and data on the number of employees dismissed or disciplined for violating company policies including our Code of Conduct.

Information on ethical issues in R&D is available in the Research section of this report. This includes our policies governing our relationship with doctors involved in clinical trials (see Conduct of Clinical Trials) and our policy on disclosure of clinical trial results and writing of articles for medical journals (see Clinical Trial Information and Results).

Information on our relationships with governments is available in the section on Government and external affairs. For our policies on making our products more widely available, see Access to medicines.

More background information on our ethics policies is available on our website.

### CODE OF CONDUCT

Our Employee Guide to Business Conduct sets out the standards of behaviour we expect from employees as well as the key compliance and ethics policies that guide our business activities. It requires all employees to act with integrity, comply with the law, avoid conflicts of interest and report any violations of the law or GSK's policies or any unethical behaviour.

Guidance is provided, including real-life examples, on what constitutes acceptable or unacceptable behaviour. GSK employees have access to the guide via the company intranet. Our induction training familiarises new employees with business conduct standards and provides information on where they can obtain support and answers to questions.

### Management certification on business ethics

Commitment to our Code of Conduct is reinforced by an annual management certification programme. This requires managers to certify that they comply with the statement below. In 2005 we expanded the programme to include over 12,000 managers worldwide. Eligible managers from all business units worldwide have completed the certification. Certification documentation is managed electronically and non-certification is tracked and followed up. Non-certification is typically due to extended leave of absence, such as maternity leave or long-term sick leave.

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## Ethical conduct continued

The full certification statement is reproduced below. The links have not been included below, as they are only accessible via the internal intranet. However, the Code of Conduct and The Employee Guide to Business Conduct documents are available from the 'Responsibility' section of [www.gsk.com](http://www.gsk.com).

"I certify that:

I understand that GSK is committed to the principle of 'Performance with Integrity', and in particular, to ensuring that its activities comply with all applicable laws.

I have received a copy of or have access to the GSK Code of Conduct (POL-GSK-001) and other GSK corporate policies through the Corporate Policy Index page at [link to intranet site]

I have read and understand The Employee Guide to Business Conduct, accessible at [link to intranet site]

I have complied with applicable laws, regulations, and GSK corporate and local policies and procedures.

All people under my supervision have received copies of or have access to the GSK Code of Conduct and other GSK policies and have been informed of their responsibilities.

I have put in place appropriate measures to ensure that the people under my supervision comply with the laws, regulations, and GSK corporate and local policies and procedures while working on behalf of GSK.

I understand my responsibility to promptly report any actual or suspected violations of the law, regulations, or GSK corporate and local policies and procedures.

I have reported all actual or potential compliance issues of which I am aware concerning legal requirements or company policies.

Exceptions (list any compliance issues that should have been reported previously but were not):"

In three markets, France, Germany and Belgium the statement and certification process are slightly different to reflect local legal requirements.

### Business ethics and our suppliers

In 2005 GSK produced a booklet to help suppliers to understand the requirements that they must meet in order to work with GSK. The booklet outlines the importance that GSK places on operating to high ethical standards and includes reference to the GSK policy, to which GSK employees are bound, that prohibits the acceptance of gifts and entertainment. In working with GSK, suppliers are asked to understand and respect this position and as a supplier to GSK, they are asked to adopt and follow the same high standards within their business and in their interactions with GSK.

### MARKETING ETHICS

GSK markets its medicines to doctors, hospitals and governments. In some countries, such as the US and Japan, we also advertise medicines directly to consumers.

Our specialist sales representatives meet regularly with doctors and pharmacists to inform them about our medicines and their approved uses.

We believe that our sales representatives play an important role in providing up-to-date information to doctors on our products and their benefits to patients. However, we recognise that the marketing of pharmaceutical products raises some challenging issues. In particular, some people are concerned that marketing by pharmaceutical companies exerts undue influence on doctors, that sales representatives do not always give doctors full information about potential side effects, or that promotion for unapproved uses may be common despite increased compliance training and monitoring activity and oversight by governments.

The sale and promotion of pharmaceutical products is highly regulated by governments and medical agencies. Several governments are extending legislation in this area. For instance, in the US, there are 39 proposed laws pending in 20 state legislatures that could require pharmaceutical companies to restrict or report on interactions with doctors.

All GSK employees must also comply with our Marketing Codes of Practice and our policies governing consumer advertising. These codes require that marketing be based on valid scientific evidence, be consistent with national prescribing documentation, and comply with the law.

## Ethical conduct continued

During 2005 we have updated and strengthened our policies and procedures.

Sales and marketing employees receive training to ensure they have a good understanding of our marketing policies and the legal framework governing their sales activities. We also have programmes to monitor compliance, including in some regions feedback from doctors on our sales practices.

In 2005, GSK was rated third in a survey of French doctors conducted by Insemma Marketing Research Institute that assessed how well 26 pharmaceutical companies comply with the industry marketing code.

Doctors are noticing that GSK is taking a leadership stance in the areas of gifts and entertainment in particular. Reactions vary from "well done GSK for setting a good example that others in the industry should follow" (the majority reaction) to "if you won't pay for my spouse to travel, I'll go with another company who will" (the minority reaction). In one particular case in the UK recently, GSK offered to sponsor a doctor to attend a congress. He asked for GSK to pay for his wife to accompany him to the congress. The GSK manager refused the request, as this is contrary to our marketing code of practice. The doctor was sponsored by another company to attend the congress.

### Marketing codes of practice

Our Pharmaceutical Marketing and Promotional Activity policy applies to all employees and agents. It commits us to promotional practices that are ethical, responsible, principled and patient-centred. It prohibits kickbacks, bribery or other inducements to doctors.

This policy is supported by regional marketing practices codes in Europe, our International region, Japan and the US. These codes apply the same ethical standards but reflect differences in market structures, national healthcare systems and regulations. They incorporate the principles of industry codes of practice such as the EFPIA, IFPMA, JPMA, and PhRMA marketing codes.

The codes explain our policies on issues such as:

- Providing full and accurate information – information can only be provided on approved uses for a medicine. Information must be accurate, balanced, fair, objective, unambiguous and up-to-date.
- Gifts to healthcare professionals – gifts must be given only occasionally and must be relevant to the practice of medicine. Gifts cannot be made as an inducement to prescribe any of our medicines.

- Appropriate hospitality for meetings – no entertainment is permitted. Hospitality (such as travel costs or food) may only be provided for meetings with an educational purpose. The level of hospitality must be appropriate to the occasion and must only be provided for relevant healthcare professionals, not spouses, children, office personnel, or any other guests. Travel costs are not provided in the US.

Our regional codes are available in more than 30 local languages and employees can access them via the intranet. All sales and marketing staff receive training on the codes; see Training and Awareness.

A copy of the GSK European Promotion of Medicines Code of Practice is available in our online report.

### Progress in 2005

In 2005, GSK's president of pharmaceutical operations and his direct reports conducted a review of our regional marketing codes to confirm that GSK's codes are comprehensive and consistently applied in all regions. We identified certain areas for improvement, and will update the codes in 2006 accordingly. Changes will include reducing the maximum value of nominal gifts to healthcare professionals to \$10 (less than £6), and prohibiting gifts and entertainment for medical professionals retained as consultants to GSK. We will also ensure that decisions about grants for medical education, and about donations for charitable purposes, are reviewed by departments independent of sales and marketing.

We launched a new procedure in Europe on sponsored attendance of doctors at medical conferences. This procedure specifies the circumstances under which sponsorship is appropriate and governs the provision of appropriate travel, meals and accommodation.

Compliance with policies and procedures is a formal performance objective for sales and marketing employees in the US. This is evaluated as part of employee performance reviews, thus encouraging employees to view compliance as an integral part of their overall performance. US employees in our pharmaceutical business were appraised against the following objective in 2005:

**"Consistently follow company policies and procedures, take and complete required compliance training in a timely manner, and report compliance issues to manager, Legal or Compliance."**



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## Ethical conduct continued

In addition, managers are evaluated against the following objective:

**“Ensure that supervised employees are trained on company policies and procedures and have taken all required training, and provide oversight and direction to supervised employees so that they are in compliance with company policies and procedures.”**

### Consumer advertising

This section explains our approach to advertising our prescription medicines in the US and our advertising for our consumer healthcare products in other markets.

#### Direct-to-consumer advertising

In the US\* we advertise our prescription medicines to consumers through TV and print advertisements. This is known as direct-to-consumer (DTC) advertising. DTC advertising is not permitted in most other markets, although New Zealand, Bangladesh and Korea do allow limited DTC advertising.

Promoting the use of prescription drugs directly to consumers can be controversial. Critics believe that it encourages people to request unnecessary treatment, adding to the burden on healthcare systems.

We believe that responsible pharmaceutical advertising is a useful source of health information for patients. It helps to increase awareness of conditions patients might not appreciate or otherwise know about and educates patients about treatment options. Patients must still consult with their physicians about their condition, the appropriateness of a prescription medicine, and obtain his or her consent before receiving such medicines. In countries such as the US where DTC advertising is common industry practice, we need to ensure that our products are also promoted in this way.

In Bangladesh, we run a DTC campaign for our vaccines, which includes a television commercial and newspaper advertisements. This campaign is titled ‘vaccination for all’ and has been run over a period of three years. It won the International Commercial Excellence Exchange Award 2003 (an internal GSK award) and has been approved by the local regulatory authority.

In 2005, the US pharmaceutical industry association, PhRMA, introduced new Guiding Principles on DTC advertising for prescription medicines. These were launched in January 2006.

The principles state that companies should spend an appropriate amount of time educating doctors and healthcare professionals about new drugs before consumer advertising begins. Advertising should be

designed to educate consumers about the medicine and the condition for which it is prescribed. DTC advertising for pharmaceuticals must be accurate and supported by evidence. It must also include information on the risks and benefits of treatments and other options such as diet and lifestyle changes. The principles are available at [www.phrma.org](http://www.phrma.org).

GSK was an early supporter of the new principles and we have reviewed and updated our marketing policies to incorporate all of the PhRMA Guiding Principles, as well as additional requirements, and to ensure compliance with them. Some new provisions implemented in our updated DTC policy include:

- Elimination of ‘reminder’ advertisements – short advertisements that mention the pharmaceutical brand name but not the medical condition it is designed to treat
- Submission of new television ads to FDA for review at least 30 days in advance and at the stage of development where audio and visual components are available.
- Providing information on other treatment options (such as diet and lifestyle changes) for the advertised condition, where such treatment options are referenced in the prescribing information for a product.
- Requiring a reference to PhRMA’s Partnership for Prescription Assistance in branded print ads and branded websites – this programme directs patients to members companies’ low income Patient Assistance Programs.

#### Marketing practices for non-pharmaceutical products

We advertise our over-the-counter medicines, oral healthcare products, and nutritional products to consumers worldwide. Our advertising is governed by national regulations or codes of practice for advertising. Our internal policies and procedures meet or exceed local laws.

Advertising of consumer healthcare medicines and nutritional products is generally subject to less stringent direct-to-consumer advertising requirements than prescription medicines. GSK Consumer Healthcare has global advertising guidelines which require that claims in consumer healthcare medicine advertisements be consistent with product labelling. In markets that allow comparative advertisements, GSK Consumer Healthcare guidelines require that a comparison of a GSK product to a competitor’s be supported by adequate data.

\* In a previous version of this report we incorrectly stated that we advertise our prescription medicines to consumers in Japan. Advertising of prescription medicines to consumers is illegal in Japan.

We do not advertise prescription medicines to consumers in Japan, however we do run DTC advertisements to raise awareness of disease among patients and the general public without mentioning prescription brands

## 4

## Ethical conduct continued

In the UK, there are concerns that advertising for food and drink is contributing to the rise of childhood obesity. The UK Government's Health Select Committee has made recommendations for tackling obesity, including restrictions on advertising to children and the placement of vending machines in schools.

GSK Consumer Healthcare has guidelines for advertising to children that meet or exceed local laws and codes of practice. The guidelines on advertising to children prohibit drug advertising designed to appeal to, or targeted at, children below the legally mandated minimum age. For example, in the UK we do not buy advertising space in children's media and we do not supply vending machines to primary schools.

Sports star sponsorship is important to brands such as *Lucozade Sport*. Our guidelines on sponsorship state that only people who set an appropriate example should be used for sponsorship, and they should have an appeal that is not solely to children below the age of 13.

In the US, advertising of over-the-counter medicines must comply with governmental advertising guidelines. An advertiser must have a reasonable basis for making a claim before publishing it. Comparative advertising of over-the-counter medicines is permitted in the US as long as the claims are truthful and not misleading. Consumer testimonials and celebrity endorsements are permitted as long as the statements made reflect the honest opinion of the speaker, are true and not deceptive.

GSK Consumer Healthcare is a member of the Consumer Healthcare Products Association (CHPA) which has a voluntary Code of Advertising Practices for Nonprescription Medicines. The guidelines advise against practices such as advertising that implies a casual attitude toward using drugs and suggests an over-the-counter drug can prevent or cure a serious disease that must be treated by a licensed practitioner. GSK Consumer Healthcare advertising is reviewed to ensure it meets government and industry standards.

### TRAINING AND AWARENESS

We have training and awareness programmes to make sure employees understand our policies, comply with the law and know what standards of behaviour are required.

Training starts with an induction course for new employees in the UK and the US. This covers the GSK Code of Conduct and other relevant policies. Induction

training for new sales and marketing employees covers our marketing codes of practice. These induction courses ensure that new employees understand the importance of ethical conduct from day one, know how to deal with dilemmas and where to seek help.

We provide additional training for employees who will be working in areas where there are additional regulatory requirements such as R&D, manufacturing and sales and marketing.

Sales representatives receive detailed training on the medicines they promote and the diseases they are designed to treat. Sales employees are given training on appropriate marketing practices and are required to pass a test on our marketing code before starting their sales role.

Regular refresher courses are held for all sales and marketing employees at least annually. For example, in some markets, employees look at examples of ethical dilemmas and issues that they could face in their work and guidance is provided to help them understand appropriate responses. Employees are encouraged to ask themselves the following questions before making a decision:

- Would I be embarrassed if my friends or family knew what decision I have made?
- How would my decision look to a cynic?
- What could the newspaper headline look like?
- Am I still confident that this is the right decision for GSK?

We monitor the success of our training and awareness programmes. For example in the US we conduct surveys of GSK sales representatives. In 2005, the survey revealed that:

- More than 98% of employees rated efforts to promote compliance as effective.
- More than 90% of representatives correctly answered questions on the promotional materials and sample management policies.
- Over 175 employees suggested solutions to handle compliance challenges.

We also conduct a global management survey every two years. The 2004 survey showed that 92% of managers said they understood how the GSK Code of Conduct applied to their jobs.

## 4

## Ethical conduct continued

### Activity during 2005

We launched a new half day workshop on "Ethical Decision Making", which was attended by almost 500 senior managers in the US and UK, including staff in corporate functions (such as Finance, HR, IT and Communications). This workshop gave participants practical tools to help with making ethical decisions, and highlighted managers' obligations under the Employee Guide to Business Conduct and the risks associated with non-compliance.

The managers who attended the "Ethical Decision Making" workshops chose to attend. It was recognised that there is a need to involve and engage more managers throughout GSK on an ongoing basis. So, in 2006 we will launch an additional ethics eLearning and face-to-face training package for managers.

Over 1,000 new sales and marketing staff in the US received training on compliance policies and more than 10,000 existing staff received two hours of annual refresher training in 2005. We do not track sales and marketing training hours in other countries. Another initiative to improve employee understanding is a yearly bulletin launched by the US Pharma Compliance Office on the major types of unethical conduct detected and the actions taken.

Over 1,200 R&D employees completed the 'Performing with Integrity' course during 2005. This course was established in 2004, when more than 9,000 R&D employees completed the course. This includes training on the Code of Conduct, and our policies on Conflicts of Interest and Acceptance of Gifts and Entertainment by GSK employees.

### Objectives for 2006

- Review the 'Performance with Integrity' face-to-face induction training session and make appropriate changes for new staff in the UK and the US during 2006.
- Launch an additional ethics eLearning and face-to-face training package, building on the 'Ethical Decision Making' workshop for managers.

### MONITORING AND COMPLIANCE

We recognise that strong policies, codes of practice, and good training do not guarantee that all employees will meet our standards. Our internal compliance systems are designed to identify and address breaches of our codes.

This section covers:

- The role of our Corporate Ethics and Compliance department.
- Channels for employees to report concerns or suspected cases of misconduct. The number and type of contacts through these channels in 2005.
- How we address misconduct. The number of employees dismissed or disciplined for misconduct in 2005.

### Corporate Ethics & Compliance function

Our Corporate Ethics and Compliance department works with the GSK business units to promote effective risk management and compliance programmes, identify and address compliance issues, and to ensure appropriate oversight and upward reporting for GSK senior management and the Board. We now have a dedicated, full-time compliance officer in each of our seven major business units – R&D, Manufacturing, Biologicals, Pharma Europe, International Pharma, Japan Pharma and US Pharma, in addition to the corporate compliance officer, who reports directly to the CEO.

Compliance officers are senior managers with direct access to the leadership teams of GSK functions. They are a source of expertise for anyone with a question on ethics or compliance with GSK policies. Compliance officers define training needs and communicate the latest developments on new policies and legislation affecting GSK, as well as deliver training and assess compliance issues in their business units. Many markets also appoint local compliance champions.

In the US we appointed four compliance staff as sales and marketing compliance advisers. Their role will be to provide feedback on infractions, conduct customised training, and recommend process improvements. We have also hired and trained staff for a new compliance data analysis and reporting group. This group has already begun to analyse monitoring and investigation data to highlight suitable areas for focus and follow up for each business unit in the US.

## Ethical conduct continued

Sales representatives are supervised by sales managers who regularly monitor educational events, visits to doctors, and expenses. We also have independent monitors to review records in a number of key risk areas in the US. Our internal audit department continues to deploy significant resources to provide regular audits of business processes, including auditing our sales and marketing practices globally. As a result of the audit findings the decision making process for grants and donations is being updated. In Europe and our International region, these decisions will now be made by the relevant medical department, instead of commercial staff.

The European code of marketing practice includes a quarterly reporting mechanism where the markets confirm whether any breaches of the code of practice have occurred, the severity of any breaches and what actions have been taken to prevent recurrence. These reports are reviewed by senior managers. A similar procedure for monitoring expenses was launched in 2005, which highlighted some inconsistencies across countries, and other areas for improvement. During 2006, the countries in our European region will receive more central direction regarding monitoring of expenses and other relevant expenditure.

### Reporting channels

Employees are encouraged to seek help and to report any concerns or suspected cases of misconduct. They can do this through their line management, a compliance officer, or through our confidential Integrity Helplines or offsite post office box (in the US).

The Helplines and post office box are promoted through the Employee Guide to Business Conduct, on the GSK intranet and during training. The Corporate Ethics and Compliance function is promoted as a source of information and advice, as well as a mechanism for reporting concerns.

In 2005 there were:

- 3,644 contacts with the compliance functions, mainly in the US. This is an increase from 2,593 last year.
- Of these, 77% were from employees seeking advice or information; 23% were from employees reporting suspected cases of misconduct.

Outside the US, mechanisms to track this information are evolving with general trends and issues being visible to senior management and addressed through action where necessary.

Doctors can raise any concerns or report unethical conduct by GSK sales representatives through our customer response centres, during our market research or via industry associations such as PhRMA and the ABPI. Staff retrained to deal with concerns about marketing practices that might be raised by healthcare professionals, patients or the public. They redirect calls to appropriate senior management or a compliance officer if necessary.

### Addressing misconduct

Our Corporate Ethics and Compliance department monitors and tracks allegations and suspected cases of legal, ethical or policy infractions. It also ensures that all such allegations are appropriately investigated. Disciplinary action, up to and including dismissal, is taken where necessary.

In 2005:

- 1,126 employees were disciplined for misconduct (compared with 954 in 2004).
- Of these, 331 were dismissed or agreed to leave the company voluntarily, compared with 256 in 2004.
- Other disciplinary actions included verbal and written warnings (795 instances) and financial penalties. Employees staying with the company received re-training and increased monitoring.

The numbers have increased since 2004. We believe this is probably due to better reporting of breaches, as people become more familiar with what should be reported and when. It is anticipated that the numbers may continue to increase during 2006, as detection and reporting mechanisms are further refined.

The 1,126 disciplinary actions included 278 cases of employees breaching sales and marketing codes. These 278 cases resulted in 91 dismissals or separations from the company. There were also 100 verbal warnings and 87 written warnings. These included many small over spends on the allowed limits for hospitality during scientific meetings.

# Employment practices

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## Employment practices

GSK employs over 100,000 people in 119 countries.

**Our goal to be the best place for the best people to do their best work is central to our business strategy and key to business success. We aim to create a positive working environment, offer competitive reward packages that emphasise performance, provide opportunities for training and advancement, and listen and respond to employee feedback. (See our Annual Report for more details on our business strategy).**

We expect employees to meet high standards in the way they carry out their work for GSK. The GSK Spirit defines our culture and the principles we expect employees to work by. These are:

- Performance with integrity
- Entrepreneurial spirit
- Focus on innovation
- A sense of urgency
- Passion for achievement

Regular performance appraisals assess whether employees have upheld these principles and the requirements of our Code of Conduct in their work (see Ethical Conduct for more on our Code). The results affect bonuses and career progression.

This section explains our approach and performance in 2005. It covers:

- our regular employee surveys
- our programmes to recruit and retain a diverse workforce;
- employee development, performance appraisals and talent management;
- how we communicate with employees and get their feedback;
- our health, safety and wellbeing programmes.

### EMPLOYEE SURVEYS

The sustainability of our business rests on factors that are difficult to measure such as the quality of our leadership, our culture and our ability to develop talented people. Regular employee surveys help us to monitor the evolution of GSK's culture and overall employee satisfaction. The results are used to assess the effectiveness of our people management practices and identify areas for improvement.

We conduct a Global Leadership Survey every two years. Over 10,000 managers took part in the last survey in 2004. Results showed a significant improvement on 29 of 31 items compared with 2002 results. For details of the results see our 2004 Corporate Responsibility Report. The survey findings are reviewed by GSK's Corporate Executive Team and our business units have implemented action plans to deliver improvements in key areas. For example, GMS have extended our core Leadership Edge programme to over 1000 leaders and have increased focus on staff development, including through mentoring and coaching. R&D have implemented a quarterly "pulse" employee survey to understand better where there are opportunities to enhance employee engagement and satisfaction. They have also launched the "Focus on the Patient" initiative to build on our strength of putting the patient first in our plans and decision making.

### Activity in 2005

We conduct a range of interim employee surveys to gauge satisfaction, motivation and engagement between Leadership Surveys.

Our annual US Inclusion and Resilience Poll was sent to 1,000 US employees in 2005. The survey gathers feedback on work-life and resilience issues and how we are progressing towards our diversity vision. The scores for diversity were all higher than 2002. Other results included:

| Question  | % favourable |      |      |
|---|--------------|------|------|
|   | 2002         | 2004 | 2005 |
| How would you rate your overall satisfaction with GSK at the present time?                | 64           | 72   | 75   |
| I feel valued as an employee of GSK.  | 51           | 63   | 68   |
| My manager enables flexible and innovative solutions for managing work and personal life. | 66           | 70   | 76   |
| My work environment enables me to maintain a healthy lifestyle.                           | 57           | 61   | 60   |



## Employment practices continued

### DIVERSITY

GSK is committed to employing a diverse workforce in an environment where all employees are treated with respect and dignity.

Diversity benefits our business. A workforce with diverse backgrounds, cultures and outlooks helps us to understand the needs of different patients and customers. Only by delivering genuine equality of opportunity can we be sure that we have the best people in the right jobs doing their best work for GSK.

We have a range of initiatives to ensure we meet our diversity commitments. We also monitor and report data on gender diversity by management grade worldwide and on ethnicity in the UK and US. For more background information see our website.

### Activity and performance in 2005

Our annual US Inclusion and Resilience Poll includes questions on diversity. These were all rated higher in 2005 than in 2002:

- 56% of respondents agreed that senior management shows by its actions that creating an inclusive environment is a top priority at GSK (compared with 50% in 2004 and 44% in 2002)
- 77% thought their workgroup has a climate in which diverse perspectives are valued (compared with 65% in 2004 and 67% in 2002);
- 77% thought their manager demonstrates the ability to manage a diverse workgroup (compared with 66% in 2004 and 68% in 2002).

GSK received a 100% score for corporate equality from the US Human Rights Campaign Foundation that measures companies' treatment of gay, lesbian, bisexual and transgender employees, consumers and investors. Companies scoring 100 percent are included in the organisations' "Best Places to Work for GLBT Equality" list.

### Gender diversity (worldwide)

| Women in Management Grades      | % of positions held by women |      |      |
|---------------------------------|------------------------------|------|------|
|                                 | 2003                         | 2004 | 2005 |
| A&B Bands*                      | 20                           | 19   | 21   |
| C01 - C03**                     | 31                           | 33   | 33   |
| C04 - C05***                    | 37                           | 38   | 38   |
| Total for all management grades | 34                           | 35   | 35   |

\* Corporate Executive Team, Senior Vice Presidents, Vice Presidents

\*\* Director Level

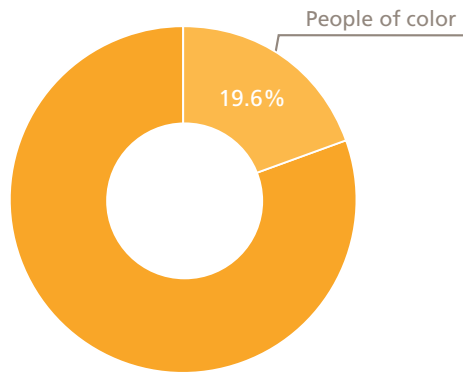
\*\*\* Manager Level

Women remain under-represented in senior grades. We will continue to focus on ways of ensuring women have genuine equality of opportunity in GSK.

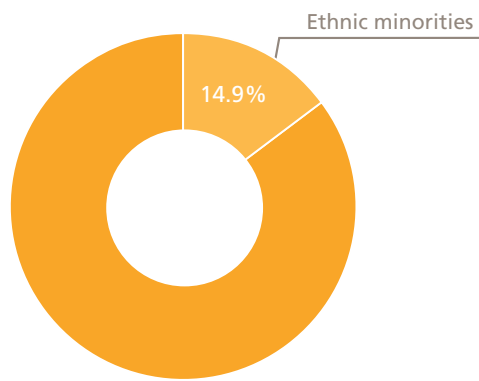
We hold a Women in Science event in the UK each year, enabling female science graduates to give feedback on how GSK could attract more women scientists. A similar event was launched in the US in May 2005, attended by over 100 female and male employees. The focus was on development of women scientists in GSK.

## Employment practices continued

### Ethnic diversity



| Employees                                     | %     |
|---|-------|
| People of color in the US employee population | 19.6% |



| Employees                           | %     |
|-------------------------------------|-------|
| UK employees from ethnic minorities | 14.9% |

## 5 Employment practices continued

In the US, people of colour made up 19.6% of our workforce, compared with 19.5% in 2004. In the UK, ethnic minorities (as defined by the UK Commission for Racial Equality) accounted for 14.9% of employees, compared with 14.8% in 2004. In our 2004 CR Report we wrongly reported the number of ethnic minority employees as 19.8%. This was due to an error in our data collection system which we have now corrected.

### *Multi-Cultural Marketing and Diversity Awards*

Our annual Multi-Cultural Marketing and Diversity Awards recognise staff who have found creative ways to reach a wider audience of employees, customers and communities. Awards are given in several categories including one for Employee Attraction, Development and Retention. This year's winners included:

- The UK R&D Residential Chemistry Training Experience, designed to increase the diversity of candidates attracted into chemistry roles. Final year undergraduates spent a week with GSK on the programme. Applications were particularly sought from ethnic minority students from non-traditional universities for GSK recruits. The 20 participants received coaching on technical, personal and professional subjects and interacted with GSK employees at all levels.
- The *Niquitin* team, Birmingham, UK, who raised awareness of smoking cessation among ethnic populations who have higher than average smoking rates.
- The US Consumer Healthcare Hispanic Employee Network who worked with a number of GSK brands to help them understand and improve their appeal to the Hispanic community. This included our *Sensodyne* brand, which with the network's input, increased sales by 22.1% in the Hispanic community, compared with the general market increase of 7.2%.

### *Employee networks*

Our employee networks include programmes for Asian, African American, Hispanic and gay and lesbian employees. They provide a forum for employees with similar backgrounds to meet and discuss issues of shared concern.

"I set up the Gay and Lesbian Staff Network UK for a very simple reason: to enable positive inclusion of lesbian, gay, bi and transsexual staff in the GSK culture. Team work is an essential requirement of the modern pharmaceutical industry. Exclusion on grounds of sexuality or sexual orientation is an obstacle to effective team work and personal development."

Chair and Founder, GSK R&D UK GLSN

### EMPLOYEE DEVELOPMENT AND TALENT MANAGEMENT

GSK invests in training and development to enable employees to perform to the best of their ability and to develop their careers. Our talent management processes help us identify and develop leadership candidates.

#### Training

We provide job-related training courses for all employees and leadership training for managers. Employees can enrol in training programmes through our myLearning intranet site in the UK and US. During 2005, 4,886 employees attended 368 development programmes in these countries. Similar opportunities exist for employees worldwide but data are not currently collected on the take-up of programmes.

In 2005, 97 people attended Leadership Edge, our global programme for senior managers, and 108 attended Leadership@GSK, the programme for middle managers. We ran five Inspirational Leadership Workshops attended by 72 executives and senior leaders, with significant influence over large numbers of staff. These focus on the senior leadership role of inspiring and motivating people to high performance to meet business challenges. A further 79 employees attended our foundation programme for new managers, Management@GSK. This programme is designed to help managers improve the performance of their staff and to increase their insight into differing work styles, strengths and motivation.

#### Development

Regular performance appraisals reward strong performance and help employees set objectives and identify the training they need. More than two-thirds of GSK employees receive an annual performance appraisal through our Performance and Development Planning (PDP) programme.

PDP includes an assessment of how well employees have implemented the GSK Spirit - the principles we use to define our culture. It can have a significant impact on bonus payments, potentially reducing them to zero if an employee is found not to have followed the Spirit, and can also affect future career development.

#### Talent management

We identify the highest performing employees in each business and function through our annual talent management cycle. Talented individuals take part in our leadership programmes and are exposed to top management through programmes such as the Chief Executive Forum.

## 5 Employment practices continued

A pool of potential successors is identified for all Vice-President and senior management positions. These are reviewed annually by the appointments sub-committee of the Board.

### INTERNAL COMMUNICATION

Good internal communication is important in achieving our business objectives as well as creating an open and inclusive work environment. We have a range of communications channels to keep employees up to date with company news and enable them to give feedback. These include:

- myGSK, our global intranet site, provides news and updates and a Q&A section where employees can put questions directly to the CEO and other senior executives. In 2005, JP Garnier, GSK's Chief Executive answered 364 questions. Behind the News, a section of the GSK intranet, gives the company's position on important issues linked to press stories about GSK. myGSK was updated in 2005 to ensure that all employees can access news and policies.
- Web-broadcasts from GSK senior management, including 18 from executive team members, for employees at our major sites. In February, GSK's CEO, Chairman and head of R&D hosted a global broadcast viewed by 30,000 employees at 86 sites. More than 1,000 employees completed a follow-up survey, with 92% agreeing that the broadcast had increased their understanding of GSK's priorities for 2005 and beyond. A second broadcast in December celebrated 'The year of the vaccine', was shown in over 140 venues and recognised employees that have made outstanding contributions to the company.
- Spirit, our internal magazine, reaches around 50,000 employees throughout the company four times a year. Many sites also produce local newsletters.
- Confidential feedback mechanisms enable employees to raise concerns. These include our integrity helpline. See Ethical conduct.
- Employee surveys are carried out regularly throughout the organisation, see Employee surveys. We will conduct our next biannual Leadership Survey in 2006.

- We consult employees on changes that affect them and discuss business developments through our Works Councils and European Employee Forum. We have similar forums in other countries where this is national practice. In 2005 the European Employee Forum discussed topics including the transformation and optimisation programme for Europe IT, proposals for change to GSK's European Distribution and Supply Chain and the company's approach to stress in the workplace. A new UK Information and Consultation Forum will be established during 2006 to address strategic level business developments and company proposals for change in areas such as employment policy and pensions.
- 43 'townhall' sessions for employees at all levels of the company were hosted by senior management. Employees have the opportunity to discuss the progress of the business, raise questions and give feedback.

We also keep employees informed about corporate responsibility (CR). During 2005, 55,000 copies of our CR Overview brochure were distributed to employees directly and through Spirit magazine. An online CR survey was sent to 980 randomly selected GSK employees to assess awareness of our approach to CR and CR reporting, see Stakeholder Feedback.

We are developing an internal communication initiative on ethical leadership and the role of every employee in protecting and enhancing GSK's reputation. It will be launched in 2006 and will include an e-learning module, guidance for managers on facilitating discussions on GSK's ethics policies with their team and new material on myGSK.

We track the effectiveness of communications through questionnaires and employee surveys. We monitor the questions employees put to senior managers through the Q&A pages on myGSK to ensure we pick up potential areas of concern. We also track readership of news stories on myGSK to help improve the relevance and interest of the content.

## Employment practices continued

### HEALTH AND SAFETY

The health and safety of employees and contractors is an absolute priority for GSK. We have programmes to systematically assess the risks associated with our operations. We monitor performance and the causes of incidents. We aim to assess what can be learned and take action to protect employees and others in the workplace. We need to improve implementation at some sites.

Our aim is to eliminate all work-related injuries and illnesses (I&I). Our main measure is the number of cases resulting in time off work (lost-time cases) and our target over the last 5 years has been to reduce the number per 100,000 hours worked by 15% every year. We achieved the target on average for the first two years but the rate has remained almost constant since 2003, so we did not meet the five-year target.

We will be setting a new I&I target for 2006-2010 as part of the Plan for Excellence 2006-2015, and will set targets for reportable I&I – cases that GSK defines as more serious than first aid. Some of these may also be reported under government regulations in some countries. Safety theory suggests that addressing reportable I&I will help to eliminate risks and hazards, which should lead to fewer reportable cases as well as lost-time I&I cases.

#### About the Health and Safety Section of This Report

This section contains information about how we manage health and safety as part of overall EHS management and describes our programmes. It reports injury and illness rates highlights serious incidents and fatalities, and covers health and safety audits of GSK operations.

Our programmes cover a wide range of H&S aspects, from providing safety training for sales employees, who tend to have the highest number of fatalities, to working with all employees to improve their general health.

This is the 6th year that we have reported on our health and safety performance. The legacy companies (Glaxo Wellcome and SmithKline Beecham) individually published EHS reports for a number of years prior to the formation of GSK in 2000. Copies of these reports are available on the Corporate Register website [[www.corporateregister.com](http://www.corporateregister.com)].

#### Scope of Data

The health and safety data covers the calendar year 2005. It is collected from all of our 81 pharmaceutical and consumer manufacturing sites, seven of eight biologicals manufacturing sites, and all 20 pharmaceutical and

consumer research and development sites, as well as all seven distribution centres, all eight major office locations and 56 of approximately 65 smaller offices and sales locations. We include available data for sites that were in operation for all or part of the year. Notes attached to the charts explain the scope and data collection process for each parameter in more detail. We also include data (in the injuries and illness page) for a number of suppliers who provided information.

#### Verification

The environment, health and safety sections of this report are externally verified by ERM (Environmental Resources Management). Web pages to which the verification applies are indicated by this symbol. ERM's verification statement is on page 70.



#### How we Manage Health and Safety

We manage health and safety through an integrated environment, health and safety (EHS) management system. The system incorporates our EHS and Employee Health Policies, EHS Vision and 64 Global EHS Standards. Our EHS Plan for Excellence sets out our strategy for improving EHS performance up to 2010 and is currently being renewed to extend to 2015.

Our Corporate Environment, Health and Safety (CEHS) and Employee Health Management (EHM) teams help coordinate our health and safety programmes.

In these pages we summarise activities during 2005 that relate specifically to health and safety. See the EHS Management pages for information on how we manage environmental and broader EHS issues.

#### Training and awareness

EHS training is targeted to match employee responsibilities. Employees with responsibility for H&S issues receive regular training about initiatives in areas such as ergonomics, chemical exposures and driver safety. This is handled through regional meetings of H&S staff. They in turn train employees in manufacturing, research, sales and other divisions. CEHS and EHM arrange annual meetings to determine training issues and provide training materials.

We also want employees to be aware of health and safety in their personal lives. Employee bulletins, announcements on the myEHS website, the CEO's EHS Excellence awards programme and Health and Safety Week activities aim to raise employee awareness of issues such as wearing seat belts, being careful with electricity and using ladders appropriately.

## 5 Employment practices continued

We conduct a Health and Safety Week every October (to coincide with the European Health and Safety week and Fire Safety Awareness Month in the United States). Information kits are sent to all sites to help them develop ideas and plan activities.

In 2005, over 17,500 employees from 70 sites in 32 countries took part in the Health and Safety Week. Activities included sports days, safe driving education, ergonomics training, awareness-raising on noise and safeguarding hearing, healthy eating and lifestyles, and family participation events.

### Health and Safety Feedback From our EHS Audits

We aim to conduct EHS audits at each operational site at least once every four years. We carry out more frequent visits at selected sites, depending on an assessment of risk and the issues raised by previous audits.

At the end of 2005 we assessed the performance of all facilities (except small commercial sites) using self-assessment and internal audit. (We audited 33 sites). The average score was 77%, but 3 sites achieving a score below 50%, which we regard as unacceptable. While the average score exceeds our target of 75% we will aim to correct unacceptable performance and continue to pursue further improvements to achieve best practice.

Our audits identified several priority areas:

- Chemical exposure risks
- Chemical risk assessment and control
- Managing resilience and mental well-being
- Ergonomic risk assessment and control
- Scope and adequacy of workplace risk assessments
- Self-auditing of health and safety programmes
- Management systems implementation

We aim to drive improvements in poorly-performing areas through actively tracking audit findings and identifying improvements with follow-up audits. For sites scoring less than 50%, we also provide increased support from the audit team, including follow-up visits to ensure progress, and discussions with senior business management about increased site resources. Many sites require several years to put adequate systems and programmes in place in these areas.

We also introduced or continued specific work in the following areas in 2005 to achieve improvements:

- **Chemical Agents** – targets set within manufacturing for promoting more accurate exposure determinations and ensuring adequacy of respiratory protective equipment at unit operations; discussions and presentations during Network Meetings
- **Resilience** – rollout of the tool for assessing team resilience, training during EHS Network Meetings
- **Ergonomics** – training in ergonomic risk assessment during Network Meetings as well as regional training
- **Risk assessment** – the Guideline was revised and aligned with the risk assessment requirement in the Quality group
- **Self audit** – training and workshop on self-auditing conducted at EHS Network Meetings
- **Management System elements** – rollout of the Management System Toolkit as described below

All sites are required to develop plans to address any weaknesses and potential improvements identified in the audit. Auditors monitor sites' progress in implementing the plans. Auditors are trained and their findings compared to ensure consistency. In 2005 we continued to refine the EHS audit process and scoring system based on experience and feedback. We have also installed EHS auditing software on our intranet to help sites and auditors track progress.

### OHSAS 18001 Certification

In 2005, two additional sites achieved certification to the international health and safety standard OHSAS 18001. This brings the total number of manufacturing sites certified to 16 out of 89 pharmaceutical, consumer and vaccine manufacturing sites, with one additional site that certified only the utilities area. The certified sites are in China, Egypt, France, India, Kenya, Mexico, Poland, Saudi Arabia, Turkey and the UK. See audits and certification for information on certification to the environmental management standard ISO14001.





## Employment practices continued

### Excellence Awards

The Chief Executive Officer's Environment, Health and Safety (EHS) Excellence Awards recognise and reward innovation by GSK sites. These were the winning entries in the EHS Initiative health & safety category in 2005:

**First Place:** Barnard Castle, UK for "Proven Capability for the 'Shirt Sleeve' Working Environment"

The site has moved toward controlling operator exposure to highly potent compounds by using containment for routine tasks, rather than using respiratory or protective equipment to guard against exposure. EHS considerations are integrated into the site's business model for introducing new products, which has allowed containment to be integrated into the design for manufacture.

**Second Place:** Wavre, Belgium for "SOBANE" an Innovative Approach to Safety"

Wavre introduced a new approach to safety management in 2005 that has significantly reduced the number of injuries. It is one of three GSK Biologicals sites in Belgium involved in the research, development and production of vaccines.

The site has a specially-designed building where more than 100 employees work filling vials and syringes with vaccines. During 2003 there were seven lost-time injuries in the building and in the first nine weeks of 2004 there were five accidents resulting in disability, with the type of injuries sustained getting significantly worse. The EHS department responded by introducing a new safety management methodology known as 'Sobane'.

The Sobane method involves the active participation of staff in screening for potential safety risks and finding solutions. Every member of staff becomes a member of a team with an active safety role.

The method was introduced in May 2004 and has resulted in 96% of potential safety risks being solved by staff. Between May 2004 and May 2005 there were no lost-time injuries and more than 400 days passed without an accident resulting in disability.

The method has since been expanded to all GSK Biological sites in Belgium and we plan to introduce it to all GSK Biological sites around the world.

**Third Place:** Cork, Ireland for "Bulk Solvent Metering in a Research and Development Pilot Plant"

The introduction of bulk solvent metering at the Cork pilot plant has eliminated the need for handling of 2,018

drums of solvent per year. This has reduced the risk of solvent being spilled as well as reducing cleaning and disposal requirements for waste drums and pallets. No musculoskeletal injuries were reported nor were there any incidents involving chemical burns or solvent splashes from the time the metering system was introduced until the award was given.

See CEO's EHS Excellence Award on the website for more about the awards programme and winners from previous years.

### Injury and Illness Rates and Causes

Our main measure of injury and illness is the number of incidents which result in one or more days away from work (lost time). We express this as a rate per 100,000 hours worked.

Our target was to reduce this lost-time rate by 15% each year to the end of 2005. In fact this rate has not improved since 2003, which suggests that we have reached a plateau in the effectiveness of our prevention programmes.

In 2006 we will renew efforts to improve the effectiveness of these programmes, but will also focus on reportable injuries and illnesses that do not result in time off work. (Reportable incidents are more serious than first aid, even though they do not result in a day off work.) Safety experts believe that addressing the causes of these less serious injuries will result in improvements in both categories.

We also measure the number of days lost from injuries and illnesses. This provides an indication of the severity of the incidents, although it is only a rough guide. For example, an illness could lead to permanent hearing loss or other disability without resulting in significant lost time.

The main data covers GSK employees and contract workers who we directly supervise. Separately, we report data for contractors who work on GSK sites but supervise their own staff. (This data is not covered by the ERM verification).

### Causes of Injuries and Illnesses

Injuries with and without lost time arise mainly from slips, trips or falls, over-exertions or strains and motor vehicle accidents.

Lost-time illness stems mainly from mental ill-health and musculoskeletal problems (primarily repetitive strain injury). Musculoskeletal illness is the main cause of reportable illness which does not lead to days off work, accounting for almost a third of the total.

## Employment practices continued

### Mental ill-health

Cases of work-related mental ill health are excluded from the overall illness rate. This is because the consistency of reporting such cases is less robust than other occupational illnesses and there are variations in the way these illnesses are defined under local legislation which affects reporting. We are working to address these inconsistencies and aim to include these cases in the future. In 2005, the mental ill health rate (involving lost time) was 0.01 per 100,000 hours worked. Mental ill-health was the second most significant cause of work-related sickness absence, accounting for 41% (1026 days) of the total.

For information on programmes to reduce illness and injury, see Health Programmes and Safety Programmes.

### 2005 Highlights

At 77 sites in 30 countries, there were no lost time injuries or illnesses during the year. In addition:

- one site in India achieved 5 million hours worked without a lost time injury or illness;
- one site in Singapore achieved 4 million hours worked without a lost time injury or illness;
- six sites in Canada, China, India and Pakistan achieved 2 million hours worked without a lost time injury or illness;
- fourteen sites in China, France, India, Mexico, Pakistan, Philippines, South Africa, UK, and the US achieved 1 million hours worked without a lost time injury or illness.

### Performance

The table summarises our experience in 2005, while the charts illustrate trends.

In 2005 we recorded 984 injuries and 344 illnesses, compared to 949 and 406 respectively in 2004. Employees lost working days in 624 of these incidents (580 in 2004). Comparing our record with the expected relationship between incidents that result in lost time and those which don't suggests that we undercount the real number of injuries and illnesses that do not result in lost time. We are working to improve our reporting of these injuries and illnesses.

In 2005, approximately 17% of illnesses resulted in permanent disabilities, such as noise-induced hearing loss, sensitisation to chemicals and some musculoskeletal illnesses.

GSK's injury and illness performance placed us in the third quartile of a benchmark industry group in 2004.

### Causes of injuries and illnesses

The main causes of injuries were motor vehicle accidents, slips, trips and falls. Illnesses leading to lost time were mainly musculoskeletal or concerned with mental ill-health. Chemical-related dermatitis following exposure to chemicals at work caused a significant number of illnesses which did not lead to lost time.

### Our record in 2005

Workplace injury and illness incidents

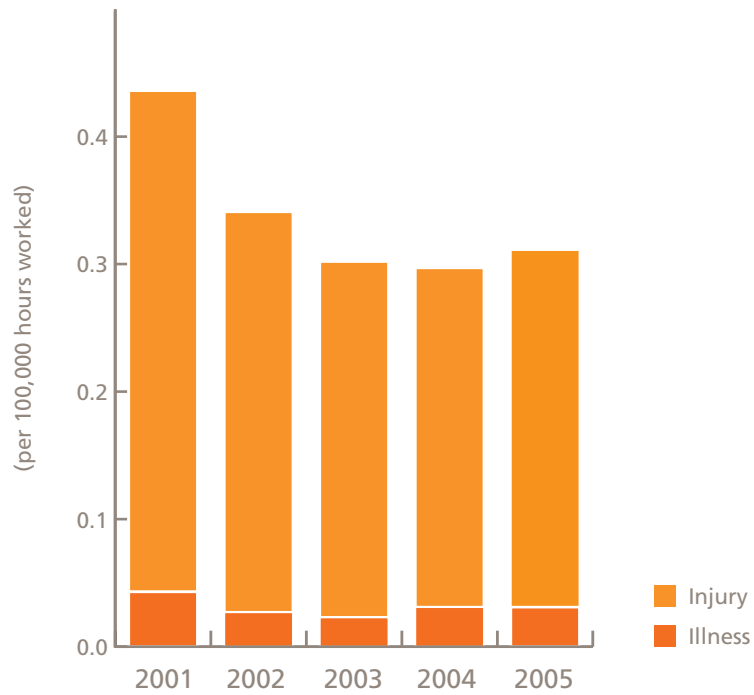
|  | GSK employees |           | Contractors* |
|--|---------------|-----------|--------------|
|  | Injuries      | Illnesses |              |
| <b>Incidents leading to lost time</b>                  | 547           | 50        | 100          |
| – musculoskeletal (included above)                     | 90            | 30        |              |
| – mental illness (not included above)                  |               | 27        |              |
| <b>Days lost (excluding mental illness)</b>            | 11,080        | 1,492     | 1,551        |
| <b>Reportable incidents (not leading to lost time)</b> | 437           | 261       | 276          |
| – musculoskeletal (included above)                     | 73            | 80        |              |
| – mental illness (not included above)                  |               | 6         |              |

\*contractor data is not included in the verification by ERM



## Employment practices continued

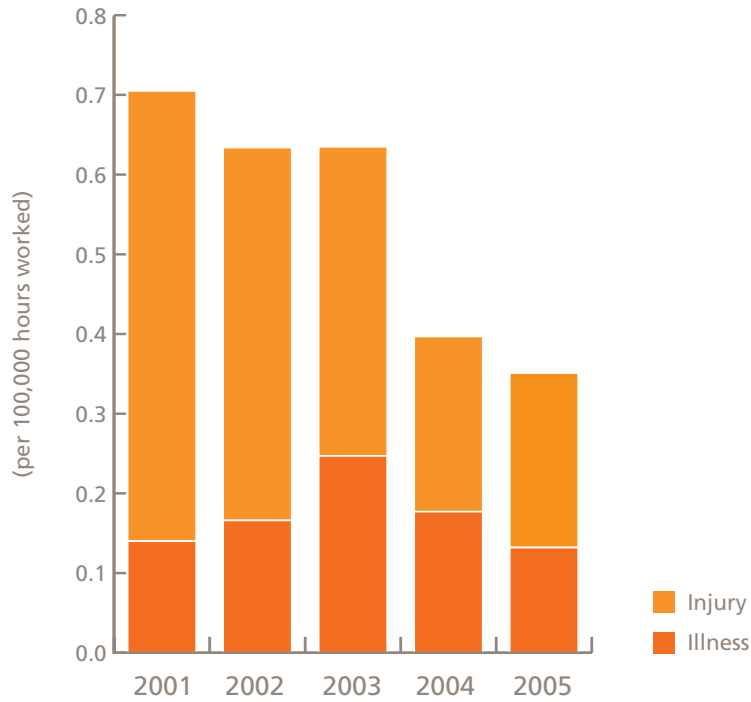
### Lost time injury and illness rate



| Lost time injury and illness rate |         |        |       |
|-----------------------------------|---------|--------|-------|
| Year                              | Illness | Injury | Total |
| 2001                              | 0.04    | 0.39   | 0.43  |
| 2002                              | 0.03    | 0.31   | 0.34  |
| 2003                              | 0.02    | 0.28   | 0.30  |
| 2004                              | 0.03    | 0.27   | 0.30  |
| 2005                              | 0.03    | 0.28   | 0.30  |

## Employment practices continued

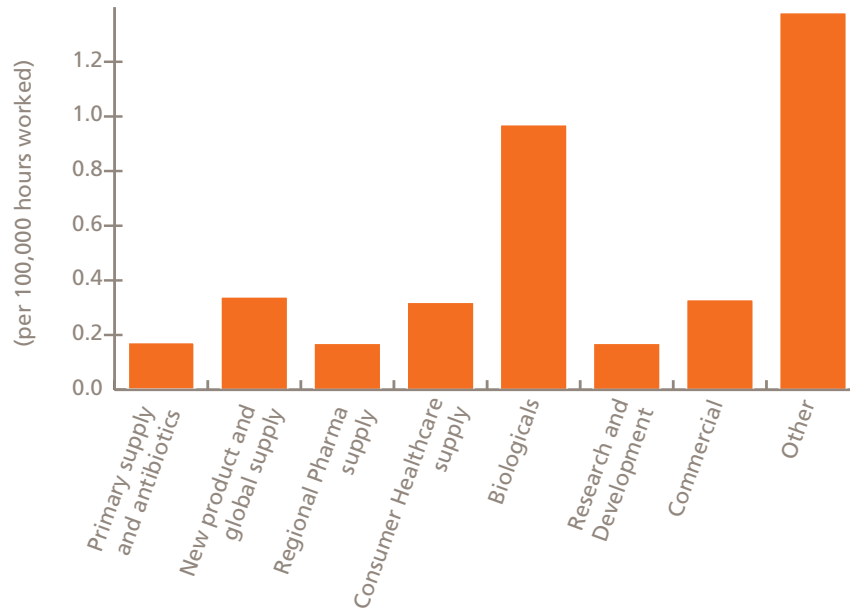
### Reportable injury and illness without lost time rate



| Reportable injury and illness without lost time rate |         |        |       |
|--|---------|--------|-------|
| Year   | Illness | Injury | Total |
| 2001   | 0.15    | 0.56   | 0.71  |
| 2002   | 0.17    | 0.47   | 0.63  |
| 2003   | 0.25    | 0.39   | 0.64  |
| 2004   | 0.18    | 0.22   | 0.40  |
| 2005   | 0.13    | 0.22   | 0.35  |

## Employment practices continued

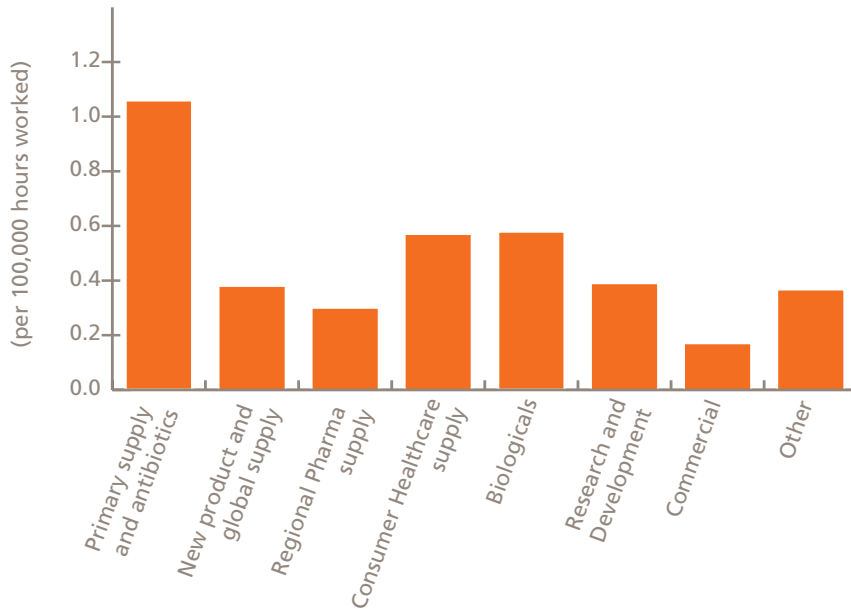
### Lost time injury and illness by business



| Lost time injury and illness by business |          |
|--|----------|
|  | I&I rate |
| Primary supply and antibiotics           | 0.17     |
| New product and global supply            | 0.34     |
| Regional Pharma supply                   | 0.17     |
| Consumer Healthcare supply               | 0.32     |
| Biologicals                              | 0.97     |
| Research and Development                 | 0.17     |
| Commercial                               | 0.33     |
| Other                                    | 1.38     |

## Employment practices continued

### Reportable injury and illness without lost time by business

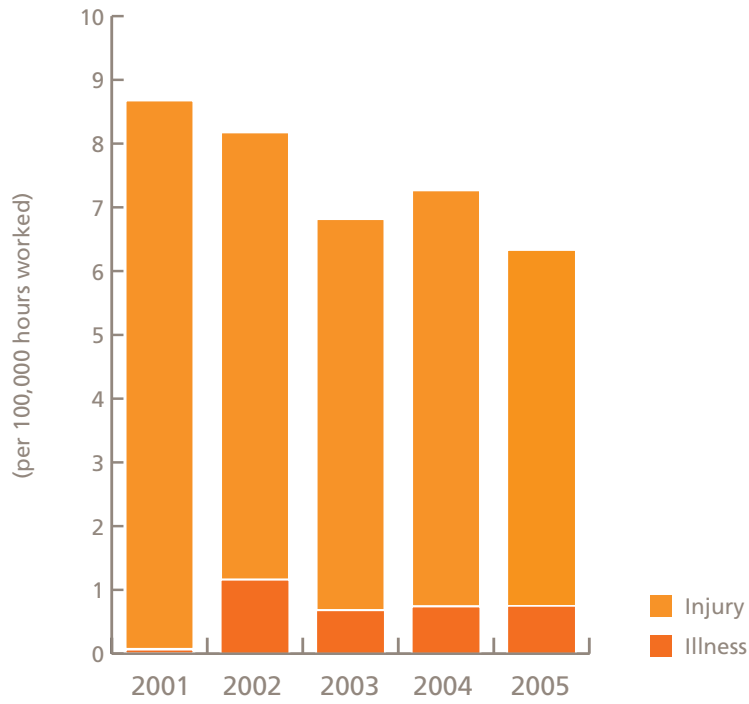


| Reportable injury and illness without lost time by business |          |
|---|----------|
|   | I&I rate |
| Primary supply and antibiotics                              | 1.06     |
| New product and global supply                               | 0.38     |
| Regional Pharma supply                                      | 0.30     |
| Consumer Healthcare supply                                  | 0.57     |
| Biologicals   | 0.58     |
| Research and Development                                    | 0.39     |
| Commercial  | 0.17     |
| Other   | 0.37     |



## Employment practices continued

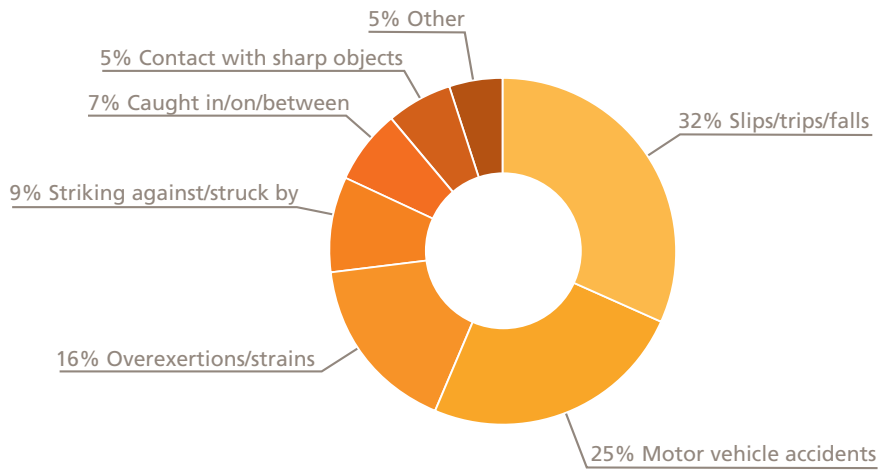
### Calendar days lost rate



| Calendar days lost rate |         |        |       |
|-------------------------|---------|--------|-------|
| Year                    | Illness | Injury | Total |
| 2001                    | 0.07    | 8.61   | 8.68  |
| 2002                    | 1.16    | 7.02   | 8.18  |
| 2003                    | 0.68    | 6.14   | 6.82  |
| 2004                    | 0.74    | 6.53   | 7.27  |
| 2005                    | 0.75    | 5.58   | 6.34  |

## Employment practices continued

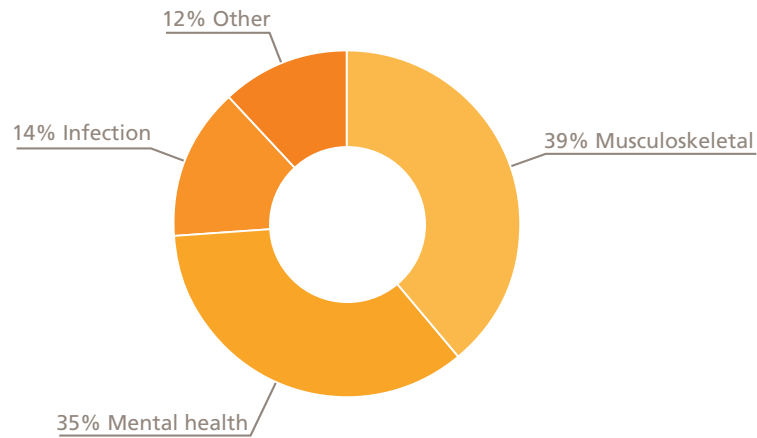
### Categories of lost time injury



|                            |            |
|----------------------------|------------|
| Slips/trips/falls          | 174        |
| Motor vehicle accidents    | 137        |
| Overexertions/strains      | 90         |
| Striking against/struck by | 51         |
| Caught in/on/between       | 37         |
| Contact with sharp objects | 30         |
| Burns-thermal/chemical     | 17         |
| Foreign bodies/objects     | 6          |
| Other                      | 3          |
| Workplace violence         | 1          |
| Electrical/fire/explosion  | 1          |
| Animal/insect              | 0          |
| <b>Total</b>               | <b>547</b> |

## Employment practices continued

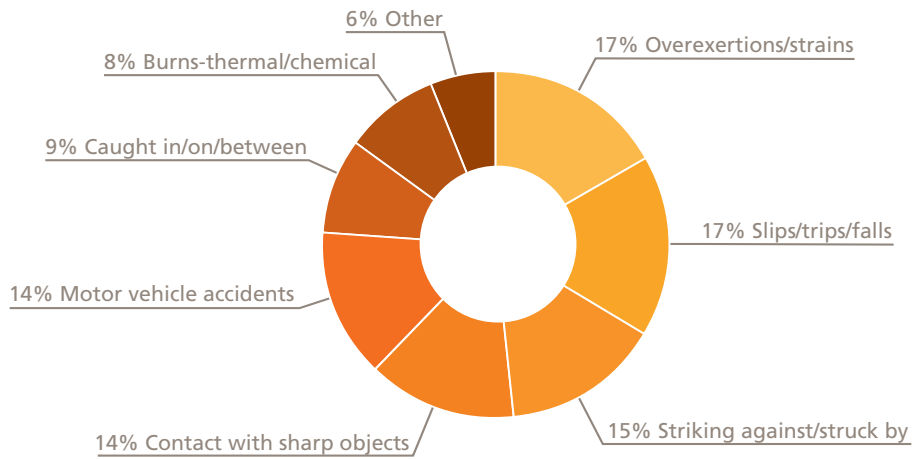
### Categories of lost time illness



|                          |           |
|--------------------------|-----------|
| Musculoskeletal          | 30        |
| Mental health            | 27        |
| Infection                | 11        |
| Other                    | 5         |
| Non-allergic respiratory | 2         |
| Allergic respiratory     | 2         |
| Non-allergic dermal      | 0         |
| Systemic                 | 0         |
| Allergic dermal          | 0         |
| Physical                 | 0         |
| Cancer                   | 0         |
| Reproductive             | 0         |
| <b>Total</b>             | <b>77</b> |

## Employment practices continued

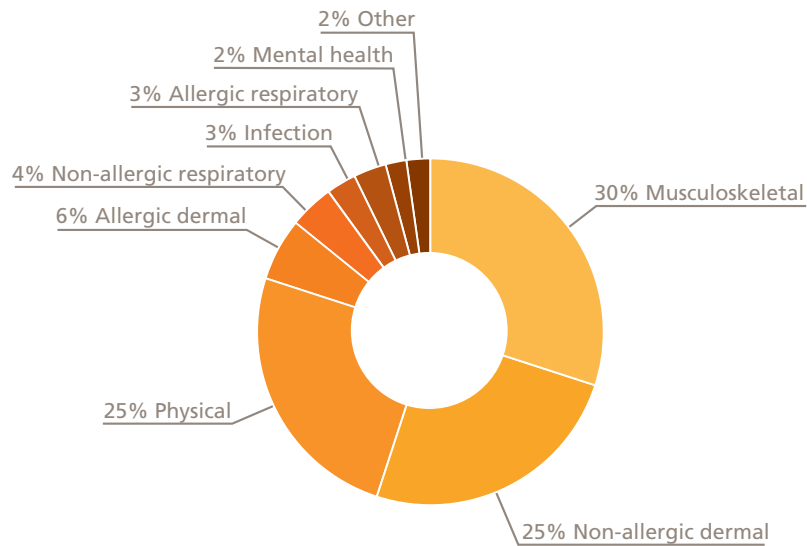
### Categories of reportable injury without lost time



|                            |            |
|----------------------------|------------|
| Overexertions/strains      | 73         |
| Slips/trips/falls          | 75         |
| Striking against/struck by | 66         |
| Contact with sharp objects | 62         |
| Motor vehicle accidents    | 59         |
| Caught in/on/between       | 40         |
| Burns-thermal/chemical     | 37         |
| Animal/insect              | 14         |
| Foreign bodies/objects     | 8          |
| Other                      | 2          |
| Electrical/fire/explosion  | 1          |
| Workplace violence         | 0          |
| <b>Total</b>               | <b>437</b> |

## Employment practices continued

### Categories of reportable illness without lost time



|                          |            |
|--------------------------|------------|
| Musculoskeletal          | 80         |
| Non-allergic dermal      | 68         |
| Physical                 | 68         |
| Allergic dermal          | 15         |
| Non-allergic respiratory | 11         |
| Infection                | 8          |
| Allergic respiratory     | 7          |
| Mental health            | 6          |
| Other                    | 2          |
| Systemic                 | 2          |
| Cancer                   | 0          |
| Reproductive             | 0          |
| <b>Total</b>             | <b>267</b> |

## Employment practices continued

### Summary tables

| Injuries and Illnesses with lost time – rate per 100,000 |        |         |
|--|--------|---------|
| Year   | Injury | Illness |
| 2001   | 0.39   | 0.04    |
| 2002   | 0.31   | 0.03    |
| 2003   | 0.28   | 0.02    |
| 2004   | 0.27   | 0.03    |
| 2005   | 0.28   | 0.03    |

| Injuries and Illnesses without lost time – rate per 100,000 |        |         |
|---|--------|---------|
| Year  | Injury | Illness |
| 2001  | 0.56   | 0.15    |
| 2002  | 0.47   | 0.17    |
| 2003  | 0.39   | 0.25    |
| 2004  | 0.22   | 0.18    |
| 2005  | 0.22   | 0.13    |

| Calendar days lost – rate per 100,000 |        |         |
|---------------------------------------|--------|---------|
| Year                                  | Injury | Illness |
| 2001                                  | 8.61   | 0.07    |
| 2002                                  | 7.02   | 1.16    |
| 2003                                  | 6.14   | 0.68    |
| 2004                                  | 6.53   | 0.74    |
| 2005                                  | 5.58   | 0.75    |

### Supplier Health and Safety Performance

In 2005 we requested information from 39 suppliers (includes both contract manufacturers and key suppliers), 23 of which provided data. Some of these had not provided data in 2004 so we do not have comparative figures. In 2005, these 23 suppliers reported a total of 32.7 million work hours.

### Lost Time Injury and Illness

There were 187 lost time injuries and 16 lost time illnesses, a rate of 0.62 lost time injuries and illnesses per 100,000 hours worked.

### Injury and Illness Without Lost Time

There were 641 injuries without lost time and 75 illnesses without lost time, 2.18 injuries and illnesses without lost time per 100,000 hours worked.

### Calendar Days Lost from Injury and Illness

There were 2,668 lost days from injuries and 940 days lost from illnesses, 11.03 calendar days lost per 100,000 hours worked.

### Notes to charts

The health and safety data cover both our employees and contract workers who are directly supervised by GSK employees.

All injury and illness rates are per 100,000 hours worked.

Lost time injuries and illnesses are work-related injuries and illnesses that are serious enough to result in one or more days away from work.

Lost calendar days are the calendar days that employees could not work because of work-related injuries and illnesses. This helps to provide a measure of the severity of injuries and illnesses.

Reportable injuries and illnesses without lost time are reported incidents that did not result in time away from work (lost time). They are more serious than first aid but generally less serious than lost time.

We do not include cases of mental ill health in our lost time or reportable illness rates. This is because of variations in the way mental ill-health is defined and reported across sites globally, which we are working to address.

## Employment practices continued

### Serious Incidents and Fatalities

We deeply regret that one employee died in a work-related driving incident in Egypt, and two members of the public were killed during 2005 in driving accidents involving GSK employees.

We are working to reduce traffic related accidents through our driver safety programme (see safety programmes).

We have seen a reduction in the number of work-related fatalities in the last few years. This is consistent with the targets for improving health and safety performance set out in the Plan for Excellence. Contractor fatalities have remained largely constant over the same period.

Five year trend in employee fatalities:

|      | Fatalities |
|------|------------|
| 2001 | 5          |
| 2002 | 3          |
| 2003 | 5          |
| 2004 | 2          |
| 2005 | 1          |

We also report serious incidents ie incidents that result in permanent disability or those that are reported to regulatory authorities. In 2005, accidents involving machinery resulted in three employees (at sites in South Africa, the US and Puerto Rico) suffering finger amputations. One contract temporary worker at a site in the US had to have his lower leg amputated as a result of a forklift incident. Twenty two employees had to be evacuated from a site in France following the accidental release of a hazardous chemical. Nine needed medical treatment, eight of whom were hospitalised for the night. One sales employee in the US was involved in a multi vehicle road accident that resulted in severe injury and hospitalisation. An employee in the UK suffered burns to 18% of his body as a result of burst pipework releasing boiling water and steam.

We investigate the circumstances of all fatalities and other serious incidents and assess what can be learned to reduce the risks. We also issue global alerts (posted on our intranet site) to communicate information that could help prevent similar incidents at other sites.

### Employee Health

A workplace culture that supports a healthy and resilient workforce drives positive business performance. Protecting and promoting the wellbeing of our employees increases employee productivity and attendance, reduces health care and health insurance costs and supports us in our goal to be an employee of choice. This is aligned with GSK's mission of improving quality of life.

In the sections below, we focus on the steps we have taken to improve ergonomics, resilience (managing pressures and stress) and attendance. We also provide information on our HIV initiatives and planning process for a potential worldwide influenza pandemic.

### Health Programmes

Our health programmes enable employees and their families to benefit from better health and enhanced quality of life, while the business gains from increased employee commitment and productivity and from reductions in the financial impact of ill-health.

We have a range of programmes to support employee wellbeing including on-site health and fitness centres, flexible working arrangements, and family support services. Healthcare benefits focus on prevention and access to innovative and proven treatments. For example, in the US employees receive free immunizations, cancer screening, help with smoking cessation and regular check ups. We assist employees suffering from chronic diseases with their medical plans and provide support to help them continue with treatments.

We have developed a scorecard to measure and track our progress in improving employee health and adding value to the business. The scorecard contains quantitative measures including ill-health absence rates. We will report our performance against these measures and targets in 2006.

In 2005 we held five workshops globally with Environment Health & Safety and Human Resources to share information and best practice. Our Employee Health Management Department supports sites across GSK in implementing our Employee Health Policy and achieving consistent standards. We carry out internal audits to monitor site performance and oversee improvement plans.

### Ergonomics

Musculoskeletal illness and injury is one of the leading causes of ill health resulting in time away from work. In 2004 we appointed a full-time professional ergonomist to lead the development of our ergonomics strategy. We have set a target to reduce the number of ergonomic



## 5 Employment practices continued

illnesses and injuries 10% by 2010. Improving workplace and job design will also improve efficiency and productivity.

An internal 'ergonomics university' was established in 2005 to increase knowledge of ergonomic issues and best practice among GSK employees. We introduced computer presentations on a variety of ergonomic topics and a CD-based programme for commercial field-based employees covering ergonomics "on the go". A Global Ergonomic Community website was developed for employees to discuss issues, share ideas and access resources. It includes best practice examples ranging from laptop ergonomics to lifting.

We launched an on-line ergonomics risk assessment for office-based employees to help reduce ergonomic injuries associated with computer use. The programme is used at over 150 GSK sites worldwide and has been translated into Spanish, French, Italian and Polish. In 2005, 5,540 employees completed the computer-based risk assessment. We are developing a similar risk assessment tool for non-office based employees that will be piloted in our US manufacturing sites.

In 2005 we established employee-led ergonomic improvement teams at 26 manufacturing sites in the UK, US, and Latin America. Their role is to embed ergonomic design considerations into workplace practices and procedures. For example, the team at our Zebulon site in the US has made a number of improvements to the work environment. These include the use of adjustable height carts to reduce injuries from lifting heavy items such as rolls of material. It also reduces waste due to reduced manual handling of the materials. We will launch ergonomic improvement teams at manufacturing facilities across Europe and Asia in 2006.

### Resilience

Mental illness is another one of the leading causes of ill health resulting in time away from work. We use the term 'resilience' to describe the set of skills and behaviours needed to be successful in a highly pressured, fast-paced and continuously changing environment. This enables us to support employees to manage work and home demands more effectively, and minimises the adverse health affects of stress. Data from our resilience programmes show that this can improve business results along with employee commitment and engagement. These programmes fully support UK legislative requirements to tackle sources of workplace stress.

Our team resilience programme is a participatory, proactive quality- improvement process utilizing assessment tools to identify sources of workplace stress with a team-based solution focused process. It looks at issues that can cause pressure and affect performance such as work demands, team relationships, management practices, career and development concerns and work culture. Individual team members get a confidential personal profile and a tailored action plan is developed by the whole team. In 2005, 5,800 staff took part in team resilience programmes. The programme has been translated into Spanish, Portuguese, French, German, Italian, Japanese and Mandarin.

The majority of GSK sites have programmes to reduce workplace pressures and help employees achieve a good work-life balance. These include time management training, flexible working options, health awareness and education initiatives. Over 50% of our employees worldwide have access to Employee Assistance Programmes that provide confidential support 24 hours a day along with additional counselling as needed.

The team resilience programme received external recognition from the UK Health and Safety Executive (HSE), and was nominated for several awards which included winning Personnel Today's Managing Health at Work award.

### Attendance

Long-term employee absence has a financial impact on GSK through lost productivity and efficiency. By limiting employee absence and helping those off work return as soon as appropriate, we can minimise these costs and improve employee wellbeing.

In 2004 we launched a new case management approach to long-term employee absence in the UK. This involves close collaboration between the EHM team, HR staff, line managers and the employees themselves. Key elements include accurately measuring absence and ensuring that we maintain regular contact with employees who are off work. We make sure that employees and their doctors know about the wide-range of in-house support available at GSK, including access to physiotherapists, counsellors and occupational health physicians.

A rehabilitation plan is agreed with the employee. This may include making modifications to their workplace, reducing work hours or finding alternative work until they are fully recovered.

## 5 Employment practices continued

Initial results suggest that this approach has led to a fall in absence rates at several sites from approximately 7% to around 3% over 2 years. It is estimated that one manufacturing site in the UK has experienced cost savings of about £1.5 million based on the direct and indirect costs of absence. Employees are returning to work more quickly as they are not being signed off for longer than necessary. Staff feedback indicates that the majority of employees feel better-informed, valued and supported.

During 2006 we will continue to roll out the new procedures across our sites in the UK. We plan to complete this process by mid 2006. Our target in the UK is to reduce the number of days lost due to long-term absence by 10% in 2006. We have set a target for our manufacturing sites worldwide to achieve at least 98% attendance by 2010.

### HIV/AIDS

We provide antiretroviral treatment (ARV) to all HIV positive GSK employees (full and part-time) and their families in the developing world where treatment is not provided adequately or consistently by the local healthcare system.

We offer preferentially priced ARVs to other employers in Sub-Saharan Africa who provide care and treatment for staff. See Preferential Pricing.

We have developed awareness-raising initiatives for use worldwide. In 2005, educational materials developed by GSK Kenya and the Positive Action Programme [[www.gsk.com/positiveaction](http://www.gsk.com/positiveaction)] were adopted by other companies in Kenya, reaching an estimated 10,000 employees in the public and private sectors. The materials have been translated into French and are now available to companies in Burkina Faso, Cameroon, Chad, Gabon, Madagascar and Mali. In early 2006, the materials will be translated into Arabic with help from companies in Morocco. GSK Mexico and GSK Dominican Republic will develop similar, Spanish-language resources for use in Central America. GSK India has also started this process with three employee workshops on HIV and AIDS and a pilot survey demonstrating the need for more employee HIV education.

### Influenza Pandemic

Global outbreaks of Avian Influenza (bird flu) have highlighted the danger of a potential worldwide influenza pandemic. Externally, we are working with governments and the WHO to assist with the provision and development of antiviral drugs and vaccines to manage a potential pandemic. Internally, we have a cross business

team that has developed a global policy and plan for GSK business continuity and employee health preparedness. A plan that minimises the impact of a pandemic on our employees, and ensures we are able to continue manufacturing medicines and vaccines.

### Safety Programmes

We systematically assess risks to anticipate potential accidents, and put programmes in place to minimise them. We learn from investigating the causes of accidents and make improvements accordingly. In this section we cover three key areas: driver safety, process safety and chemical exposure.

For information on our approach to ergonomics see Employee Health.

### Driver Safety

Our sales representatives drive long distances every year and are therefore particularly at risk of being involved in work-related road traffic incidents. In 2005, there were 137 driving accidents resulting in lost time, and these accounted for 25% of lost-time injuries.

Our Global EHS standard on Occupational Travel includes requirements on driver safety. In 2004 we developed 11 technical instruction documents to help GSK businesses comply with the standard. These cover topics such as training, vehicle selection, risk assessment, accident reporting, driving and the environment. In 2005 we combined these documents with additional safety guidelines to create a compliance tool for commercial businesses called 'EHS Essentials'.

Approximately 60% of GSK's Commercial businesses have extensive driver safety programmes in place. They include driving licence checks, guidance on the use of mobile phones in vehicles, driver safety training, tracking and reporting incidents. We are working to ensure all sites have the same high standards in place.

In a few countries we provide motorbikes or scooters for employees and have produced a GSK Motorbike Rider Safety Manual. This has been translated and distributed to employees in countries such as Bangladesh, India, Indonesia, Pakistan and Vietnam. These countries have now also fully implemented the GSK requirement for every driver of a motorbike to wear a helmet. We will continue to follow up and monitor the implementation of the motorbike safety programme.

## 5 Employment practices continued

### Process Safety and Safety Engineering

Our process safety programme ensures that safety is built into all manufacturing, research and development processes. The programme is based on hazard identification, control and risk assessment. During 2005 we expanded our Risk Assessment Tools & Evaluations (RATE) System. It now includes tools covering: Failure Mode & Effects Analysis, Hazard & Operability, and Failure Mode Effects Criticality Analysis. The programmes apply globally, allowing us to standardize assessment documentation and share safety information across all business sectors.

In 2005 we launched an initiative to ensure our Primary Supply and Antibiotics Supply Chain has updated safety plans that focus on key risks and regulatory compliance.

### Material Hazard Information

Our HazClass System tracks hazardous material shipments worldwide and monitors the transportation of over 10,000 materials per month.

We have developed safety data sheets (SDSs) for more than 1,200 of our products. Some 600 of these for pharmaceutical products that are sold in the US or Europe are available on our website [www.msds-gsk.com](http://www.msds-gsk.com). An email notification tool automatically keeps employees up-to-date with changes to SDSs. We have started to make environmental testing data available on our SDSs.

### Occupational Hygiene and Control of Chemical Exposure

In 2005, exposure to chemicals resulted in 4 respiratory or skin-related lost-time incidents and 101 cases which did not result in lost time. Together, they accounted for 31% of work-related illnesses.

In 2004 we developed a strategy to control chemical exposure up to 2010. This sets out a plan of action for achieving our 2010 goal of a 'shirt sleeve' working environment – a workplace where we contain chemicals using engineering controls during manufacture so that employees do not need to wear protective equipment.

In 2005 we introduced several steps to help us achieve this goal:

- we commissioned a benchmarking study of containment methods for potent chemical compounds
- we seconded a member of Engineering staff to Corporate EHS to work on ensuring that all relevant operations have engineering controls
- our new product support process is designed to integrate EHS considerations into product design. Teams include a product stewardship/occupational toxicology expert whose role is to ensure that chemical exposure and other EHS considerations are built into product design
- we began recruiting Regional Hygienists to deliver an improved Occupational Hygiene (OH) service to businesses
- we began to design dispensary equipment for powdered pharmaceutical ingredients which eliminates the need for protective equipment



## Human rights

**Human rights is a broad subject that is relevant to GSK in a number of different contexts. In this section we discuss human rights for GSK employees and human rights in our supply chain.**

**For information on our preferential pricing arrangements for HIV/AIDS medicines, see Access to medicines.**

Most of our direct employees are well educated and skilled people for whom we are striving to make our company an attractive employer. Generally our employment standards on issues such as diversity, equal opportunities and health and safety provide adequate safeguards on human rights for these employees.

Our supply chain is complex, diverse and global. We recognise it is possible that suppliers in some countries do not fully respect the human rights of their workers or local communities. Within our sphere of influence, we have begun work to ensure that our suppliers observe similar standards to ours in their relations with employees and communities.

The risk of human rights issues occurring is not as significant for GSK as for companies in some other industries. Nevertheless there are several reasons why we need to take human rights seriously. Achieving high standards on human rights supports our reputation and our goal of operational excellence. It helps us to get the best from our employees. By working with suppliers that match our standards, we help ensure the smooth operation of supplier contracts and therefore a reliable supply of high quality products.

### EMPLOYEE HUMAN RIGHTS

The human rights of our employees at work are protected by our employment policies and procedures. For more details see Employment.

We operate globally, including in countries where the government does not fully respect human rights. We believe our presence in these countries is vital to ensure continued access to medicines for their people. We aim to create a workplace for employees in these countries where the standards match those in our operations elsewhere, and thereby contribute to improving employment practices generally.

We conduct an annual human rights employment audit to make sure we are delivering our commitment to international human rights standards. The head of Human Resources in each country where we operate is required to report on whether GSK employment practices meet these

standards via a self-assessment questionnaire. In 2005 this audit did not identify any human rights issues in our workforce

We can confirm that GSK does not employ children or anyone younger than 16. All our employees are entitled to join trade unions and to organise, in countries where this is permitted by national legislation. We are committed to listening and responding to the views of our employees, including through works councils and staff consultation committees, see Internal communication.

Discrimination and harassment are not tolerated under any circumstances. Employees can report any concerns to senior management on a confidential basis, using our global integrity helpline. During 2005 there were no cases reported by employees to our compliance function that directly raised human rights issues.

### SUPPLY CHAIN HUMAN RIGHTS

Our supply chain is complex, with over 75,000 suppliers worldwide. It ranges from major strategic relationships with suppliers that manufacture raw materials and packaging for GSK medicines through to local contracts for goods or services such as office equipment, cleaning and security.

We endeavour to ensure that all our suppliers follow the same high standards on human rights that apply to GSK. Given the size and global scope of our supply chain we recognise that some suppliers may not fully respect the human rights of their workers or local communities.

We have started to work with suppliers on these issues through the inclusion of human rights clauses in supplier contracts (see next page).

We also cover human rights issues during our routine interactions with two categories of critical suppliers – the contract manufacturers that make GSK-branded medicines and consumer health products and the suppliers of raw materials and packaging to our manufacturing sites. Historically these suppliers have tended to be based in Europe and North America, but there is a growing trend towards sourcing these materials from other areas of the

## Human rights continued

world such as Asia. We visit our critical suppliers regularly to review performance and to identify and resolve any issues, including any potential human rights issues. These interactions include:

- Pre-assessment of potential new critical suppliers through questionnaires, on-site reviews and Quality and EHS Audits. These assessments cover facilities which will directly supply GSK.
- On-going critical supplier reviews include follow-up visits by Procurement, Quality and EHS staff. We also hold global and regional supplier review meetings where senior GSK managers address and interact with suppliers on key issues.

It is important that our procurement teams understand our human rights standards. We provide training and guidance on human rights for GSK procurement staff as part of our Sourcing Group Management programme. This explains how we develop sourcing strategies and our criteria for supplier selection, including human rights. The training is compulsory for all new procurement staff.

Given the size and complexity of our supply base it is not possible to engage directly with all our suppliers on human rights. As well as our routine engagement with critical suppliers, during 2006 we will start a pilot project to assess the risk of human rights issues occurring among suppliers of services where there is a large labour input, for example cleaning or security.

We also engage with suppliers on environmental, health and safety issues, see Environment and Working with our Ribena suppliers to improve biodiversity, below.

### Supplier contracts

We are adding human rights clauses to our supplier contracts. These require suppliers to confirm that they comply with minimum wage legislation; provide a healthy, safe workplace free from discrimination; and do not use any form of slavery or exploitative child labour.

So far, we have incorporated human rights clauses into all central contract templates for use with new suppliers. Human rights clauses are also being introduced into contracts for existing suppliers as they are renewed. Most contracts are renewed on a three-year cycle.

During 2005 we worked with our local procurement teams to incorporate human rights clauses into local supplier contracts. Given the size of the supply chain we have prioritised contracts into which the human rights clause must be inserted. The initial focus is:

1. Suppliers providing goods that are used to make GSK-branded products e.g. contract manufacturers, raw materials and packaging; and
2. Suppliers providing human resources e.g. cleaning services, security services, contingent worker services, outsourced services, testing, research and development services.

This scope will eventually be extended to all contracts.

### Engagement with critical suppliers

Our critical suppliers must work to the highest quality standards and produce an uninterrupted supply of materials and services to GSK. If they do not, the safety, effectiveness or availability of our medicines could be affected. For these reasons, we seek long-term relationships with critical suppliers and regularly monitor all aspects of their performance, including human rights.

Critical suppliers must pass a detailed assessment before they can be selected. As well as looking at quality issues, we also assess their policies and procedures for health and safety, human rights, and environmental issues. These rigorous assessments reduce the risk of issues of non-compliance after the contract has been signed. Where suppliers do not meet our required standards, we work with them to agree a remedial programme which must be implemented or completed before we award any new business to them. All contract manufacturers must also be approved by the applicable regulatory authority before they can start manufacturing GSK medicines.

After a contract has been awarded we seek to develop strong, open relationships with critical suppliers. This includes formally agreed Supplier Reviews, to assess performance and identify and agree areas for improvement. After a Supplier Review the agreed action plan is signed off by GSK and the supplier. Where a supplier can't or won't improve their performance we will move our business to an alternative supplier.

We have launched a preferred global vendor programme to reduce the number of suppliers. As well as reducing costs and increasing efficiency this will make it easier to monitor and influence supplier standards.

### Supplier audits

We conduct regular Environment Health and Safety audits of our contract manufacturers that include questions on human rights. In 2005 there were 41 audits conducted and no human rights issues of significant concern were noted.



## Human rights continued

### GSK Supplier human rights clauses

The human rights clause (below) is based on international workplace norms in the International Labour Organisation conventions and the UN's Universal Declaration of Human Rights.

The text below sets out the standard English-language version of the contract clause, but it must be noted that the exact wording may vary between contracts. GSK attorneys may amend the wording of the HR Clause during negotiation with third parties or during translation to suit local law. However GSK attorneys have been instructed not to change the Human Rights Clause in any way that reduces its contractual impact or intent.

#### THE GSK STANDARD CONTRACT CLAUSE FOR ETHICAL STANDARDS AND HUMAN RIGHTS

##### Ethical Standards and Human Rights

Unless otherwise required or prohibited by law, the Supplier warrants, to the best of its knowledge, that in relation to the supply of goods or services under the terms of this Agreement:

- (a) it does not employ engage or otherwise use any child labour in circumstances such that the tasks performed by any such child labour could reasonably be foreseen to cause either physical or emotional impairment to the development of such child;
- (b) it does not use forced labour in any form (prison, indentured, bonded or otherwise) and its employees are not required to lodge papers or deposits on starting work;
- (c) it provides a safe and healthy workplace, presenting no immediate hazards to its employees. Any housing provided by the Supplier to its employees is safe for habitation. The Supplier provides access to clean water, food, and emergency healthcare to its employees in the event of accidents or incidents at the Supplier's workplace;
- (d) it does not discriminate against any employees on any ground (including race, religion, disability or gender).
- (e) it does not engage in or support the use of corporal punishment, mental, physical, sexual or verbal abuse and does not use cruel or abusive disciplinary practices in the workplace;
- (f) it pays each employee at least the minimum wage, or a fair representation of the prevailing industry wage, (whichever is the higher) and provides each employee with all legally mandated benefits;
- (g) it complies with the laws on working hours and employment rights in the countries in which it operates;
- (h) it is respectful of its employees right to join and form independent trade unions and freedom of association.

The Supplier agrees that it is responsible for controlling its own supply chain and that it shall encourage compliance with ethical standards and human rights by any subsequent supplier of goods and services that are used by Supplier when performing its obligations under this Agreement.

The Supplier shall ensure that it has ethical and human rights policies and an appropriate complaints procedure to deal with any breaches of such policies.

GSK reserves the right upon reasonable notice (unless inspection is for cause, in which case no notice shall be necessary) to enter upon the Supplier's premises to monitor compliance by the Supplier of the warranties set out in the clause above and the Supplier shall, subject to compliance with law, furnish GSK with any relevant documents requested by GSK in relation thereto. {this sub-section will only be required where there is no general right of audit elsewhere within the Agreement}



# Environment

|          |   |      |  |
|----------|---|------|--|
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## Environment

This year we have completed the first five years of our Environment, Health & Safety (EHS) Plan for Excellence, which marks an important milestone in our journey to environmental sustainability. Environmental performance is reported in these pages. Health and safety performance is reported in the Employee section

### INTRODUCTION

In 2001, we set "stretch" targets in consultation with the business to address EHS issues of concern to our stakeholders. When we set these targets we had identified some proposed improvement projects which would help us to achieve them but we did not have specific underpinning projects to achieve all the environmental targets.

### Performance

We have achieved many of the EHS targets. We met or surpassed targets in energy consumption (and related carbon dioxide emissions), water consumption, wastewater organic material (measured as chemical oxygen demand), non-hazardous waste, and ozone depleting substances used to produce our inhalers.

For volatile organic compound (VOC) emissions to air we achieved a significant reduction and almost achieved our ambitious target of a 30% reduction.

We also set an ambitious target for ozone depleting compounds in ancillary equipment, where we achieved a 36% improvement.

In some cases changes in the business helped us to make progress (eg wastewater quality and emissions of solvents to air). But in two cases – hazardous waste disposal and recycling – changes made progress more difficult. We did not meet targets in these areas due to factors such as maintenance of recycling systems, movement of products to production facilities without recycling equipment, and new product introduction.

We provide details of performance in each area on the performance pages of this section.

### EHS Management

A solid foundation of programmes and management systems contributes to the progress we have made. GSK has moved towards what I describe as a "self-regulatory" EHS culture, which focuses first on achieving legal compliance and manages EHS proactively based on our understanding of the risks, liabilities and opportunities. It is part of our strategic objectives to achieve operational excellence and to be a responsible company.

Our EHS structure includes:

1. Management system based on a set of Global Standards incorporated into a framework of EHS programmes
2. The EHS Plan for Excellence, which identifies our ten-year strategic vision for EHS in GSK
3. The CEO's EHS Excellence Awards which recognise outstanding projects at GSK sites around the world [link to Excellence awards in this document]

We feel that we have made significant progress in improving the performance of EHS in GSK but we realise that there is always more to do. First, we need to embed this culture so that people really understand the business benefits of good EHS practice: enhanced productivity, quality and employee relationships, which are beneficial for GSK's performance and reputation.

### Investors

This is already understood by investors. They appreciate not only our progress but the transparency which means we are open about the areas where we have not done as well as we had planned.

This has been borne out by the positive ratings that GSK receives from the various investor ratings.

GSK has been recognized in these indices:

- **Dow Jones Sustainability Index (DJSI) for 2005:** DJSI members are the top 10 per cent of their industry sector. They are selected from the 2,500 largest companies in the world. Selection is based on a best-in-class approach covering economic, social and environmental criteria.
- **Business in the Environment Index Premier League:** This is the third consecutive year that GSK has been listed in the Premier League, achieving a score of 97 per cent for 2004 data. The index rates environmental management and environmental performance.
- **Carbon Disclosure Project's Climate Leadership Index:** GSK is one of only three pharmaceutical companies named to the Climate Leadership Index. The Carbon Disclosure Project is a coalition of 155

## Environment continued

institutional investors with more than \$21 trillion in assets. The Climate Leadership Index includes only companies that are well positioned to respond to the financial implications of climate change, compared to their FT500 peers.

- **FTSE4Good 2005:** The FTSE4Good Index Series only includes companies that meet globally recognised corporate responsibility standards, and facilitates investment in those companies.
- **100 Most Sustainable Companies:** GSK was one of only four pharmaceutical companies identified in the Global 100 Most Sustainable Corporations in the World. This is a project initiated by Corporate Knights with Innovest Strategic Value Advisors, a leading research firm specialising in analysing “non traditional” drivers of risk and shareholder value covering performance on social, environmental and strategic governance issues. Launched in 2005, the annual Global 100 is announced each year at the World Economic Forum in Davos.

Ratings like these help investors identify companies that will meet their investment goals and are important to GSK's reputation. They are achieved by our pro-active approach to EHS and sustainability and the company-wide reporting of EHS performance data. These index listings are a tribute to the many EHS professionals and other managers and staff at all the GSK sites who report the data on which these listing are based,

Investors and other stakeholders also appreciate our commitment to dialogue – just as much as we appreciate the value of stakeholders' perspectives. We have now created a formal Stakeholder Panel but we have also consulted widely with GSK people as we move to the next five-year plan period.

### The Future

Internal and external engagement has helped us to focus on these major challenges for the immediate future:

- Occupational exposure to chemicals [see occupational hygiene page nn]
- Driver safety [see page nn]
- Process safety [see page nn]
- Pharmaceuticals in the environment [see page nn]
- Hazardous chemicals usage

- Energy conservation

In the longer term, we can see three possible steps to becoming a more environmentally sustainable business:

- Improve natural resource efficiency and decrease the amount of waste we generate. We are looking more broadly than production to include the efficiency of all our operations [LINK to Materials efficiency]
- Move from relying on non-renewable chemicals to renewable materials
- Move from using synthetic chemical routes to biological systems to create medicines

It will take many years to achieve this transition, but it is part of the journey towards being an environmentally sustainable company.

### James Hagan

Vice President,  
Corporate Environment, Health and Safety

### About the Environment Section of This Report

This is the 6th year that we have reported on our environmental performance. The legacy companies (Glaxo Wellcome and SmithKline Beecham) individually published EHS reports for a number of years prior to the formation of GSK in 2000. Copies of these reports are available on the Corporate Register website [www.corporateregister.com].

Further background information on our approach to managing environmental issues is available in the Environment, Health and Safety section of our website [www.gsk.com].

### Note on the scope of the data

The environmental data covers the calendar year 2005. It is collected from all of our 81 pharmaceutical and consumer manufacturing sites, six of our eight Biologicals manufacturing sites and 18 of 20 pharmaceutical and consumer research and development sites as well as all seven distribution centres, six of eight major office locations and four of the smaller office and sales locations. We include available data for sites that were in operation for all or part of the year.

Notes attached to the charts explain the scope and data collection process for each parameter in more detail. Unless specified as being per unit of sales, figures are absolute numbers (ie total consumption of energy, water etc.)

## Environment continued

### Verification

The environment, health and safety sections of this report are externally verified by ERM (Environmental Resources Management). Pages to which the verification applies are indicated by this symbol. ERM's verification statement and our response follow.



### ERM VERIFICATION STATEMENT

Environmental Resources Management Limited (ERM) was appointed by GSK to undertake an external verification assessment of its environment, health and safety (EHS) reporting within the GSK 2005 *Corporate Responsibility* report (The section on Environment and the Health & Safety pages within the Employee Practices section).

This is the fifth year of our involvement as an external verifier with GSK. The objectives of our assessment were to: check that the EHS data presented are accurate, and that they represent GSK's performance fairly; critically review the completeness and relevance of the information presented; and, assess the effectiveness of GSK's data management and reporting systems. The pages of GSK's report that contain EHS data verified by ERM are marked with the following symbol.



### Scope of assessment

During the period October 2005 to February 2006 we conducted the following tasks:

- Assessments at six globally significant sites ( ) and telephone interviews with 13 additional sites to review EHS data management and reporting processes;
- Review of corporate data collation and internal verification processes at GSK offices in the UK;
- Review of the content of the EHS sections of the 2005 *Corporate Responsibility* report, including checking sample group data, to assess its completeness, relevance and accuracy; and
- Interviews with corporate personnel to obtain supporting information on GSK's EHS performance in the following areas: acquisitions and divestitures; contaminated land; auditing of GSK sites, suppliers and contract manufacturers; H&S reporting relating to the US sales force; and, setting of performance targets.

### Overall assessment

Subject to the scope of our assessment and comments set out below, we believe GSK's EHS reporting in the 2005 Corporate Responsibility report is a complete, relevant and accurate representation of GSK's performance. From our review we have made the following findings and recommendations.

### Findings

#### Reporting

This year, GSK has reported on its progress against the five year performance targets it set in key areas of environment, health and safety. We found that GSK has made good progress on strengthening internal reporting processes and better understanding the reasons for EHS performance change against its targets.

GSK provides a wide range of information in its report but it is not always clear which are the material issues facing the business. We found inconsistency in the level of detail provided on reasons for performance change, for example how changes at major contributing sites significantly affect the Group total.

GSK has improved collection of data from contract manufacturers and suppliers, and has expanded the number of contract manufacturers from which it collects key EHS data in 2005. There are ongoing challenges in collecting complete and accurate data for GSK to be able to report on its broader EHS footprint.

One of our 2004 recommendations related to the limitations of EHS performance data, in particular the potential scale of statistical uncertainty, which is under consideration by GSK. The 2005 report does not consistently cover the significance of potential limitations of the data such as calculation method or robustness of sampling techniques to understanding performance change, for example calculating VOC emissions.

#### Data Accuracy

GSK has continued to make progress to improve the accuracy of its EHS data by introducing further internal data checks with the globally significant sites. ERM identified a number of material data inaccuracies through its assessments at site level and checking of sample group data, in part due to changes in the reporting schedule in 2005 that were introduced to meet the deadlines of the Corporate Reporting program. These inaccuracies were subsequently addressed by GSK to ensure accurate reporting in the 2005 Corporate Responsibility report.

## Environment continued

There have been improvements in energy performance following the introduction of a business-specific energy management programme which have also helped to ensure more accurate data reporting. GSK is rolling out new system functions to help integrate EHS management and data collection.

We found challenges associated with accurate and complete health and safety incidents reporting and investigation at site level, including a weakness in formal internal processes to check compliance with GSK's requirements on accurate reporting and full investigation of incidents. In addition, we found examples of misreporting due to poor understanding of the corporate reporting requirements and data entry errors.

### Recommendations

We recommend that GSK:

- Explains which of the issues it reports on are material to the business and prioritises its reporting accordingly;
- Reports further on how trends in outsourcing affect its overall EHS footprint and performance, and expand further the reporting on EHS impacts of contract manufacturers and suppliers;
- Improves the accuracy of environmental and incidents data by introducing additional mechanisms to check completeness of data reported by sites and by providing additional training to sites on reporting and data management;
- Reviews formal processes to check compliance with GSK's requirements on accurate reporting and full investigation of incidents; and
- Looks for opportunities to further align data management at corporate and site level, integrating reporting and core business processes where practicable.

### ERM

March 2006

### GSK RESPONSE TO VERIFICATION STATEMENT

After verifying GSK's EHS reports for five years, many of ERM's recommendations point to improvements that we work on every year. For example, every year we improve processes for collecting data, clarify definitions and instructions, provide training to the people at sites who gather and enter their site data, improve the processes for analysing and summarising the data and try to understand the changes from year to year.

#### 1. Explain materiality:

In 2001, as part of the planning process that resulted in our 10-year EHS Plan for Excellence, we conducted a review of reporting. We considered the measures of our EHS impact used within the company. We used the Global Reporting Initiative and surveys from investment rating organisations and environmental organizations as indicators of stakeholder expectations for EHS reporting by companies of our size. From this exercise we concluded that the information and metrics we include in this report are material to GSK. We decided to be consistent in our reporting for the five year period of our Plan for Excellence. As we move into the next five year period, we will again review the materiality of the information and metrics we report and will continue to report what our external stakeholders consider important.

#### 2. Trends in outsourcing:

It is our goal to report, in the aggregate, the EHS performance of our contract manufacturers and key suppliers. We hope to use this to report the total EHS footprint for GSK products and to use this as the basis for our improvement targets. We request EHS information from all our contract manufacturers and key suppliers every year but response is voluntary and the rate is very low. We intend to make response to this questionnaire an integral part of future contracts.

#### 3. Accuracy of site EHS data

A comprehensive global EHS information management system is in place to help sites manage their EHS data. We use the same system to collect the data for this report and for internal reporting. We recognise that the past error rate of initial entry varies between 25% and 50% and we have put in place a thorough data verification process to correct the errors. We are attempting to address this situation by providing additional web-based training. We are also conducting a formal review of the information that has been requested from sites to see if it can be simplified, while still meeting the needs of our stakeholders.

## Environment continued

### 4. Review the processes to check compliance with reporting and investigation of incidents

We have completed the first phase of our audit programme, conducting a comprehensive baseline review. In 2006 we are starting a risk-based audit process. We will include a review of reporting EHS data and investigation of incidents as part of this process. We will also increase our level of training in these areas.

### 5. Align Corporate and site data management

We will be conducting a formal review of our information management practices to identify improvements that can be made in both the Corporate and site processes.

## ENVIRONMENTAL MANAGEMENT

Environmental issues are managed together with health and safety through an integrated EHS system that aims to ensure issues and risks are identified, standards are established, training is provided, targets set and audits conducted.

We have a clearly defined EHS management structure. Overall responsibility rests with the Corporate Executive Team and the Board. The Board champion for EHS is JP Garnier, the Chief Executive Officer. Rupert Bondy, General Counsel, is the operational champion of EHS on the corporate executive team. We also have a Corporate Responsibility Committee and Corporate EHS department. See more on our EHS management organisation and system on our website

Our EHS Policy, Vision and 64 Global EHS Standards set the overall framework for managing issues. In 2005 we distributed an EHS management toolkit which provides sites with instructions and descriptions of appropriate procedures for managers worldwide.

Our EHS Plan for Excellence which was developed in 2001, sets out our 10-year strategy for improving our environmental performance. In 2005 we came to the end of the first 5-year period and began revising and extending the Plan to 2015.

Stakeholder engagement plays an important role in how we manage EHS. In 2005 we carried out a special engagement exercise with employees and set up a standing panel of external EHS stakeholders. Feedback from staff and external sources identifies issues and provides insights that help us determine how to move forward.

Our CEO's EHS Excellence Awards recognise and reward GSK sites that show leadership in EHS. The Awards highlight sites that have demonstrated exceptional commitment, with innovative approaches that provide examples of good practice on EHS management to share with other sites. The winners of our 2005 Excellence Awards demonstrate that many projects which improve environmental performance also save money.

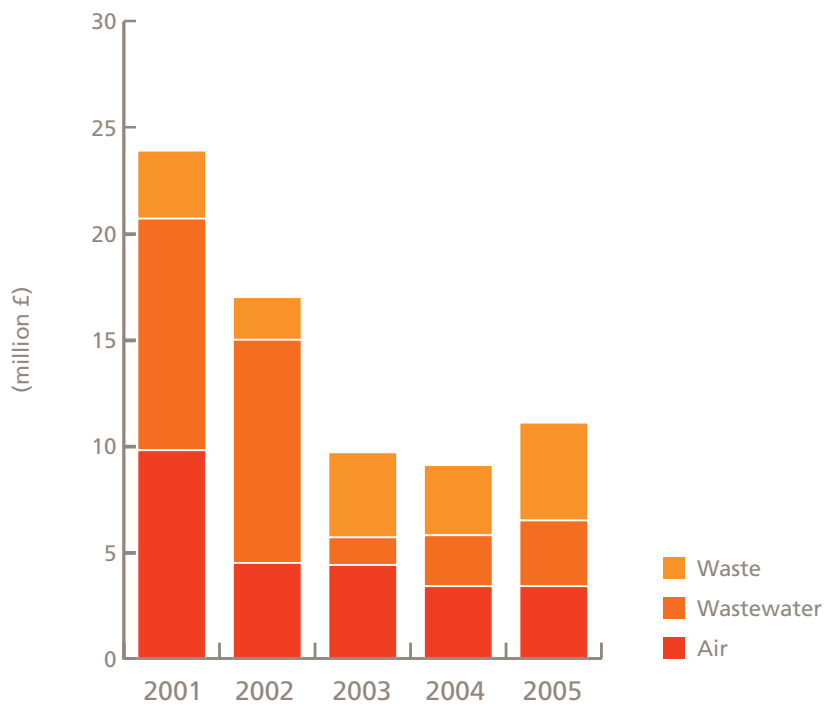
We carry out regular EHS audits of GSK operations, contract manufacturers and key suppliers to assess the extent to which management systems and standards are being implemented to improve performance and achieve compliance.

### Environment Costs

In 2005, our capital investment in environmental projects was £11.2 million and our operating and maintenance costs were £37.8 million. This expenditure relates to wastewater treatment, waste management and air pollution control.

# Environment continued

## Capital investment

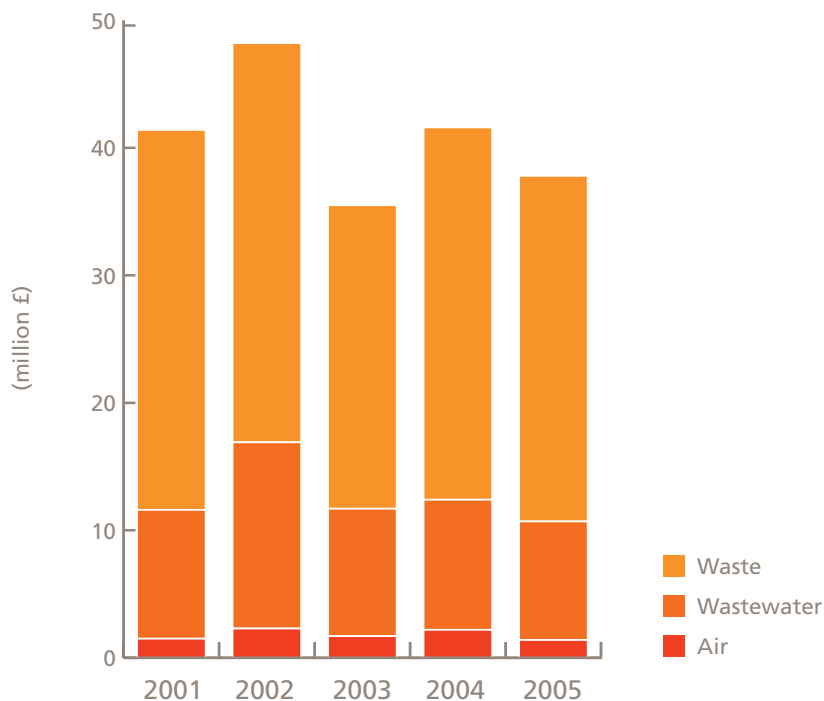


| Capital investment |     |            |       |       |
|--------------------|-----|------------|-------|-------|
| Year               | Air | Wastewater | Waste | Total |
| 2001               | 9.8 | 10.9       | 3.2   | 23.9  |
| 2002               | 4.5 | 10.5       | 2.0   | 17.1  |
| 2003               | 4.4 | 1.3        | 4.0   | 9.7   |
| 2004               | 3.4 | 2.4        | 3.3   | 9.2   |
| 2005               | 3.4 | 3.1        | 4.7   | 11.2  |



## Environment continued

### Operations and maintenance costs



| Operations and maintenance costs |     |            |       |       |
|----------------------------------|-----|------------|-------|-------|
| Year                             | Air | Wastewater | Waste | Total |
| 2001                             | 1.5 | 10.1       | 29.8  | 41.3  |
| 2002                             | 2.3 | 14.6       | 31.3  | 48.2  |
| 2003                             | 1.7 | 10.0       | 23.8  | 35.4  |
| 2004                             | 2.2 | 10.2       | 29.2  | 41.6  |
| 2005                             | 1.4 | 9.3        | 27.1  | 37.8  |

## Environment continued



### Compliance

As a minimum we aim to comply with all legal requirements. We regret that in 2005 we were in breach of regulations in these cases:

- a UK consumer healthcare manufacturing site paid a £15,000 fine and £6,650 court costs following a prosecution by the UK Health and Safety Executive for an incident that occurred in 2004 and resulted in amputation of an employee's finger tip
- a US consumer healthcare manufacturing site paid a \$11,063 fine to their state environmental authority for not completing required report of storage of hazardous waste
- a Puerto Rico pharmaceutical manufacturing site paid a \$1,600 fine to the US Environmental Protection Agency as a result of failure to fully comply with the Resource Conservation and Recovery Act
- a US consumer healthcare manufacturing site paid a \$1,000 fine to the US Occupational Safety and Health Administration (OSHA) related to non-compliance with OSHA eyewash requirements

We also received the following notices of violation which did not result in fines or penalties

- a consumer healthcare manufacturing site in Australia, for exceeding allowable limits for suspended solids in wastewater
- two consumer healthcare manufacturing sites in the US, for exceeding permitted substance levels in wastewater

### Plan for Excellence

Our EHS Plan for Excellence set out a strategy to improve our EHS performance over a ten-year period from 2001 to 2010. With the end of the first five year period in 2005 we have taken stock and begun extending the Plan for a further five years to 2015.

We developed the plan following the merger of Glaxo Wellcome and SmithKline Beecham. It aligned the EHS systems of the two parent companies and laid out an approach for establishing a new EHS framework for GSK.

We use annual action plans to focus our efforts on selected priority issues. As the half-way point in the ten year plan, 2005 was important because it was the year when we aimed to have our fundamental EHS programmes in place, and to reach our first set of EHS targets. The theme for the year was 'Completing Core Programmes'.

Our goal was to ensure that core programmes covering health & safety and the environment were in place throughout the global business, measured by the following:

- implementing at all operations our EHS management system – which is aligned with ISO14001 and OHSAS 18001
- achieving acceptable audit scores at all our manufacturing and R&D operations. We aimed to achieve an average score of at least 75% in each business unit, with no site achieving less than 50%
- achieving the 5-year EHS global targets (see Progress Towards Targets)
- analysing performance against the first set of targets in the Plan for Excellence
- formalising our external stakeholder engagement process

We report performance against these objectives in these pages.

In 2005 we began extending the Plan for Excellence to 2015. We aim to move from a focus on fundamental EHS programmes to address broader environmental sustainability issues. This requires a new approach to manufacturing processes and measuring progress.

We began our review of the Plan for Excellence with an extensive consultation with key internal and external stakeholders to ensure relevant EHS concerns and the needs of the business would be reflected in the extended plan.

- We engaged with external stakeholders about key EHS concerns and expectations of GSK and the pharmaceutical industry
- We undertook a company-wide intranet survey seeking comment on a discussion document that reviewed emerging issues for the business and EHS
- We held individual discussions with selected senior managers in all parts of the business
- We held workshops around the world with GSK's site-based EHS professionals, including sessions on vision and strategy with the Corporate EHS team.

Our managers and EHS professionals told us they want GSK to be among the top pharmaceutical companies in this area, but also that our activity must "add value" to the business.

## Environment continued

They want us to work with external organisations, and to be flexible in embedding EHS in business practices – adopting approaches which are appropriate for each business unit.

External stakeholders highlighted climate change, pharmaceuticals in the environment and our policy on the use of chemicals as key areas of concern. They told us GSK should be at the forefront of EHS and sustainability issues and exert a positive influence over others in the industry and in its supply chain.

We published feedback from these discussions in a consultative document for further comment by both internal stakeholders and GSK's new EHS External Stakeholder Panel. See Stakeholder Engagement for more information.

We expect to publish the renewed 10-year EHS Plan for Excellence in mid-2006.

### Audits and Certification

Our audit programme requires all manufacturing and R&D sites to be audited. Internal auditors (who are certified as lead auditors against the international environment health and safety management standards: ISO 14001 and OHSAS18001) assess how well EHS management systems and standards are being implemented and how well our sites comply with key legislation. In 2006 we are revising the audit process to focus on significant health and safety risks and environmental impacts. The frequency of site audits will be determined by factors such as EHS risks, profile and performance.

At the end of 2005 we assessed the performance of all facilities (except small commercial sites) using self-assessment and internal audit. (We audited 33 sites.) The average score was 77%, but 3 sites achieved scores below 50%, which we regard as unacceptable. While the average score exceeds our target of 75% we will aim to correct unacceptable performance and continue to pursue further improvements to achieve best practice.

In 2005, two sites (in the US and Spain) achieved "leadership" scores above 90%, while a further seven achieved scores over 80%.

The best performance on environmental issues was in air emissions, ozone depleting substances and waste management. Sites were generally weakest on biodiversity, risk assessment and self-auditing. Self-audit nevertheless achieved one of the biggest improvements over the year, along with process risk management.

Sites are required to develop plans to address any weaknesses and improvements identified in the audit. Auditors monitor sites' progress in implementing the plans. In 2005 the EHS audit process and scoring system were further refined based on experience and feedback, including assessing auditors' reports to ensure greater consistency. EHS auditing software is available on our intranet to help sites and auditors track progress.

### EHS Certification

At the request of the Audit Committee of the Board of Directors, GSK has embarked on a programme to achieve ISO 14001 and OHSAS 18001 certification. In 2005, three additional sites achieved certification to the international environmental management standard, ISO14001. Two of these also achieved certification to the international health and safety standard OHSAS 18001 bringing the total of dual certified sites to 16. One certified site left the GSK network. This means that 23 out of 89 pharmaceutical, consumer and vaccine manufacturing sites are now certified (6 sites are certified to ISO 14001 only) and one site's utility area is certified to both. The certified sites are in China, Egypt, France, Germany, India, Italy, Mexico, Poland, Saudi Arabia, Spain, Turkey, Kenya and the UK.

In 2006 we continue to work on increasing the number of certified sites by encouraging sites to volunteer for certification. We will also launch a pilot project to investigate the feasibility of certifying Research & Development sites. We will then be in a position to move towards global certification.

### Stakeholder Engagement

We have frequently engaged through ad hoc meetings with a range of external stakeholders to help us understand their perspectives and identify emerging issues. In 2005 we stepped up our internal and external engagement on EHS issues.

### External engagement

We established a standing panel of external stakeholders to provide ongoing advice and comment on our EHS performance. The panel is facilitated by The Environment Council, an independent charity which brings people together to develop long-term solutions to environmental issues. The 10 members include representatives from our customers, suppliers, regulators, environmental organisations and socially responsible investors.

The panel met for the first time in September 2005 to review our draft position papers on pharmaceuticals in the environment, climate change, and policy on the use of chemicals – issues identified as important in previous

## Environment continued

stakeholder discussions. Members wanted us to show leadership on all three issues, and provide a better explanation of how the papers fit in with our EHS strategy. Their comments were considered in our internal discussions, before we finalised the position papers, which have been approved by the Corporate Executive Team. These position papers are available via the relevant sections of this site.

The Panel also reviewed our proposal for revising the EHS Plan for Excellence. Members expressed a desire to see us at the forefront of EHS and sustainability issues, exerting a positive influence over others in the industry and its supply chain. Their comments (see side panel) will be considered in developing the Plan further.

### Internal engagement

We regularly gather staff feedback through employee surveys but in 2005 we used the intranet to conduct our most extensive survey yet about the views of all employees on our EHS plans. This feedback will also be used to revise and develop our Plan for Excellence

Employees told us:

- The EHS strategy must add value to GSK's business as well as "doing the right thing"
- Employees want GSK to be among the top pharmaceutical companies in EHS and to collaborate with other major players in the industry
- We need to embed EHS into the business, not just with systems but by instilling a culture where all employees contribute to EHS
- GSK should be a champion for transparency in EHS
- We should do more to track and influence new regulations through more involvement in trade associations
- We need to do more to address EHS issues in contract manufacturing
- The Plan for Excellence must be flexible enough to allow for different rates of progress in different parts of the business

### Partnerships

We also partner with a number of environmental organisations in specific areas. For example, in 2005 we worked with Forum for the Future to evaluate the role of a pharmaceutical company in a sustainable society. We also worked with the environmental organisation Earthwatch Institute (Europe) to look at ways to address

biodiversity more effectively in our audit programmes, and we sponsored the policy group Green Alliance to conduct a study on how to achieve better environmental regulation.

We are conscious that our stakeholder engagement activities are heavily focused on the UK. We have begun to explore ways to extend them to Europe, the US and beyond over the next few years.

Many of our sites also engage with stakeholders locally, for example, through open days, newsletters and community projects.

### Regulation

GSK is keen to see proper measures in place to protect the environment and safeguard the development and launch of new medicines. In 2005 we engaged with regulatory agencies in Europe and the USA on the issues of pharmaceuticals in the environment (PiE) and the environmental risk assessment of pharmaceuticals.

- In the US, we engaged with the newly established intergovernmental task force on PiE through the trade association PhRMA;
- We are an active member of the Association of British Pharmaceutical Industries' working group on PiE which has been liaising with the UK Environment Agency;
- In Sweden we participated in an initiative organised by the trade association LIF to develop a voluntary scheme to classify pharmaceuticals by their environmental effects. The scheme has now been published [see <http://www.fass.se>] and an initial set of pharmaceuticals have been evaluated.
- Through the European trade association EFPIA, we contributed to the development of guidelines for the environmental risk assessment of pharmaceuticals by the European Medicines Evaluation Agency (EMA). The guidelines are expected to be finalised in 2006.

We welcome the introduction of formal requirements for the conduct of environmental risk assessment established in the EU's New Medicines Legislation. GSK has lobbied for the environmental impacts of pharmaceuticals to be regulated solely through the European Agency for the Evaluation of Medical Products, and not also through the proposed framework for the Registration, Evaluation and Authorisation of Chemicals (REACH). We believe this would lead to duplication of efforts and place an unnecessary burden on the pharmaceutical industry.

## Environment continued

### Training and Awareness

Raising employees' awareness of environment, health and safety issues and improving their skills through training are key parts of our EHS programme. Employees at all levels need to understand the EHS issues in their working environment. For example, employees who handle waste at GSK sites need to know about its properties, the regulations that govern its disposal, and which materials can be recycled.

We help employees deal with these issues through meetings, bulletins, and information on our intranet site, as well as specific training events

The intranet site, myEHS Community, contains links to a range of programmes, including the EHS Manager information system which contains policies, standards, guidelines, tools, training materials, examples of best practice and news. It also provides customised management reports on EHS performance by site. EHS training is also accessible through myLearning, GSK's online training service.

### Training

Training takes place at site level, in accordance with our EHS Standard on training. EHS requirements and programmes are routinely included in site induction training for new employees. We regularly assess additional needs to make sure they match employee responsibilities and local regulatory requirements.

In 2005 we carried out additional EHS management training for our Consumer Healthcare and Regional Pharma Supply organisations. We made site visits for one-on-one training, and sent EHS Essentials (a CD-based compliance tool) to 140 sales offices around the world to improve EHS awareness.

During 2005 we held regional meetings in the UK, Mexico, China and Spain for EHS and Employee Health professionals to share information and best practice. More than 120 employees from 79 sites took part. The meetings included training on EHS management system auditing, auditing of hazardous waste disposal sites, injury and illness reporting, ergonomic risk assessment, resilience and mental well-being.

EHS managers are encouraged to attend conferences and training programs sponsored by local environmental organisations and academic institutions.

### Awareness

We use several means of raising awareness of EHS issues and complementing our training programmes:

- the Chief Executive Officer's EHS Excellence Awards scheme recognises outstanding efforts in EHS and helps raise the profile of these issues around the business.
- We publish regular bulletins which are distributed to all sites for posting on bulletin boards. Three bulletins were circulated in 2005.
- We include articles on EHS in our internal magazine (GSK Spirit), our manufacturing magazine and site newsletters.
- We run an Environment Week every June (to coincide with the World Environment Day). Information kits are sent to all sites to help them develop ideas and plan activities. In 2005, over 11,000 GSK employees from more than 60 sites worldwide took part in Environment Week. Activities focused on issues as varied as biodiversity, sustainable purchasing and waste management.

We also encourage employees to consider environmental issues outside the workplace, such as minimizing household waste, energy and water conservation, and encouraging the use of fuel-efficient vehicles.

### EHS Excellence Awards

The Chief Executive Officer's EHS Excellence Awards recognise and reward GSK sites for innovation in EHS Community Partnership, Green Chemistry/Technology, and EHS Initiative (one for environment, one for health and safety). Each winner receives a trophy and selects a charity to receive a donation from GSK.

The Vanguard Award was introduced in 2005. It is given at the discretion of the CEO to honour recurring, lasting and far reaching accomplishments in EHS.

In 2005 – the fourth year of the Awards – there were 120 entries from 26 countries, the same as in 2004. There were applications from all GSK's business sectors: R&D, Manufacturing and Commercial, and for the first time entries from Facilities Management teams.

The winners were chosen by a panel that included experts from academia, government and NGOs. In 2005, 12 projects representing sites in Europe, North America, and Asia received top honours. The winning projects covered areas as diverse as safe driving programmes and new product processes that use less energy and reduce waste.

## Environment continued

### The 2005 award winners were:

#### Vanguard Award

Rajahmundry, India received the first ever Vanguard Award for recurring, lasting and far reaching accomplishments in EHS

Rajahmundry, where Horlicks and related products are made, has an outstanding record in the EHS Excellence Awards. In 2003, they received two First Place awards and one Second Place, and were awarded a Special Commendation in 2004. This year they received another First Place in the EHS Initiative category. Their first rate 2005 EHS Community Partnership entry demonstrated a continuing passion for building good relationships between GSK and the local community through imaginative environment, health and safety partnerships. Also, in 2005 they became the first GSK site to achieve accreditation to the international standard for Social Accountability, SA-8000, following ISO 14001 and OHSAS 18001 accreditation for Environment and Health & Safety.

#### Community Partnership

**First Place:** Aranda, Spain for: Supporting Implementation of 'Agenda 21' in Schools

Agenda 21 emerged from the Earth Summit in Rio de Janeiro in 1992 as a plan for sustainable development. Aranda has contributed to its introduction at eight schools in the local community, promoting environmental education.

**Second Place:** Nabha, India for "Ignited Minds – Building Awareness of Road Safety"

The project aimed to raise children's awareness of safe driving and road safety in five government schools in Nabha, reaching a total of 7,000 children.

#### Green Chemistry/Technology

**First Place:** Tonbridge, United Kingdom for: Development of a Green Process for GW873140A

This new manufacturing process for the antiretroviral drug GW873140A has significant environmental benefits as well as cost savings. It produces no solid waste to be sent to landfill, reduces liquid waste by 37%, and the uses 16% less energy.

**Second Place:** Research Triangle Park, United States of America for: Development of the Manufacture Route for GW677954X

A new manufacturing process for this diabetes drug has reduced the number of stages required for its synthesis, increasing yields by 39%, reducing waste by 70% and avoiding the use of some hazardous materials

**Third Place:** Tonbridge, United Kingdom for: Development of an Environmentally Friendly Process for Manufacture of GW274150F

Tonbridge developed a new process for synthesising this potential asthma drug, using cheap and readily available materials which reduce health and safety concerns and the amount of solvent required in manufacturing.

#### EHS Initiative – Environment

**First Place:** Rajahmundry, India for: Use Methane

A Waste Management review revealed that most of the methane generated at the Rajahmundry's effluent treatment plant was burnt through a flare stack. The EHS team diverted the methane to use as fuel in the site canteen instead of liquefied petroleum gas

**Second Place:** Rixensart and Wavre, Belgium for: Management of Green Spaces

The Rixensart and Wavre sites in Belgium have teams to develop and manage green spaces. They have developed a number of short and medium term projects to protect the natural environment and improve biodiversity in and around the sites.

**Third Place:** Thane, India for: Water Conservation

The site carried out a water conservation project that included raising employee awareness and focused on three initiatives: harvesting rainwater for reuse, introducing water saving and recovery measures in the site's heating and cooling systems, and recycling treated effluent water for gardening.





## Environment continued

### PROGRESS TOWARDS TARGETS

Our EHS Plan for Excellence identified targets in 10 areas, with interim targets for 2005 – halfway through the plan period. So we can now review progress over the five years, as well as beginning work to extend the Plan for a further five years to 2015.

We have achieved six targets and missed four.

#### Targets achieved

- Energy use
- Global warming potential from energy use
- Ozone depletion potential from production of inhalers
- Water consumption

- Wastewater quality measured by chemical oxygen demand
- Non-hazardous waste disposed

#### Target nearly achieved

- Volatile organic compounds emitted to air

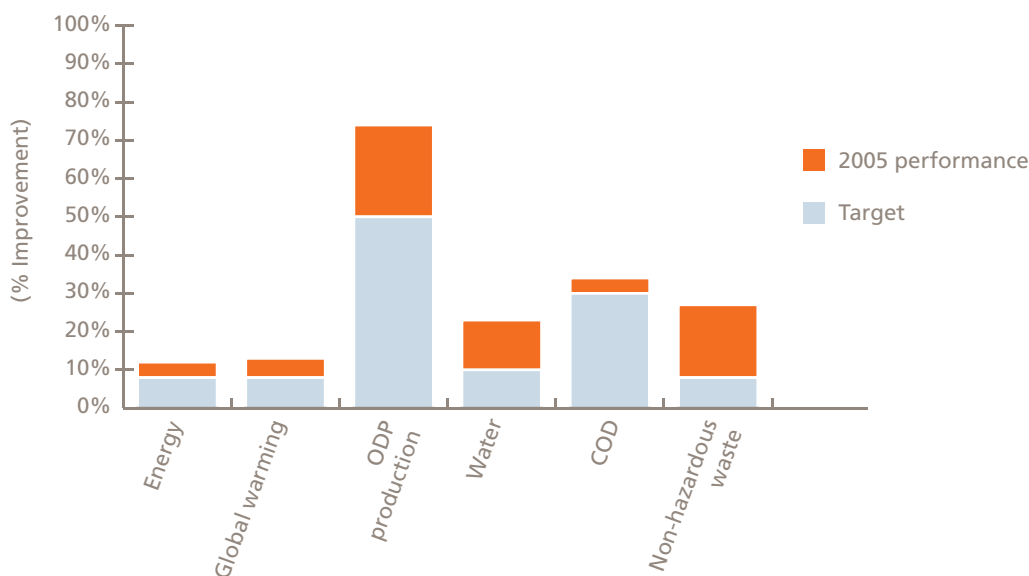
#### Targets not achieved

- Ozone depletion potential from ancillary equipment
- Hazardous waste disposed
- Waste recycled

The chart summarises our progress since 2001 and in comparison to our targets (per unit of sales).

### Targets achieved

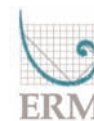
Targets are per unit sales as compared to a 2001 baseline



| Targets achieved                          |                  |        |
|---|------------------|--------|
|   | 2005 performance | Target |
| Energy consumption                        | 13%              | 08%    |
| Global warming from energy                | 13%              | 08%    |
| Ozone depletion potential from production | 74%              | 50%    |
| Water consumption                         | 23%              | 10%    |
| Chemical oxygen demand of wastewater      | 34%              | 30%    |
| Non-hazardous waste disposed              | 27%              | 08%    |

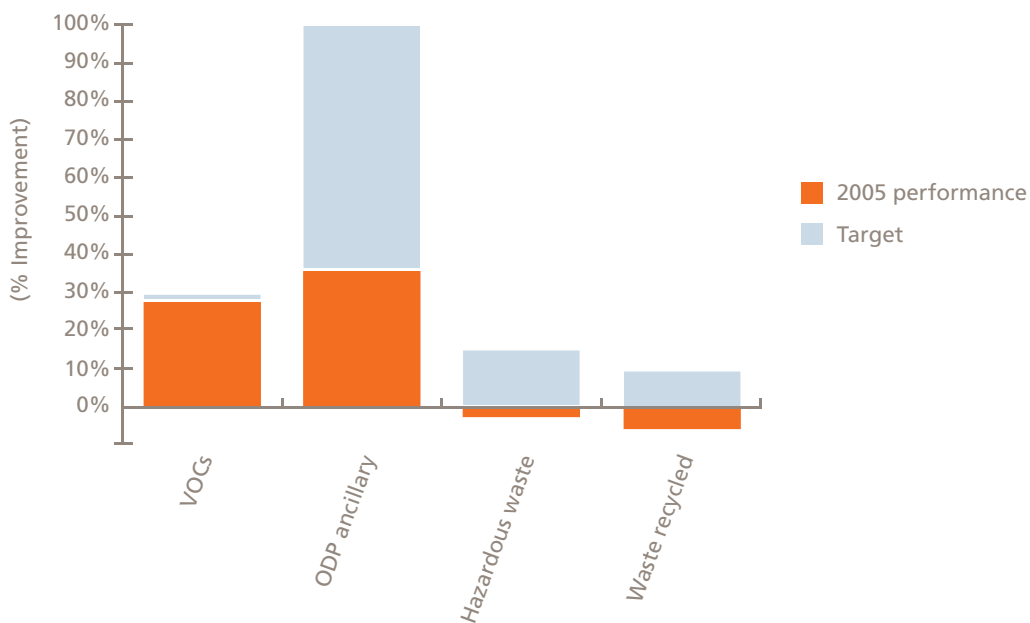


# Environment continued



## Targets not achieved

Targets are per unit sales as compared to a 2001 baseline



| Targets not achieved                               |                  |        |
|--|------------------|--------|
|  | 2005 performance | Target |
| Volatile organic compound emissions to air         | 28%              | 30%    |
| Ozone depletion potential from ancillary equipment | 36%              | 100%   |
| Hazardous waste disposed                           | -3%              | 15%    |
| Waste recycled                                     | -6%              | 10%    |

## Environment continued

Our performance has been affected by significant business changes such as outsourcing, which has reduced our water consumption and improved wastewater quality. In other cases, such as solvent recovery, product transfers and new product introductions have made it more difficult to achieve targets.

We met the targets for energy consumed and the associated global warming potential. This is largely due to significant improvements in energy savings in our primary manufacturing plants, while Research and Development used more energy due to increased activity.

We missed targets for recycling and for disposal of hazardous waste (four-fifths of which is solvent). Performance was affected by a complex mixture of factors. On the one hand:

- Phase-out of some older products over the years (some with more steps) contributed to a reduction in solvent waste;
- New products being made tend to have fewer manufacturing steps than old products, which means less solvent and energy is used
- Some sites modified their equipment to recycle solvents that had been received when processes were moved from other facilities in previous years

However

- New products mean our pilot plants are running more and manufacturing plants will take some time to adjust solvent recycling operations to new solvents
- It will take some time to adjust solvent recovery operations to the new products
- And in one case a site needed to refurbish its solvent recovery equipment and so had to dispose of solvent that would ordinarily be recovered and reused

The plan for the next 10 years, with interim targets for 2010, is now under construction. [link to Plan] It will be aligned with the GSK business drivers and will state aspirations to move towards environmental sustainability. We have consulted internally and externally on the Plan to ensure that it is reasonable and reflects measures which drive positive practices in the businesses and align with stakeholders' expectations. The extensive consultation means that the full plan will not be ready for publication until at least mid-2006.

Full details of performance are shown in each section of this report.

### MATERIALS EFFICIENCY

Improving the efficiency with which we convert raw materials to finished product is an important objective for environmental sustainability. It will help us to reduce our consumption of natural resources, waste generation and the cost of production. We believe we will be able to double material efficiency by 2010 for new processes coming out of R&D Chemical Development, achieving material efficiencies for active pharmaceutical ingredient of 2% (i.e. 2 tonnes of active pharmaceutical ingredient for every 100 tonnes of input chemicals) for these new processes. We will propose this as a target for the new 5-year plan.

Our efforts are supported by the US drug regulator, the Food and Drug Administration (FDA). The FDA is now focussing on process technologies and recommends that pharmaceutical manufacturers increase their focus on manufacturing processes.

The pharmaceutical industry has tended to use much more raw material for every kilo of finished product than other process sectors such as the agrochemicals and fine chemicals industries. Pharmaceutical processes are typically very complex, usually involving many separate operations and often requiring relatively large amounts of solvent. Typically, the industry uses about 100 kg of material for every kilogram of active pharmaceutical ingredient produced. That 1% material efficiency compares to about 20% for fine chemicals and 50% for bulk chemicals. It represents a waste of valuable resources, with financial as well as environmental consequences, and GSK aims to make improvements in the future.

Our approach to addressing EHS issues already includes minimising the amount of material used. The FLASC green chemistry tool (see Product Design) includes the mass of material used as part of the lifecycle assessment of material impacts. But Chemical Development scientists have other targets, especially quality issues and minimising the timescale for developing the manufacturing process, which may conflict with improved material efficiency.

We have begun placing a higher priority on improving our use of materials and are bringing together R&D and manufacturing teams to increase the focus on material efficiency in the product development stage, as well as for selected existing products. We use two key measures of production efficiency:

- Mass productivity – the mass of all materials used in the process compared to the mass of product produced

## Environment continued

- Reaction Mass Efficiency (RME), which gives a measure of the efficiency of putting together the key building blocks of a drug molecule – excluding the large volumes of solvents which are normally used as a medium for the chemical reactions, and other materials which are essential to the reaction or process

We are already making dramatic improvements to materials efficiency. For example, the R&D team at Tonbridge, UK, increased production mass efficiency to 2.7% in the production of an anti-retroviral drug. The chart shows substantial efficiency improvements during the development phase of several new compounds during 2005. These examples demonstrate the potential for improvement, although this scale of improvement cannot be achieved in all processes. We aim to build on such successes in R&D and manufacturing. The EHS Plan for Excellence will include an improvement target for material efficiency for products emerging from R&D.

### CASE STUDY

#### Material Efficiency at Tonbridge

GSK's Research and Development site at Tonbridge, UK, has dramatically improved the material efficiency in developing a robust manufacturing process for an antiretroviral compound for treating HIV.

The original process required substantial energy, both in manufacturing and for dealing with waste. It also used a hazardous solvent (Dimethylformamide) and acid (Methanesulfonic). The final process, which is based on the same chemistry, does not use these hazardous materials.

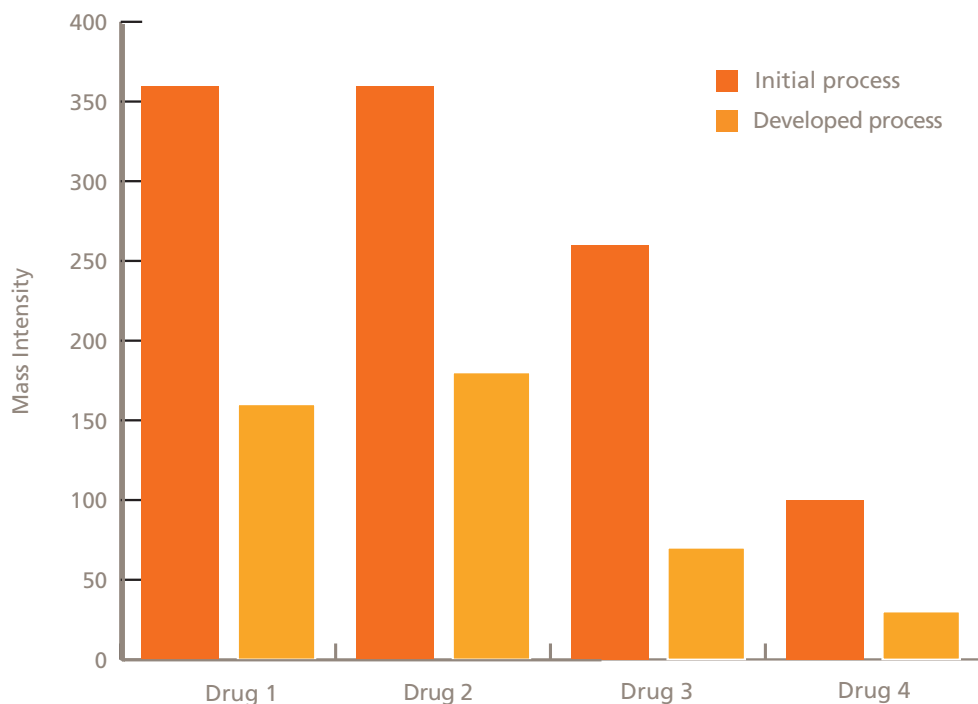
The new process increased mass efficiency from 2.2% to 2.7% (an increase of 23%) because the Tonbridge team identified more effective reagents – which may also be potential substitutes in other GSK processes.

The process requires 16% less energy than the original route because the cycle time is shorter and it uses lower processing temperatures. A reduction in contaminated aqueous waste also results in significant energy savings because this waste requires energy-intensive incineration. Tonbridge estimates that the new process requires only two-thirds of the incineration energy for waste disposal, which at peak production rates could avoid 600,000 kg of carbon dioxide emissions a year – equivalent to driving an average family car more than two million miles.

Tonbridge won first place in the Green Chemistry/Technology section of our EHS Excellence Awards for its work on this process.

## Environment continued

Graph showing how R&D process development reduces the amount of material needed to manufacture drugs



\*The mass intensity represents the number of kilograms of material to produce one kg of product

## Environment continued

### PRODUCT STEWARDSHIP

We address environmental issues associated with our products throughout their life cycle. This begins with product design and continues through managing the impacts of our manufacturing operations, including contract manufacturing, to eventual disposal. We refer to this as product stewardship.

This section focuses on:

- Product design – how we are incorporating environment, health and safety considerations into the design of new products
- Pharmaceuticals in the environment – what we are doing to understand and minimise the impact of pharmaceuticals released to the environment after use
- Specific issues with metered dose inhalers – how we are progressing against our target to eliminate the use of CFCs (an ozone depleting gas) from our product portfolio by 2010.

You can see more about other environmental issues associated with our products on our Corporate Responsibility website, including the use of genetically modified organisms, the use of natural resources, and potential impacts on biodiversity. The research and development section of this report covers our approach to animal testing.

### Product Design

We are working to incorporate environment, health and safety considerations into the design of new products through EHS staff participation in and support for new product teams, and through the use of our Eco-design Toolkit.

In 2005 we continued to integrate the EHS Milestone Aligned Process (MAP) into our product development and supply processes, including the R&D “design for manufacture” initiative. About 500 R&D and manufacturing staff have been trained over the past two years on the EHS Map Process.

EHS involvement in the new product teams also provides a unique opportunity to influence supply chain decisions and highlight systemic EHS issues early in the product development process. Involvement in the teams which are responsible for products as they move from R&D to manufacturing also means that residual EHS risks are identified so they are managed appropriately in manufacturing.

### Toolkit

Our Ecodesign Toolkit is used by R&D and manufacturing scientists and engineers to highlight potential EHS issues as early in the development process as practicable. The toolkit currently has five modules. Four of these were significantly revised during 2003 to make them easier to use, and they continue to be updated as appropriate. In 2005 we added a guide to hazardous chemicals legislation.

The toolkit is available on the GSK intranet and consists of:

- A **Green Chemistry/Technology Guide**, which helps GSK scientists and engineers apply Green Chemistry concepts to achieve more efficient use of resources, reduce environment health and safety impacts, minimise costs and reduce EHS impacts
- **materials guides**, containing information on a range of materials used within GSK operations, including solvents that should be avoided. One guide covers solvent selection while a second deals with chemical base selection
- a **Green Packaging Guide** – an assessment tool which includes guidance and a business process for evaluating and selecting packaging options for the Pharmaceuticals and Consumer Healthcare businesses.
- **FLASC** (Fast Lifecycle Assessment for Synthetic Chemistry) – a web-based tool and process launched in 2003 that allows bench chemists to perform a streamlined lifecycle evaluation of the environmental impacts of new or existing processes based on the materials used. FLASC helps scientists and managers to rapidly identify the “greenest” materials option by comparing and benchmarking processes and routes to make GSK products. It identifies the materials that have the most significant lifecycle environmental impacts and provides guidance on how to reduce those impacts
- The **Chemicals Legislation Guide (CLG)** is the newest product stewardship tool. It identifies chemicals legislation in various parts of the world aimed at phasing out hazardous substances from routine use. The CLG incorporates hazard information, volume and the phase of use to provide risk-based guidance about a variety of chemicals of concern, in a form that is easy for scientists to use.

Each module was designed to ensure that all EHS impacts of materials, processes and services are considered, from the manufacture of the raw materials through to the ultimate fate of products and wastes in the environment.

## Environment continued

During 2005 we have been working with key R&D groups to make the Eco-design Toolkit more compelling and useful to our R&D and manufacturing scientists and engineers.

### Pharmaceuticals in the Environment

Drugs work through active pharmaceutical ingredients that are absorbed in the patient's body. These materials – including anything that is not absorbed – are eventually excreted through the body's normal mechanisms and enter the sewage system. Wastewater treatment plants remove most pharmaceutical residues, but small concentrations do end up in rivers or in the sea. In areas without wastewater treatment, higher concentrations enter the environment.

Pharmaceuticals have been detected in surface, ground and drinking waters in the US and Europe. This has raised concerns about potential impacts on people, animals and the environment, eg: contributing to antibiotic resistance; feminisation by oestrogens; the effects of highly potent drugs on environmental organisms; the presence of anti-depressants in drinking water; the effects on wildlife of veterinary drugs such as pain killers. Regulators are now acting on these concerns. For example, the Swedish authorities now require additional information to classify pharmaceuticals by environmental impacts, the European Union is proposing more extensive environmental testing for product registrations, while others are investigating mitigation measures such as take-back schemes, water treatment upgrades, and labelling revisions.

GSK has developed business processes to ensure that we carry out appropriate environmental tests. Environmental risk assessments are part of the approval process for new drugs in the EU and US, so we provide regulatory agencies with assessments to evaluate and allow for mitigation of any potential environmental impacts.

We also work with other pharmaceutical companies, universities and research groups to develop the science and methodologies to assess the environmental risks of pharmaceuticals in the environment and increase understanding of such risks. For example, in the US, GSK has been involved with the Pharmaceutical Research and Manufacturers of America (PhRMA) in developing the PhATE (Pharmaceutical Assessment and Transport Evaluation) model based on specific local hydrology and population patterns.

### Action in 2005

We finalised the position paper on pharmaceuticals in the environment which was developed in 2004, after

extensive internal consultation. The paper was approved in December 2005.

We engaged with the US Interagency Task Force on Pharmaceuticals in the Environment, and with the UK Environment Agency through PhRMA and the Association of the British Pharmaceutical Industry respectively. We are interacting with other governmental groups working in this area, such as the US Environmental Protection Agency and the US Geological Survey and are establishing relationships with groups working on this issue in Europe.

GSK scientists who had been part of the team of experts at an international scientific workshop in 2003 on human pharmaceuticals in the environment co-authored a number of chapters in a book: *Human Pharmaceuticals: Assessing the impacts on aquatic ecosystems*, published in 2005. This work provides a roadmap for industry, government and academia for research in this area.

We have worked with PhRMA to develop a database of scientific literature on the impacts of pharmaceuticals on aquatic life. We have also collaborated to prepare detailed human health and environmental risk assessments on several frequently-detected pharmaceuticals (carbamazepine, aspirin, paracetamol, ibuprofen and naproxen). This work is part of on-going PhRMA research to improve understanding and provide data needed to prioritize further investigation.

We continued comprehensive environmental risk assessments using the PhATE™ model for the US and the GREAT-ER model for Europe for about 35 active pharmaceutical ingredients. We developed Allowable Daily Intake levels for human consumption through drinking water and fish consumption, as well as No-Effects Levels for aquatic organisms. We can make quantitative risk assessments by comparing these with predicted environmental concentrations.

These assessments will be published on our website and in the peer-reviewed scientific literature. The underlying environmental fate and effects test data for pharmaceutically active components of GSK-marketed products are now being embedded in Safety Data Sheets (SDS). These are available on our website at [www.msds-gsk.com](http://www.msds-gsk.com)

The risk assessments carried out to date indicate that our products do not appear to pose an appreciable risk for humans or the environment based on current methods for ascertaining effect levels. But we continue to monitor the latest scientific studies and findings to improve our risk assessments in this area.

## Environment continued

### Metered Dose Inhalers

Metered dose inhalers (MDIs) are used to deliver the main forms of treatment for asthma sufferers. They are pressurised, hand-held devices that use propellants to deliver doses of medication to patients' lungs. They were first introduced in the 1950s and CFCs were traditionally used as the propellant because they are non-toxic, non-reactive, non-flammable, and do not have any odour or taste.

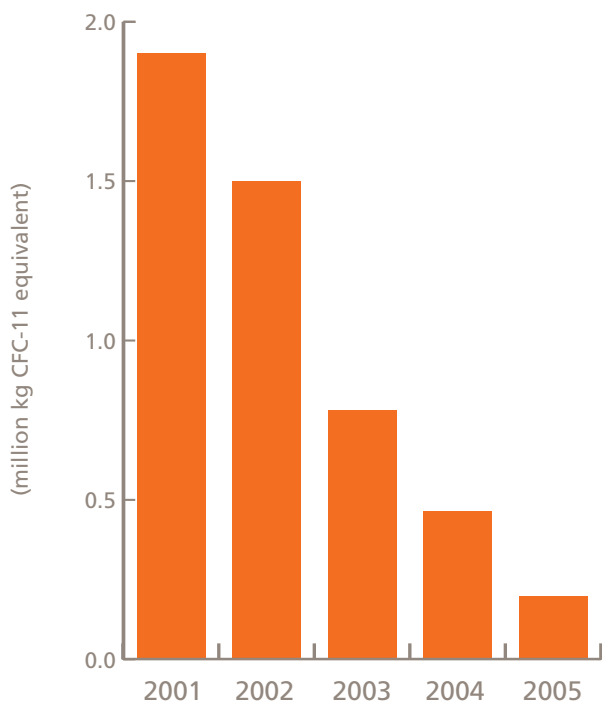
When a patient uses the MDI, the propellant is released into the atmosphere. In 2005, 198 thousand kilograms of CFC propellant were released when patients used our products in the EU and US (we do not have data for the rest of the world). A much smaller proportion of CFCs – 51 thousand kilograms – escaped to air during production of inhalers worldwide (see ozone depleting substances).

The Montreal Protocol bans the production of CFCs but it exempts a number of "essential uses" which include MDIs. Nevertheless we plan to eliminate the use of CFCs from our worldwide product portfolio by 2010. We are committed to stop making CFC devices for developed country markets by the end of 2006 and we will not request any more essential use CFC allocation for the US or the EU after 2005.

We now offer a selection of alternatives in most countries. The main alternative propellant we use is HFC 134a, which does not affect ozone but does have high global warming potential.

We have also invested heavily in dry powder delivery systems that do not use CFCs or HFCs. We estimate that we have invested more than £550 million (\$1 billion) on new plant and R&D for CFC-alternatives since we identified this as an issue in the 1980s.

Ozone depletion potential from patient use of metered dose inhalers



Ozone depletion potential from patient use of metered dose inhalers

| Year | ODP   |
|------|-------|
| 2001 | 1.900 |
| 2002 | 1.500 |
| 2003 | 0.782 |
| 2004 | 0.464 |
| 2005 | 0.198 |

#### Note to Ozone Depletion Potential Charts

We report ozone depletion potential in CFC-11 equivalents as defined by the United Nations Environment Programme (UNEP) Ozone Secretariat. The data only include EU and US.



## Environment continued

### ENERGY AND GLOBAL WARMING POTENTIAL

An increase in greenhouse gases in the atmosphere is thought by many scientists to be causing a rise in the earth's temperature, known as "global warming". Burning fossil fuels for heat and power releases carbon dioxide (CO<sub>2</sub>) – the most significant greenhouse gas.

In 2001 we set a target for 2005 to reduce the global warming potential of energy per unit sales by 8%. We more than met this target and achieved a 13% reduction per unit sales, as we report in the energy section.

GSK's global warming impact comes mainly from the energy used in our facilities (manufacturing, R&D and office sites) which accounts for two-thirds of our carbon dioxide emissions. This is where we are concentrating efforts to reduce emissions, although we are also working on emissions from transport, and compounds we use in our products.

We use compounds that contribute to global warming in producing metered dose inhalers and in some ancillary equipment. Compounds which contribute to global warming are also released when patients use metered dose inhalers. They include CFCs and HCFCs (which also deplete the ozone layer) and HFCs. We report emissions of ozone depleting compounds in the ozone depletion section. See also product stewardship for more about the use of ozone depleting compounds in our products.

Carbon dioxide and methane from waste treatment and fermentation also account for 6% to our global warming impact.

We will continue working to minimise energy use and emissions in the face of significant challenges. Expected growth in new products will require additional equipment which will require additional energy. We will work to balance this growth by continuing to find opportunities for greater efficiencies in new and existing facilities and operations. As a result, we expect energy use and related CO<sub>2</sub> emissions to reduce by 1% per unit sales each year until 2010.

#### Performance

Global warming potential decreased in 2005 by 1% (compared to 2004) and 25% since 2001.

#### Note to Global Warming Charts

Our global warming impact from energy is calculated using conversion factors from the World Business Council For Sustainable Development (WBCSD)/World Resources Initiative (WRI) Greenhouse Gas Protocol Initiative, September 2001, its Stationary and Mobile Combustion Workbooks, and the Intergovernmental Panel on Climate Change (1996).

We use conversion factors from the UK Department for Environment Food and Rural Affairs to calculate CO<sub>2</sub> from business air travel and air freight.

We will investigate and assess the use of updated conversion factors for energy beginning in 2006.

**Energy Use From our Facilities** includes all energy consumed at GSK facilities in the form of electricity and steam purchased and fuels burned in fixed combustion equipment on site, including emergency generators. Figures include fuels used to generate steam and electricity on-site but not fuel for on-site transport. The energy consumption section of this report includes a breakdown of energy data.

**Transport** includes business travel by air (including transatlantic flights between the US and UK, flights within the EU and US for routine business activities, and flights originating in the UK to large group events such as sales conventions), business travel by road (including company-owned vehicle fleets, primarily our global sales fleet), and product freight by air. The increase in global warming potential from transport since 2001 is mainly because we have improved our reporting systems to more comprehensively collect transport data. For example, the 2001 data did not include business air travel within the EU and US and did not include UK and international sales fleet travel.

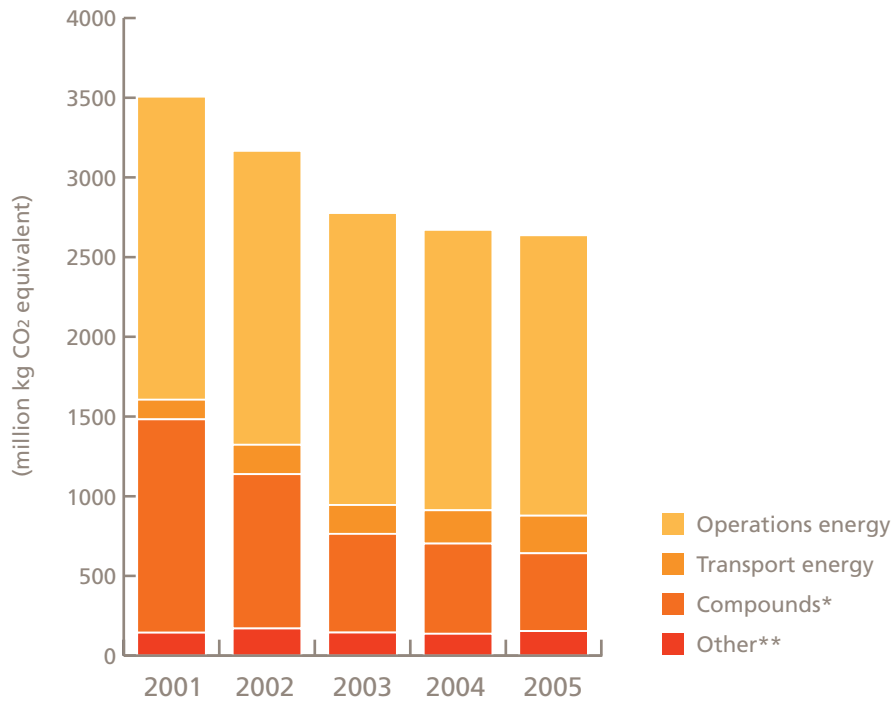
The data do not include employee travel to work. We do not collect data for flights originating in the US to large group events or for other modes of business travel including rail and bus. We do not calculate CO<sub>2</sub> emissions from road, rail or sea freight transport because our central data collection system is not as robust in these areas and the impacts are small when compared to those of air freight transport. The transport section of this report includes a breakdown of transport data.

The ozone depletion data does not include CFCs released from patients' use of metered dose inhalers.

**Other** is CO<sub>2</sub> equivalents from waste treatment and fermentation.

## Environment continued

### Global warming potential



| Global warming potential |            |           |            |         |       |
|--------------------------|------------|-----------|------------|---------|-------|
| Year                     | Operations | Transport | Compounds* | Other** | Total |
| 2001                     | 1903       | 124       | 1339       | 145     | 3510  |
| 2002                     | 1844       | 179       | 968        | 170     | 3162  |
| 2003                     | 1833       | 178       | 619        | 146     | 2775  |
| 2004                     | 1747       | 206       | 567        | 138     | 2657  |
| 2005                     | 1759       | 232       | 488        | 155     | 2634  |

\* compounds that contribute to global warming  
 \*\* includes waste treatment and fermentation

## Environment continued

### Energy Consumption

Energy use from our facilities accounts for two-thirds of GSK's global energy consumption. In 2005, we used 19 million gigajoules of energy which produced emissions of 1,759 million kg CO<sub>2</sub>. We bought 43% of our energy as electricity and a small amount (about 1%) as municipal steam or hot water. We generated the rest at our sites.

In 2005 we consulted, inside and outside the company, on a position statement on our future use of energy. This was drafted in 2004 in response to stakeholder feedback that energy use and its impact on global warming are key concerns. The draft position sets out a strategy for energy efficiency, renewable energy and emissions trading.

We continued to work on energy efficiency initiatives in 2005, as demonstrated by the following site projects:

- Stevenage, UK – installed solar-powered street lights
- Port Fairy, Australia – assessed wind turbine and bioenergy potential
- Nashik, India – installed solar heating for canteen hot water
- Research Triangle Park, US – increased its sponsorship level in the state green power programme, which will add more than 700,000 kWh of renewable energy to North Carolina's power supply
- Zebulon, US – saved energy by better control of laboratory lighting, introducing motion-activated lighting and reducing the temperature of the office buildings by 2 degrees
- US Pharma and R&D Site Operations – created the Strategic Energy Leadership Council to bring together managers with a common interest in energy management to provide leadership on energy matters. The Council has implemented energy and utilities initiatives that have saved in excess of \$2 million, including an Energy Conservation Tracking database and Energy Technology Workshops
- Suzhou, China – modified the chilled water system to avoid using the chiller when the air temperature is low enough to ensure cool water. This has saved an estimated 550,000 kWh of electricity in a year.

### Emissions trading

A number of our UK sites participate in the government's emissions trading scheme (ETS) - helping us to gain experience in carbon trading. The UK ETS is a voluntary scheme which rewards companies with lower energy taxes if they improve energy efficiency. Sites that keep emissions below an agreed target can "bank" the spare credits to help comply with limits in subsequent years, or they can sell the credits to other participants in the scheme. We achieved the required emissions in the target year, 2004 and are on course for the next target year, 2006.

The European Union trading scheme came into force at the start of 2005. The first phase runs from 2005 to 2007 and sites with greater than 20 megawatts of installed combustion capacity are required to participate. In total, 16 GSK sites will be regulated under this scheme. Our performance in 2005 has been verified by external auditors and although some sites have exceeded their cap, we anticipate that overall we will have surplus carbon credits under this scheme. We plan to bank some of these credits to help us comply with future limits, and expect to trade the remainder of the credits.

### Performance

#### *Energy consumption (excluding transport)*

Total energy consumption increased by 2% from 2004 to 2005 (but decreased by 8% since 2001). Energy consumption per unit sales decreased by 4% from 2004 to 2005 and 13% since 2001, so we have met our 2005 target of an 8% reduction per unit sales since 2001.

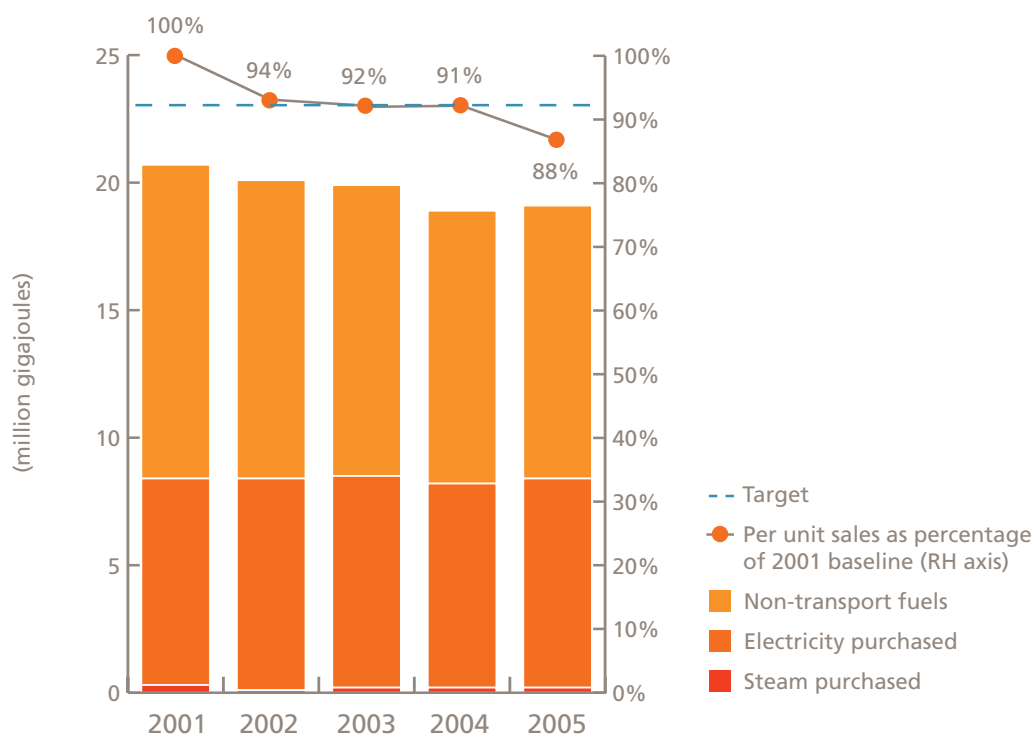
Global Manufacturing Supply (GMS) and Research and Development (R&D) have the greatest impact on GSK's energy consumption profile. They account for 59% and 26% of GSK's energy consumption respectively. In 2005 R&D used almost 4% more energy because it is expanding as products move through the R&D pipeline. This is partially offset by energy efficiency initiatives to keep the increase in energy use to a minimum. Energy managers are working on projects to improve energy efficiency so that the expanded activity will not require an equivalent increase in energy use.

Our Primary Supply & Antibiotics group within GMS reduced its total energy use by more than a third since 2001 – the greatest reduction of any GSK supply group or operation over the same time period. This significant reduction was the result of a focus on energy efficiency and a coordinated effort to identify and implement site-specific programmes at the sites in that supply group.

# Environment continued



## Energy consumption (excluding transport)

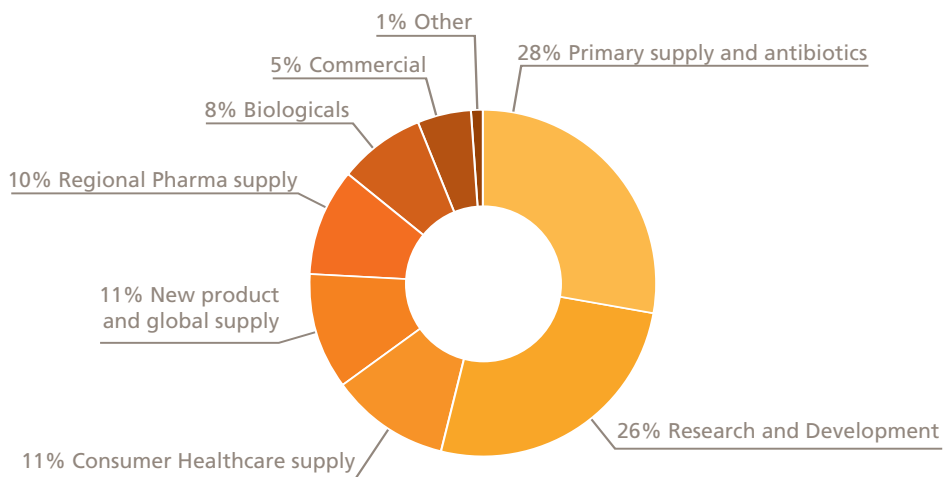


| Energy consumption (excluding transport) |       |          |                     |       |
|--|-------|----------|---------------------|-------|
| Year                                     | Steam | Electric | Non-transport fuels | Total |
| 2001                                     | 0.3   | 8.1      | 12.3                | 20.7  |
| 2002                                     | 0.1   | 8.3      | 11.7                | 20.0  |
| 2003                                     | 0.2   | 8.3      | 11.4                | 19.9  |
| 2004                                     | 0.2   | 8.0      | 10.7                | 18.8  |
| 2005                                     | 0.2   | 8.2      | 10.7                | 19.2  |

# Environment continued



## Energy consumption by business (excluding transport)



|                                |             |
|--------------------------------|-------------|
| Primary supply and antibiotics | 5.3         |
| New product and global supply  | 2.1         |
| Regional Pharma supply         | 1.9         |
| Consumer Healthcare supply     | 2.1         |
| Biologicals                    | 1.5         |
| Research and Development       | 5.0         |
| Commercial                     | 1.0         |
| Other                          | 0.3         |
| <b>Total</b>                   | <b>19.2</b> |
| (million gigajoules)           |             |

## Environment continued

### *Global warming potential from energy*

Total global warming potential from energy use at our facilities increased less than 1% from 2004 to 2005 but decreased by 8% since 2001. Global warming potential per unit sales decreased 5% since 2004 (13% since 2001) – meaning we have more than met our 2005 target of an 8% reduction per unit sales since 2001.

### *Sulphur dioxide and nitrogen oxides*

In 2005, 87,842 kilograms of NO<sub>x</sub> and 364,014 kilograms of SO<sub>2</sub> were emitted from sites with coal-fired power.

#### Note to Energy Charts

Energy consumption at our facilities is defined as all energy consumed in the form of electricity and steam purchased and fuels burned in fixed combustion equipment on site, including emergency generators. Figures include fuels used to generate steam and electricity on-site but not fuel for on-site transport.

The global warming potential from energy use at our facilities is calculated using conversion factors from the World Business Council For Sustainable Development (WBCSD) / World Resources Initiative (WRI) Greenhouse Gas Protocol Initiative, September 2001, its Stationary and Mobile Combustion Workbooks, and the Intergovernmental Panel on Climate Change (1996).

The NO<sub>x</sub> and SO<sub>2</sub> are calculated from the coal used at the only two GSK facilities (in India) that use coal, using conversion factors from the National Atmospheric Emissions Inventory (UK national methodology).

#### CASE STUDY

##### **Saving energy by using waste methane**

GSK's consumer healthcare site at Rajahmundry, India, has captured methane generated by anaerobic digestion of wastewater sludge, which was previously wasted, and now uses it instead of liquefied petroleum gas (LPG) in the site canteen. The "USE MEthane" [correct double CAP] project, which was completed in March 2005, has reduced the risk from storing LPG cylinders as well as conserving resources, saving money and eliminating waste.

Methane is generated by the factory's effluent treatment plant. Previously, the majority of this highly flammable gas was burnt through a flare stack, with some used in the production of distilled water. The USE MEthane project examined how the gas could be put to productive use and identified canteen fuel as the best solution.

The factory laid a pipeline from the anaerobic digestion to the canteen, and bought new stoves adapted to burn methane rather than LPG.

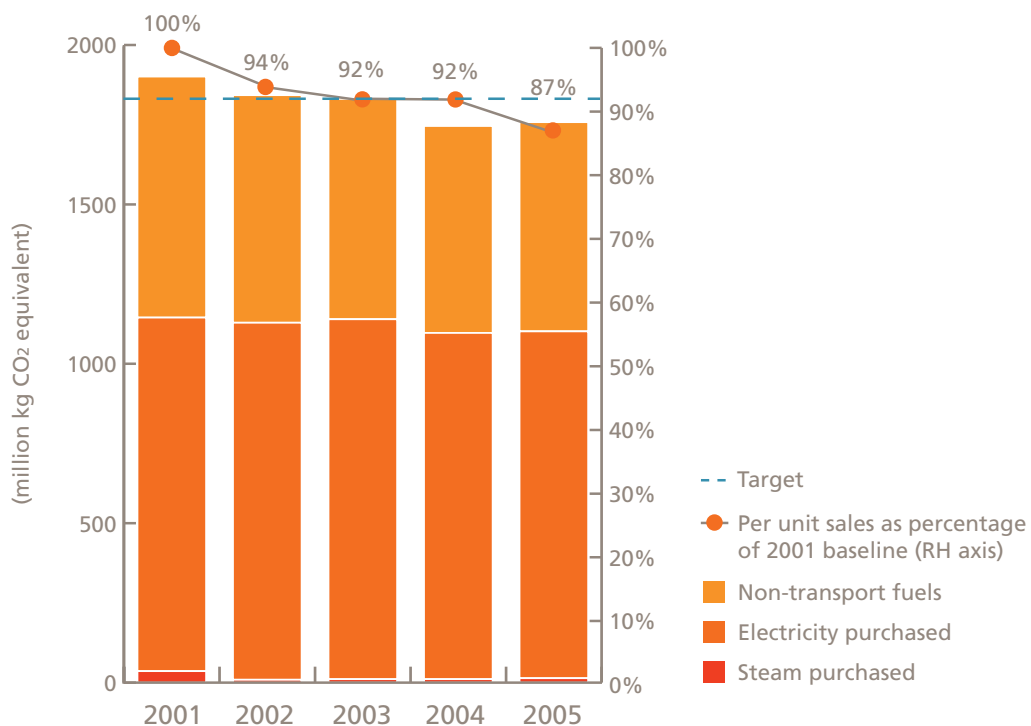
The project has reduced the amount of LPG used in the site's canteen by 80%, saving 255 cylinders of gas a year, worth more than £1,000. Storing fewer LPG cylinders has also improved safety, significantly reducing the risk of an explosion.

USE MEthane was awarded first place in the EHS Initiative – Environment category of our CEO's EHS Excellence Awards.

# Environment continued



## Global warming potential from energy (excluding transport)



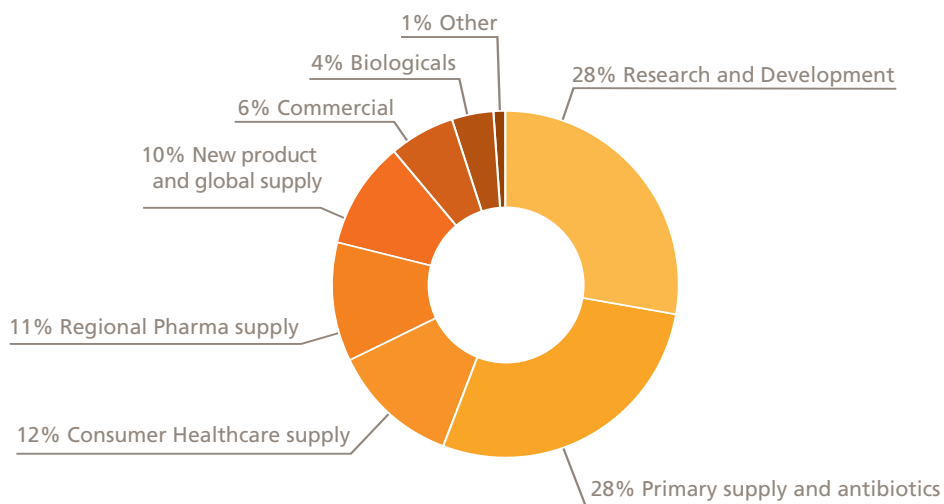
| Global warming potential from energy (excluding transport) |       |          |                     |       |
|--|-------|----------|---------------------|-------|
| Year   | Steam | Electric | Non-transport fuels | Total |
| 2001   | 37    | 1109     | 757                 | 1903  |
| 2002   | 9     | 1121     | 714                 | 1844  |
| 2003   | 11    | 1130     | 692                 | 1833  |
| 2004   | 11    | 1086     | 649                 | 1747  |
| 2005   | 14    | 1088     | 657                 | 1759  |



# 7 Environment continued



Global warming potential from energy (excluding transport) by business



|                               |     |
|-------------------------------|-----|
| Primary supply & antibiotics  | 486 |
| New product and global supply | 173 |
| Regional Pharma supply        | 189 |
| Consumer Healthcare supply    | 214 |
| Biologicals                   | 62  |
| Research and Development      | 503 |
| Commercial                    | 112 |
| Other                         | 20  |

**Total** **1759**  
(million kg CO<sub>2</sub> equivalent)

## Environment continued

### Transport

We estimate that transport accounts for 9% of our total global warming impact. In 2005 we emitted approximately 232 million kilograms of CO<sub>2</sub> from transport.

Business air travel accounts for almost half (48%) of our travel-related CO<sub>2</sub> emissions. In 2005, employees travelled a total of almost 800 million kilometres by plane (a decrease of 2% since 2004) – resulting in 112 million kg of CO<sub>2</sub> emissions. This includes transatlantic flights between the US and UK, and flights within the EU and US for routine business activities, as well as travel originating in the UK related to large group events such as sales conventions.

In 2005, our global sales fleet drove a total of over 850 million kilometres on business travel – resulting in 102 million kg of CO<sub>2</sub>.

In addition to business travel, we also transport products from our manufacturing plants to distributors. In 2005, GSK products were transported a total of 195 million kilometres – the majority (82%) by air freight. We estimate that the air freight resulted in 19 million kg of CO<sub>2</sub>. This 37% increase in 2005 is due to:

- improved data collection
- continued business growth
- increased sourcing from China
- a rise in clinical trials conducted outside the US and UK

We have launched a number of initiatives to reduce the impact of transporting products. They include consolidating freight shipments so pharmaceutical and consumer products are transported together, consolidating shipping points, and making more use of round tripping (managing inbound freight trucks so they do not return empty). We also convert air transport to sea transport where possible.

We have “green travel plans” at a number of sites to encourage employees to reduce the environmental impact of their travel to work. For example, at GSK House in Brentford, UK, privileged parking spaces are given to car-sharers and drivers of fuel efficient cars, buses run to and from the local train station, while changing rooms and showers are provided for cyclists as well as discounts for bicycle equipment and repairs.

We encourage employees to use video and teleconferencing where possible to reduce air travel. Virtual meeting software is available to employees for making presentations and collaborative working. On average, GSK employees conduct 450 video meetings, 30,000 teleconferences and 29,000 virtual meetings per month.

### Performance

Total global warming potential from transport increased by 13% in 2005 and 88% since 2001. The increase since 2001 is mainly because we have improved our reporting systems to collect more comprehensive transport data. For example, the 2001 data did not include business air travel within the EU and US, and it did not include the UK and international sales fleets. We believe we are still underestimating our global warming potential from transport because we do not have a robust system to collect group air travel not originating in the UK.

#### Note to Transport Chart

Data for business air travel includes transatlantic flights between the US and UK, flights within the EU and US for routine business activities, and flights originating in the UK to large group events such as sales conventions.

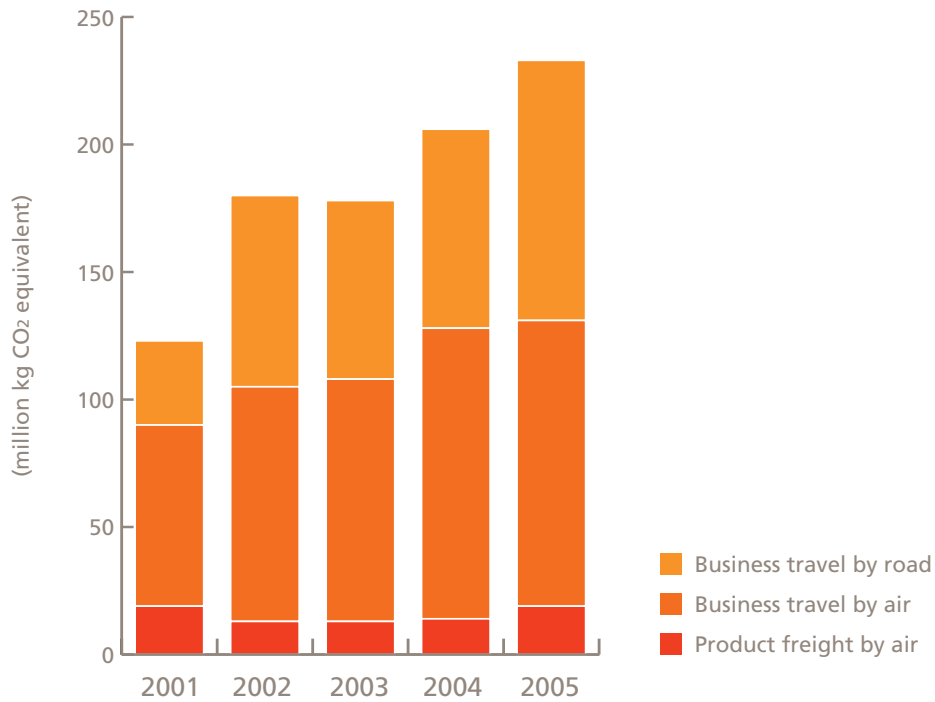
Data for business travel by road is primarily our global sales fleet. We do not collect data for other modes of business travel including rail and bus.

The CO<sub>2</sub> from air freight covers all global routes. We do not calculate CO<sub>2</sub> emissions from road, rail or sea freight transport because our central data collection system is not as robust in these areas and the impacts are small when compared to those of air freight transport.

We use conversion factors from the UK Department for Environment Food and Rural Affairs to calculate CO<sub>2</sub> from business air travel and air freight.

## Environment continued

### Global warming potential from transport



| Global warming potential from transport |         |              |               |       |
|---|---------|--------------|---------------|-------|
| Year                                    | Freight | Business air | Business road | Total |
| 2001                                    | 19      | 71           | 33            | 124   |
| 2002                                    | 13      | 92           | 75            | 179   |
| 2003                                    | 13      | 95           | 70            | 178   |
| 2004                                    | 14      | 114          | 78            | 206   |
| 2005                                    | 19      | 112          | 102           | 232   |

## Environment continued

### WATER

Water is a valuable natural resource that needs to be conserved and protected from pollution. Water conservation is particularly important in areas where water shortages are common.

GSK uses water in manufacturing (eg for processes, products, cooling and cleaning) and for general site uses including drinking, food services and sanitation. The amount of water our sites use varies according to the activities that take place. Primary supply sites – those that manufacture active pharmaceutical ingredients – are typically heavy users of water, as are sites that manufacture vaccines or produce drinks. Those involved in research and development and commercial sites typically use less.

The GSK water standard requires sites to minimise water use and re-use water whenever feasible. Sites are required to minimise the potential environmental impacts of discharging wastewater.

#### Water Use

In 2005, we used 22 million cubic metres of water. This is about average for the industry, based on benchmarking with other major pharmaceutical companies. We source water mainly from municipal water supplies (59%), wells or boreholes (40%), with a small amount from other sources.

Total water consumption increased by less than 4% since 2004 (but is down 19% since 2001). Water consumption per unit sales decreased by 3% since 2004 (23% since 2001). This means we met our 2005 target to cut water use per unit sales by 10%. This is mainly due to consolidating primary manufacturing sites following the merger in 2000, and outsourcing some fermentation processes.

We have introduced water conservation measures. For example, our site at Thane, India, won one of the CEO's EHS Excellence Awards for its water conservation measures (see below) and similar projects were submitted by sites in Pakistan, India, Indonesia, Poland and Canada.

#### Note to Water Use Charts

Water use includes water sourced from wells/boreholes, municipal and other sources (mainly wastewater from external industrial sources).

The data include water used in manufacturing processes and for general sites uses, as well as water incorporated into products

### CASE STUDY

#### Water conservation at Thasne, India

GSK's site at Thane, near Mumbai in India, manufactures medicines for the local market. Thane introduced measures to conserve and minimise water use in 2004, including rainwater harvesting, improving efficiency and installing water saving technologies. Between 2003 and 2005, the site reduced water consumption from 200,000 kilolitres per year to 160,000 kilolitres per year.

The site is located in a monsoon region, meaning it experiences irregular rainfall and water shortages during the dry season. This problem is amplified by increasing urbanisation and agricultural development. Thane receives water from the municipal supply and uses it for cooling, generating steam in the boiler, and in the gardens.

Thane installed rainwater catchment devices on roofs near the site's boiler and cooling towers. The rainwater is pumped to storage tanks ready for immediate use, or pumped into a borewell to replenish the water table. As a result, water consumption during the peak monsoon month of September dropped from 16,000 kilolitres in 2003 to 12,000 kilolitres in 2004.

Several measures were introduced to save water, including a steam recovery device for the boiler, prohibiting hose cleaning of plant floors, installing photo-sensors in the urinals and installing foot operated taps in the site's canteen.

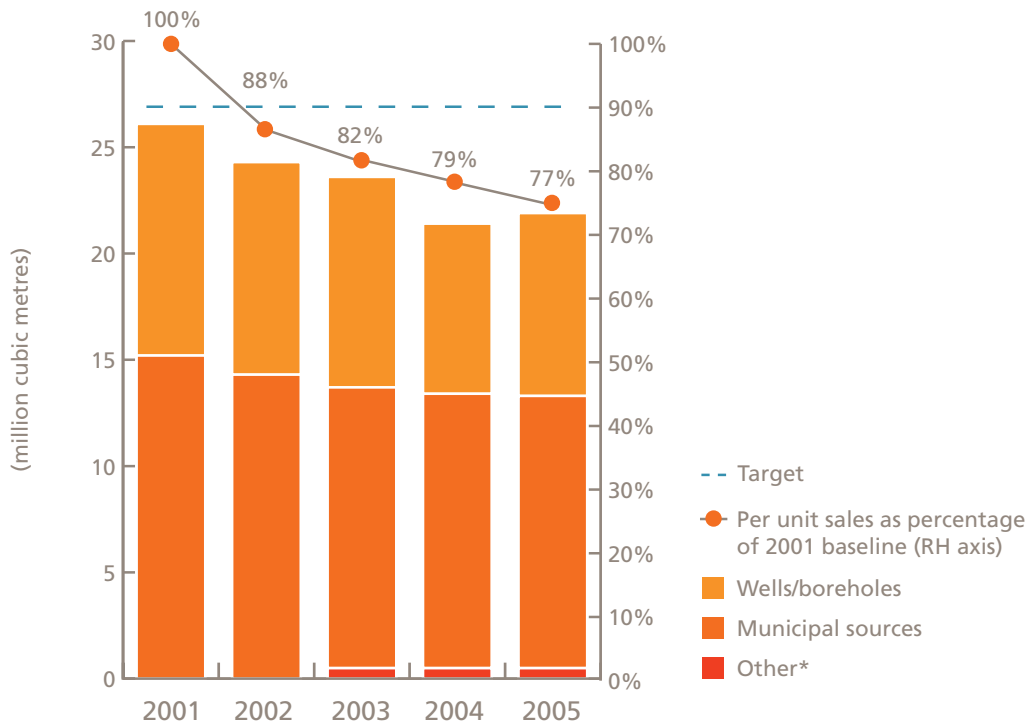
Thane installed a drip irrigation system in the garden and the sprinkler system was changed to reduce the amount of water lost through evaporation. Other changes to the garden included altering the planting season to coincide with wetter months, watering plants during the early morning and allowing the grass to grow longer so it holds in soil moisture.

Thane was awarded third place in the environment category of the CEO's EHS Excellence Awards for its water conservation improvements.

# Environment continued



## Water consumption



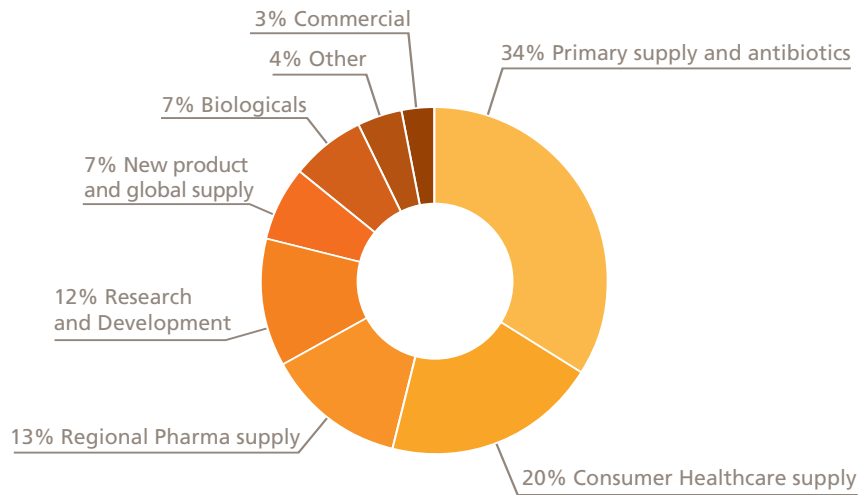
| Water consumption |                 |           |        |       |
|-------------------|-----------------|-----------|--------|-------|
| Year              | Wells/boreholes | Municipal | Other* | Total |
| 2001              | 11.6            | 15.2      | 0.0    | 26.8  |
| 2002              | 10.0            | 14.3      | 0.0    | 24.3  |
| 2003              | 9.9             | 13.2      | 0.1    | 23.1  |
| 2004              | 8.0             | 12.9      | 0.1    | 21.0  |
| 2005              | 8.6             | 12.8      | 0.4    | 21.7  |

\* mainly wastewater from external industrial sources

# 7 Environment continued



## Water consumption by business



|                                |             |
|--------------------------------|-------------|
| Primary supply and antibiotics | 7.4         |
| New product and global supply  | 1.6         |
| Regional Pharma supply         | 2.8         |
| Consumer Healthcare supply     | 4.4         |
| Biologicals                    | 1.5         |
| Research and Development       | 2.6         |
| Commercial                     | 0.6         |
| Other                          | 1.0         |
| <b>Total</b>                   | <b>21.7</b> |
| (million cubic metres)         |             |

## Environment continued

### Wastewater

In 2005, we generated 17 million cubic metres of wastewater from our manufacturing processes and various site operations. This is 1% less than 2004 (20% since 2001). The decrease is mainly due to consolidating primary manufacturing sites following the merger in 2000, and outsourcing some fermentation processes. We reused, recovered or recycled 6% of total wastewater.

GSK's EHS Standards require sites to reuse water whenever feasible and ensure that all wastewater is treated and discharged in a way that minimises adverse environmental impacts. Most sites discharge wastewater to municipal treatment facilities either with or without prior treatment. Some large sites, especially primary manufacturing sites, have their own on-site wastewater treatment systems. Some sites are permitted to discharge wastewater direct to sea.

All five of our sites in India have implemented "zero wastewater" discharge programmes – reusing and recycling all wastewater. They use processed wastewater for watering plants and trees, which help provide shade, improve the appearance of the site, and are also a source of food for employees. They do not discharge any wastewater to water bodies or to municipal sewers.

Our site in Xochimilco, Mexico uses processed wastewater for watering gardens around the site, washing vehicles and windows and other uses not requiring drinking water. Our sites in Turkey and the Philippines also re-use all wastewater.

We assess the quality of our wastewater by measuring the chemical oxygen demand (COD) – the oxygen required to chemically oxidise organic and inorganic compounds present in the water. (The lower the COD, the cleaner the water.)

Total COD decreased by 7% compared to 2004 (30% since 2001). Most of the reduction is due to our site at Ulverston, UK, outsourcing fermentation processes. COD per unit sales decreased by 13% since 2004 and 34% since 2001 – meaning we have achieved our 2005 target of a 30% reduction per unit sales since 2001.

### Note to Wastewater and COD Charts

Wastewater volume includes all manufacturing and site process wastewater as well as sanitary and food service wastewater.

Wastewater quality is measured by Chemical Oxygen Demand (COD) which is a measure of the oxygen required to chemically oxidise organic and inorganic compounds present in the water.

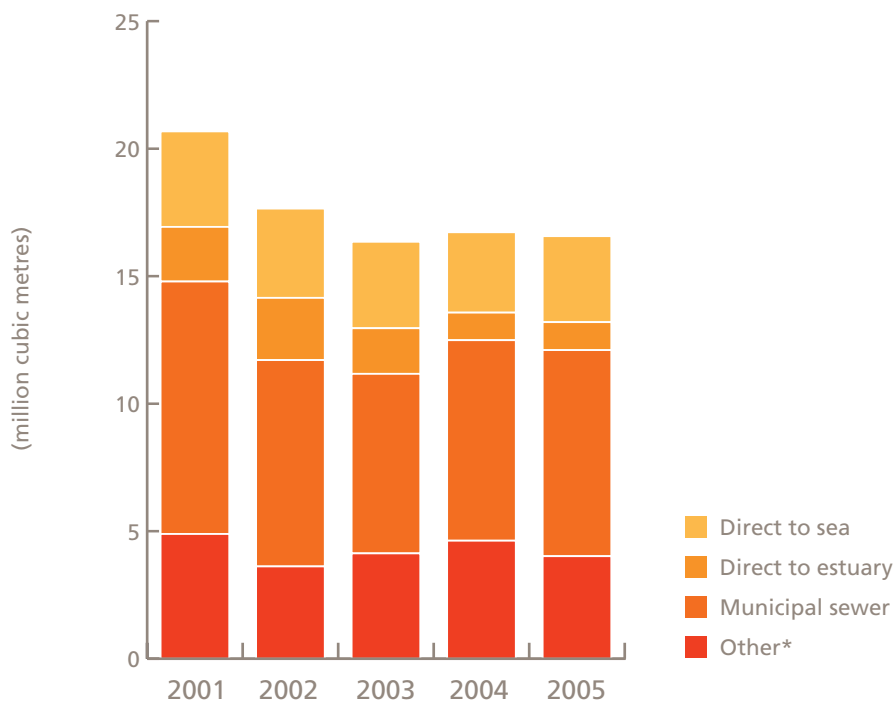
The COD is measured when wastewater leaves our sites, following any on-site treatment.



# Environment continued



## Wastewater volume



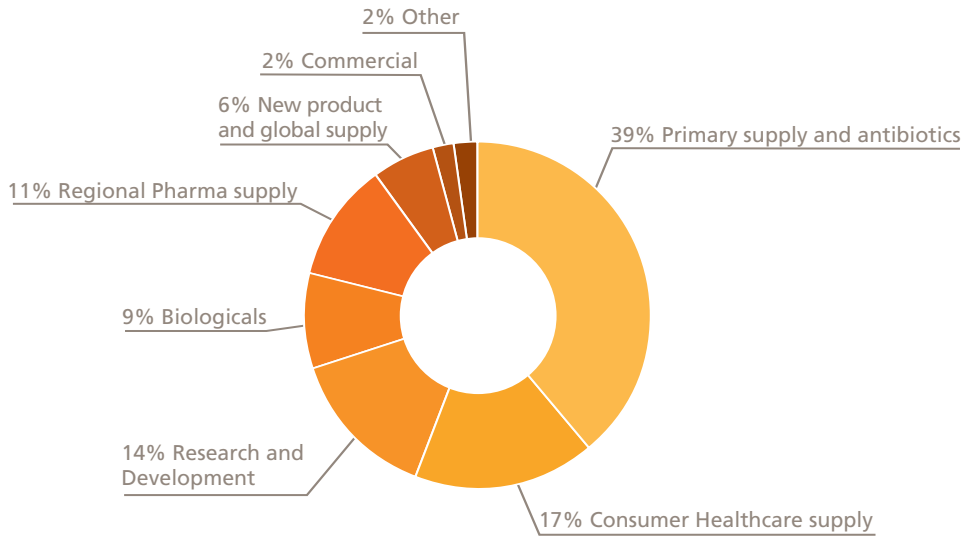
| Wastewater volume |     |         |       |        |       |
|-------------------|-----|---------|-------|--------|-------|
| Year              | Sea | Estuary | Sewer | Other* | Total |
| 2001              | 3.8 | 2.1     | 9.9   | 4.9    | 20.7  |
| 2002              | 3.5 | 2.4     | 8.1   | 3.6    | 17.7  |
| 2003              | 3.4 | 1.8     | 7.0   | 4.1    | 16.4  |
| 2004              | 3.2 | 1.1     | 7.9   | 4.6    | 16.7  |
| 2005              | 3.4 | 1.1     | 8.1   | 4.0    | 16.6  |

\* includes direct to river and reused/recovered/recycled

# Environment continued



## Wastewater volume by business

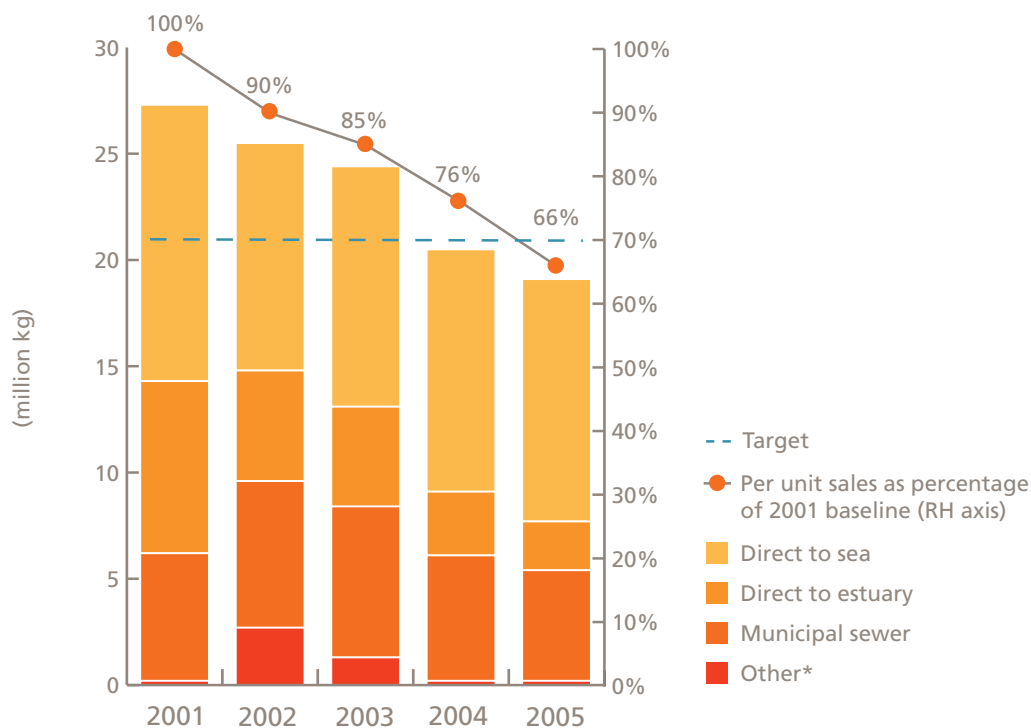


|  |             |
|--|-------------|
| Primary supply and antibiotics         | 6.4         |
| New product and global supply          | 0.9         |
| Regional Pharma supply                 | 1.9         |
| Consumer Healthcare supply             | 2.8         |
| Biologicals                            | 1.4         |
| Research and Development               | 2.3         |
| Commercial                             | 0.4         |
| Other                                  | 0.4         |
| <b>Total</b><br>(million cubic metres) | <b>16.6</b> |

# Environment continued



## Wastewater chemical oxygen demand



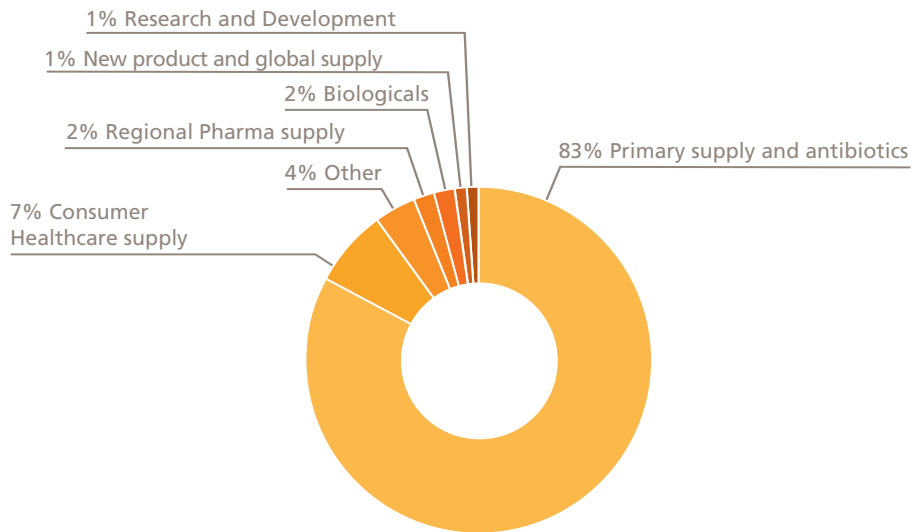
| Wastewater chemical oxygen demand |      |         |       |        |       |
|-----------------------------------|------|---------|-------|--------|-------|
| Year                              | Sea  | Estuary | Sewer | Other* | Total |
| 2001                              | 13.0 | 8.1     | 6.0   | 0.2    | 27.3  |
| 2002                              | 10.7 | 5.2     | 6.9   | 2.7    | 25.5  |
| 2003                              | 11.3 | 4.7     | 7.1   | 1.3    | 24.3  |
| 2004                              | 11.4 | 3.0     | 5.9   | 0.2    | 20.5  |
| 2005                              | 11.4 | 2.3     | 5.2   | 0.2    | 19.1  |

\* includes reused/recovered/recycled, on-site irrigation

# 7 Environment continued



Wastewater chemical oxygen demand by business



|                                |             |
|--------------------------------|-------------|
| Primary supply and antibiotics | 15.9        |
| New product and global supply  | 0.2         |
| Regional Pharma supply         | 0.5         |
| Consumer Healthcare supply     | 1.3         |
| Biologicals                    | 0.4         |
| Research and Development       | 0.1         |
| Commercial                     | 0.0         |
| Other                          | 0.8         |
| <b>Total</b>                   | <b>19.1</b> |
| (million kg)                   |             |

## Environment continued

### WASTE

Our research, production and commercial activities all produce waste, which we aim to manage safely and responsibly. We manage waste from when it is generated to its final disposal. We want to eliminate waste where we can, reduce it where we cannot, re-use materials if possible, recycle other waste and dispose of any remaining material sensitively.

We generate different kinds of waste in different parts of the business:

- Production – hazardous wastes such as solvents and other chemicals.
- R&D and quality laboratories – small amounts of chemicals including products and intermediates, as well as broken glassware and plastics
- Offices – paper and other standard commercial waste
- Renovations take place in production, office and lab space which produce non-routine waste such as obsolete equipment, office furniture, structural materials

Most of the active ingredients in our pharmaceutical products are manufactured using chemical processes. This means that a significant proportion of our waste is classified as hazardous because it contains solvents and chemicals used in these processes. We report hazardous waste separate from non-hazardous, and identify non-routine waste such as construction and demolition rubble because the volumes depend on building activity and tend to be inconsistent.

Most production facilities segregate their wastes, re-use what they can, send what they can for recycling, and incinerate or landfill anything else. Incineration is usually the preferred choice for dealing with solvents that can't be reused or recycled. Sites try to use waste management companies which use incinerators that recover energy from burning the materials.

We aim to use reputable waste handling companies for waste disposal. We require disposal contractors to comply with our EHS requirements and local regulations. Our internal EHS audit team audits waste disposal contractors to make sure they handle waste appropriately.

In the past, some waste and chemicals handling practices (which are no longer followed) contaminated land and groundwater. We are continuing to clean up these sites to deal with health and environmental hazards.

GSK and its heritage companies have spent more than £100m cleaning up more than 50 sites in the US over the last 20 years. We are continuing to clean up 25 of these sites. Most of them are waste disposal sites where GSK is one of several responsible parties.

We continue to work on reducing waste, especially hazardous waste. One of our material efficiency aspirations is to minimise the number of solvents used or use smaller amounts so we don't have so much to dispose of. Our Operational Excellence initiative, which started in 2001, has a strong focus on elimination of all types of waste from manufacturing processes. This is reflected in applications for the CEO's EHS Excellence awards – 11 projects in 2005 involved eliminating or recycling waste.

Our performance on waste is covered in the following pages.

### Hazardous Waste

More than 80% of our hazardous waste consists of solvents that are used in production processes. We also dispose of some lubricants and fluorescent lights, while research waste includes animal carcasses. Our labs generate very small quantities of radioactive waste, which is highly regulated.

Regulations vary widely around the world, but our first choice for solvents is to re-use or recycle material. When this is not possible the main disposal option for solvents is incineration. We aim to use incineration with energy recovery wherever possible.

The main focus of our work to improve material efficiency is to reduce the total amount of solvents we use.

In 2005, we disposed of 68 million kg of hazardous waste (excluding demolition and construction waste). This is mostly solvents (81%), the rest being general site waste (18%) and chemical, biological or radioactive waste (1%).

In 2005, 44% of hazardous waste disposed was incinerated with energy recovery, 54% was incinerated without energy recovery. The remaining waste was disposed to licensed landfill sites.

## Environment continued

### Performance

Total hazardous waste disposed decreased by 8% since 2004 (but is up by 9% since 2001). Hazardous waste disposed per unit sales decreased by 14% since 2004 (but increased 3% since 2001) – meaning we did not meet our 2005 target of a 15% reduction per unit sales since 2001.

Our previous trend of reducing hazardous waste per unit sales was reversed in 2004 by a combination of factors. GSK's hazardous waste is mostly solvents and one plant scheduled for closure had to dispose of redundant solvent stocks. This had a one off impact on our data. In addition, changes to production at other plants included bringing in-house processes that were previously undertaken by contract manufacturers and moving existing processes among sites. Our engineers continued to assess how to optimise the new and moved processes to reduce solvent use and increase recycling and in 2005 we resumed the downward trend.

Solvent recovery was affected by several factors in 2005:

- we had to repair solvent recovery equipment at two sites, which resulted in complete shut-down of the recovery operation. No commercial recovery operation was available, so solvent normally recovered was incinerated instead
- new products using new solvents continue to come on line. It can take time for sites to gear up solvent recovery and recycling for these new materials
- pilot plants, which are producing our new products as they go into clinical trials, work with such a wide range of different solvents that recycling is not practical
- in 2004 some of our primary sites had difficulty handling solvents received as a result of moving processes between sites. This year some of the sites began to recover from these moves and improved their solvent recovery, thereby decreasing the amount of solvents disposed
- one new site which we acquired in 2004 contributed an additional 3 million kg to the total of solvent recycled this year.

### Note to Hazardous Waste Charts

Although the external definition of what constitutes a waste varies, for GSK reporting purposes a material is considered a waste if it is no longer fit for its originally intended purpose.

Hazardous waste disposed includes disposal to landfill and incineration either on or off GSK property. Incineration with energy recovery means burning the material and using the resulting energy. Incineration without energy recovery means burning the material without using the energy or heat generated. Hazardous waste disposed does NOT include recycling on-site or off-site or non-routine waste.

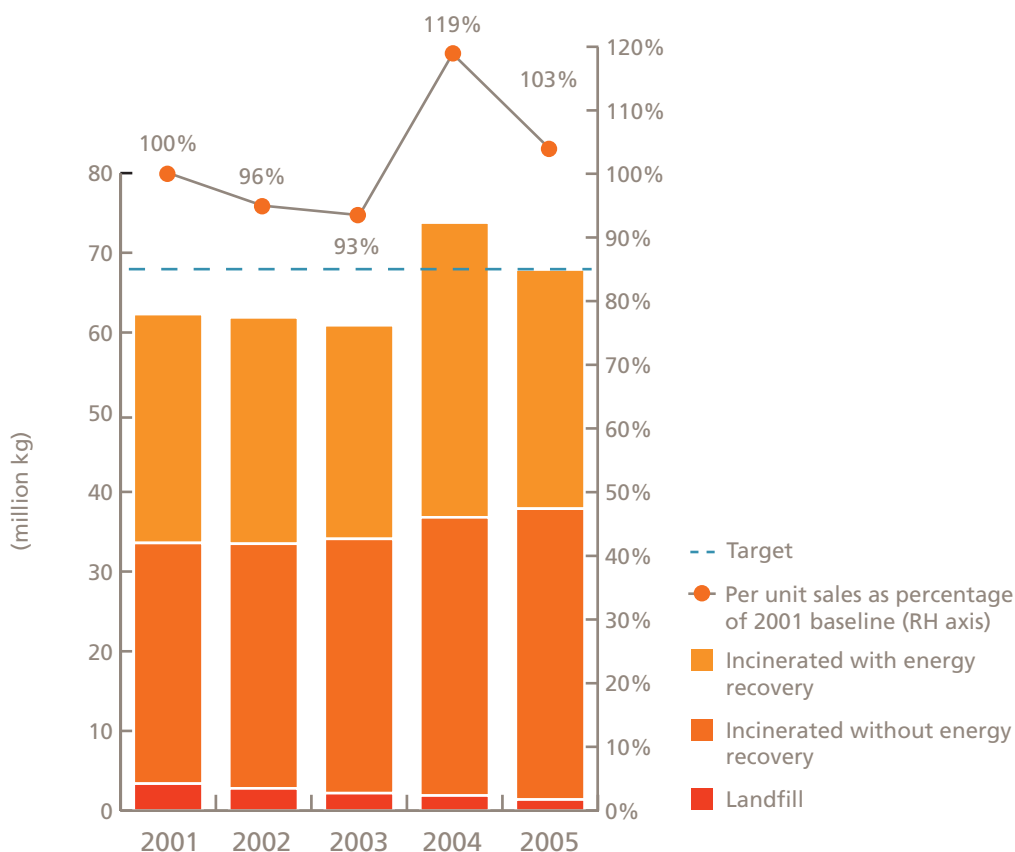
For consistent reporting, GSK considers a waste to be hazardous if it exhibits any of a number of properties as defined by the Basel Convention in 1989 of the United Nations Environment Programme (UNEP). Included in these properties are flammability, explosivity, water or air reactivity, corrosivity, oxidising potential, acute or chronic toxicity, ecotoxicity or infection. In addition, because of their nature and potential impact on research and development activities, radioactive wastes are defined as hazardous. Bioengineered and biohazardous waste is included in hazardous waste.

A waste is considered to be non-hazardous if it does not exhibit any of the hazardous properties noted above.

# Environment continued



## Hazardous waste disposed



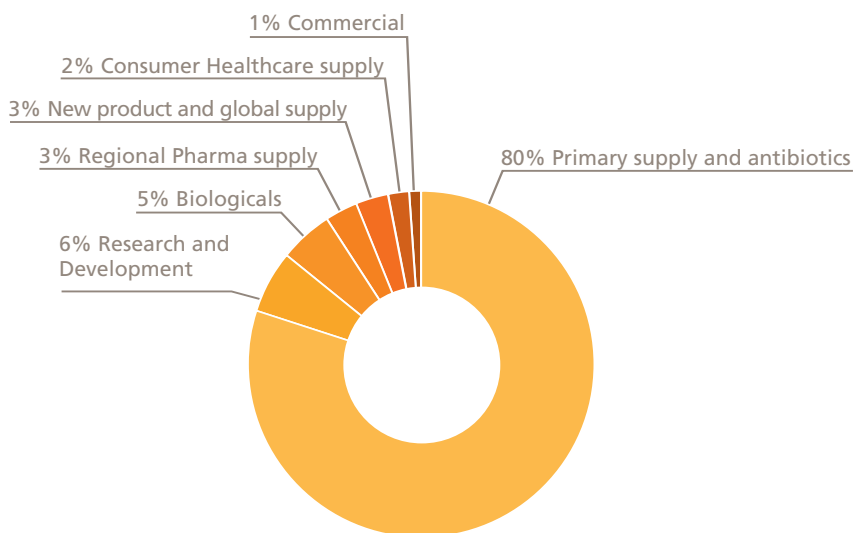
| Hazardous waste disposed |               |                  |          |       |
|--------------------------|---------------|------------------|----------|-------|
| Year                     | With recovery | Without recovery | Landfill | Total |
| 2001                     | 28.7          | 30.2             | 3.4      | 62.3  |
| 2002                     | 28.4          | 30.7             | 2.8      | 61.9  |
| 2003                     | 26.8          | 31.9             | 2.2      | 60.8  |
| 2004                     | 37.0          | 34.9             | 1.9      | 73.8  |
| 2005                     | 30.0          | 36.5             | 1.4      | 67.9  |



# 7 Environment continued



## Hazardous waste disposed by business

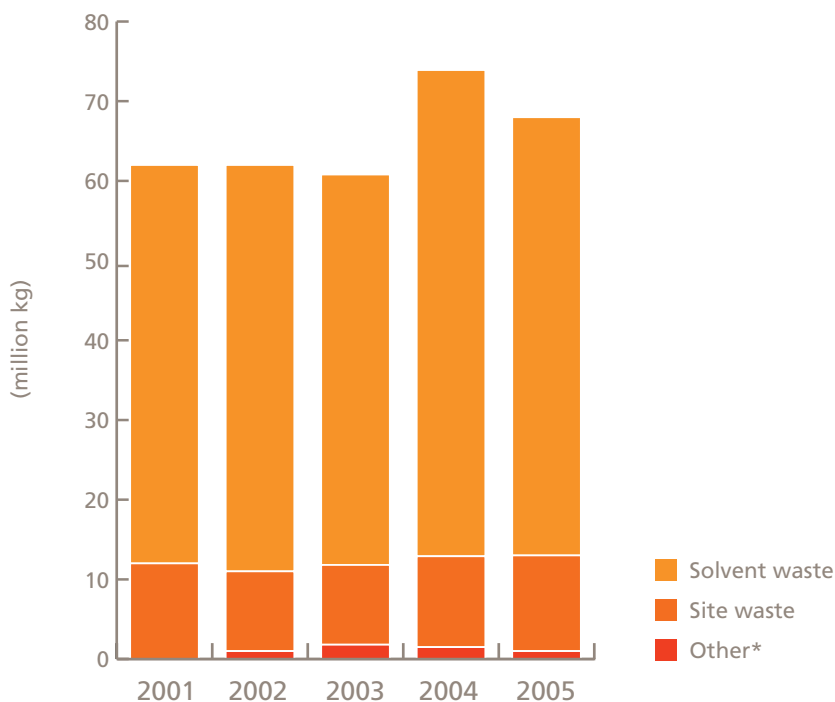


|                                |             |
|--------------------------------|-------------|
| Primary supply and antibiotics | 55.2        |
| New product and global supply  | 1.9         |
| Regional Pharma supply         | 1.9         |
| Consumer Healthcare supply     | 1.2         |
| Biologicals                    | 3.4         |
| Research and Development       | 3.8         |
| Commercial                     | 0.4         |
| Other                          | 0.0         |
| <b>Total</b>                   | <b>67.8</b> |
| (million kg)                   |             |

# Environment continued



## Hazardous waste disposed sources



| Hazardous waste disposed sources |         |      |        |       |
|----------------------------------|---------|------|--------|-------|
| Year                             | Solvent | Site | Other* | Total |
| 2001                             | 50.3    | 12.0 | 0.0    | 62.3  |
| 2002                             | 50.7    | 10.3 | 0.8    | 61.9  |
| 2003                             | 48.7    | 10.5 | 1.8    | 60.9  |
| 2004                             | 60.9    | 11.4 | 1.5    | 73.8  |
| 2005                             | 54.9    | 12.0 | 1.0    | 67.9  |

\* includes chemical/biological/radioactive/pharmaceutical waste

## Environment continued

### Non-hazardous Waste

Most non-hazardous waste is general material such as office waste paper, kitchen waste and non-hazardous substances used in manufacturing. A very small part is biological waste that has been treated so it is not hazardous. We do not include construction and demolition rubble and similar material not related to day-to-day operations, which we describe separately as non-routine waste. In 2005, we disposed of 41 million kg of non-hazardous waste.

We continue to look for ways to reduce waste and have undertaken waste management reviews at many sites.

### Performance

Total non-hazardous waste was 9% lower than in 2004 (23% lower than 2001). The weight disposed per unit sales decreased by 14% over the year (and by 27% since 2001). This means we have considerably beaten our 2005 target of an 8% reduction per unit sales since 2001.

### Note to Non-hazardous Waste Charts

Although the external definition of what constitutes a waste varies, for GSK reporting purposes a material is considered a waste if it is no longer fit for its originally intended purpose.

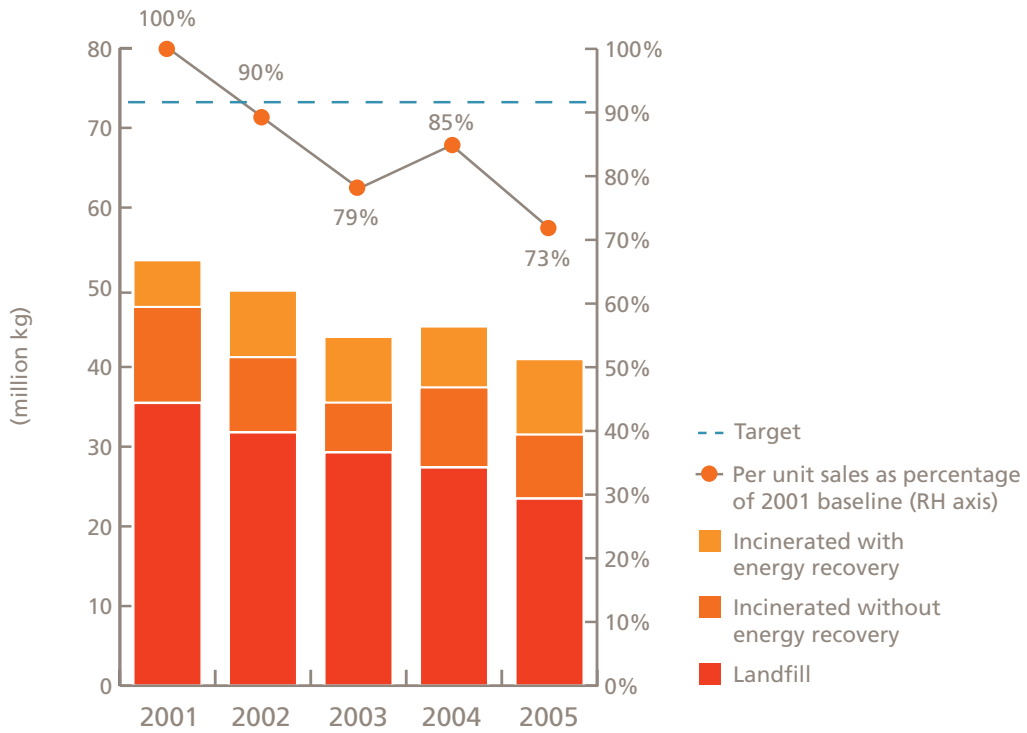
Non-hazardous waste disposal includes disposal to landfill and incineration either on or off GSK property. Incineration with energy recovery includes processes that result in beneficial energy or resource recovery and includes a small amount of composting. Incineration without energy recovery includes processes that do not result in beneficial energy or resource recovery. Non-hazardous waste disposed does NOT include recycling on-site or off-site or non-routine waste.

Biological waste rendered non-hazardous after treatment is considered a non-hazardous waste.

# Environment continued



## Non-hazardous waste disposed

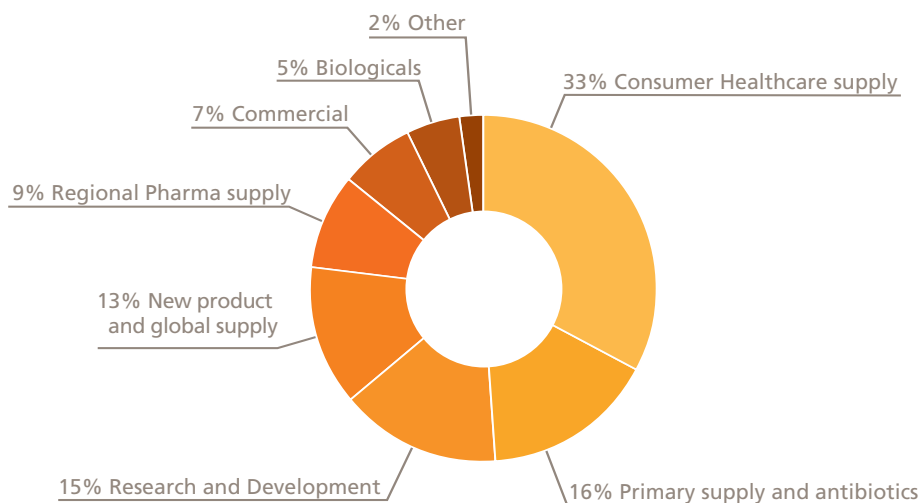


| Non-hazardous waste disposed |               |                  |          |       |
|------------------------------|---------------|------------------|----------|-------|
| Year                         | With recovery | Without recovery | Landfill | Total |
| 2001                         | 5.9           | 12.1             | 35.5     | 53.5  |
| 2002                         | 8.4           | 9.4              | 31.8     | 49.7  |
| 2003                         | 8.3           | 6.2              | 29.4     | 44.0  |
| 2004                         | 7.8           | 10.1             | 27.5     | 45.3  |
| 2005                         | 9.5           | 8.1              | 23.6     | 41.3  |

# 7 Environment continued



## Non-hazardous waste disposed by business

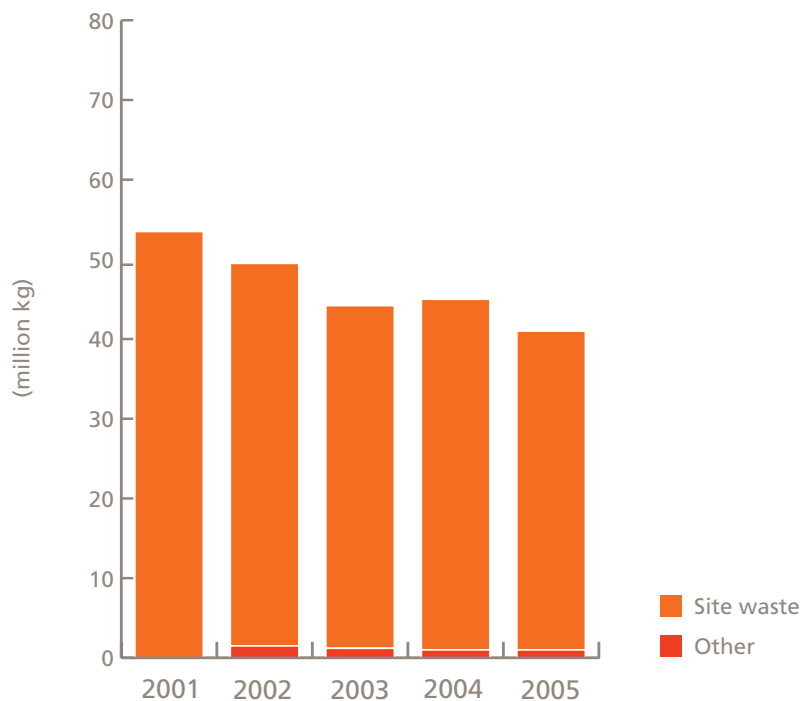


|                                |             |
|--------------------------------|-------------|
| Primary supply and antibiotics | 6.8         |
| New product and global supply  | 5.4         |
| Regional Pharma supply         | 3.5         |
| Consumer Healthcare supply     | 13.2        |
| Biologicals                    | 2.1         |
| Research and Development       | 6.3         |
| Commercial                     | 3.0         |
| Other                          | 0.9         |
| <b>Total</b>                   | <b>41.3</b> |
| (million kg)                   |             |

# Environment continued



## Non-hazardous waste disposed sources



| Non-hazardous waste disposed sources |      |       |       |
|--------------------------------------|------|-------|-------|
| Year                                 | Site | Other | Total |
| 2001                                 | 53.5 | 0.0   | 53.5  |
| 2002                                 | 48.1 | 1.6   | 49.7  |
| 2003                                 | 42.8 | 1.2   | 44.0  |
| 2004                                 | 44.2 | 1.1   | 45.3  |
| 2005                                 | 40.3 | 1.0   | 41.3  |

## Environment continued

### Recycling

We recycle hazardous and non-hazardous waste, aiming to minimise environmental impacts as well as the cost of materials and waste.

The largest waste component is solvent which has been used in the manufacturing process. Some solvent is purified on our sites and reused in the original manufacturing process. Sometimes we sell the solvent to commercial reprocessing companies, which we also include in the recycling statistics. Solvent which is not recycled in this way is usually incinerated.

Recycling non-hazardous waste such as glass or plastic usually means sending it for reprocessing so it can be reused to make new products.

### Performance

In 2005, we recycled 278 million kg of waste (72% of the nearly 390 million kg of waste generated). Over two-thirds of the total waste recycled was hazardous waste, primarily solvents. The proportion of waste recycled was 2% higher than in 2004, but has decreased by 6% since 2001, mainly because we have generated less waste. This means we did not meet our 2005 target of a 10% increase in the proportion of waste recycled since 2001.

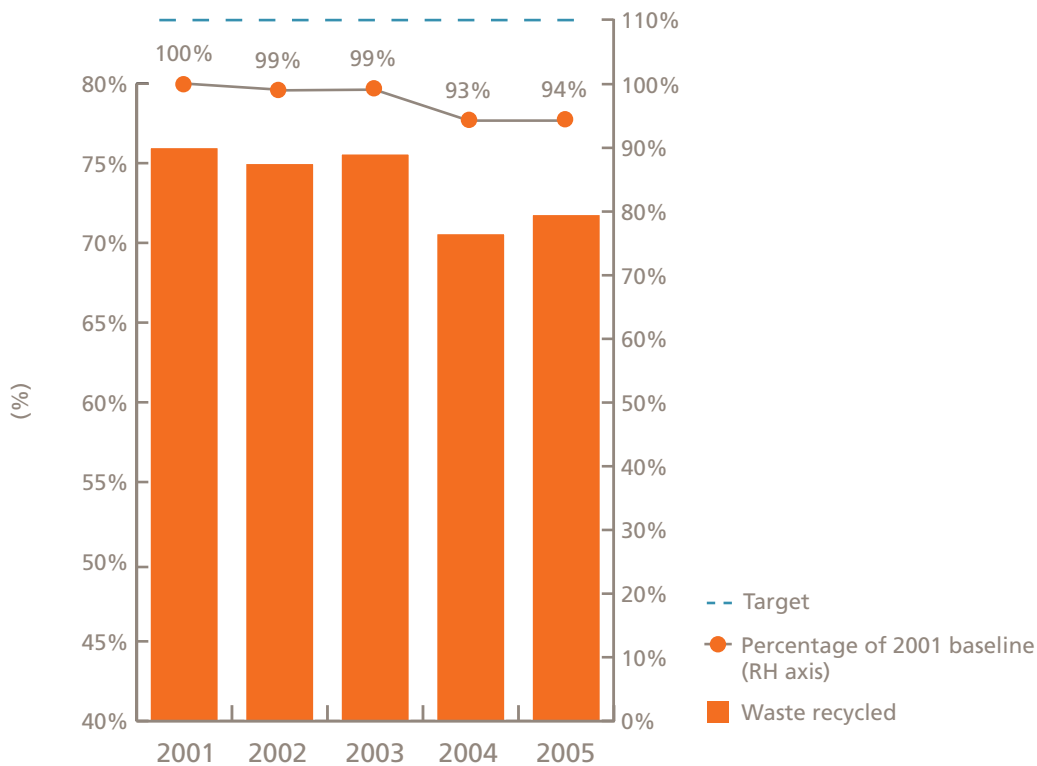
Production changes in the last two years contributed to more incineration of solvent waste, so we recycled a smaller proportion. Three of our large primary manufacturing sites are now back on track with recycling solvent, which has reversed the decline at those sites, although in 2005 we continued to have difficulty with recovery at some sites.



# Environment continued



## Proportion of total waste recycled

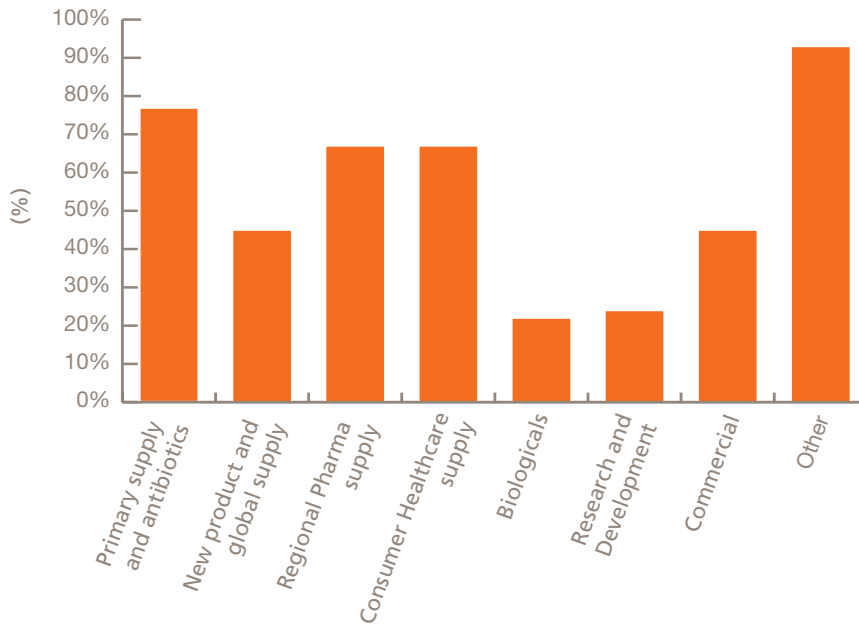


| Proportion of total waste recycled |                |
|------------------------------------|----------------|
| Year                               | Waste recycled |
| 2001                               | 76%            |
| 2002                               | 75%            |
| 2003                               | 76%            |
| 2004                               | 71%            |
| 2005                               | 72%            |

# Environment continued



Proportion of total waste recycled by business



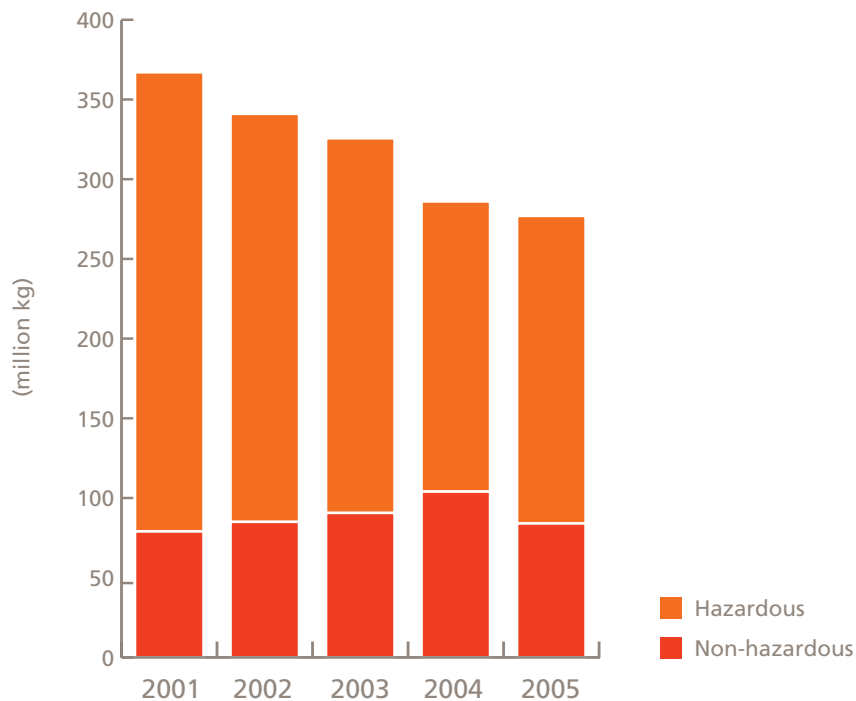
Proportion of total waste recycled by business

|                                |     |
|--------------------------------|-----|
| Primary supply and antibiotics | 77% |
| New product and global supply  | 45% |
| Regional Pharma supply         | 67% |
| Consumer Healthcare supply     | 67% |
| Biologicals                    | 22% |
| Research and Development       | 24% |
| Commercial                     | 45% |
| Other                          | 93% |

# Environment continued



## Total waste recycled



| Total waste recycled |           |               |       |
|----------------------|-----------|---------------|-------|
| Year                 | Hazardous | Non-hazardous | Total |
| 2001                 | 288.4     | 79.3          | 367.8 |
| 2002                 | 255.9     | 85.6          | 341.5 |
| 2003                 | 235.1     | 90.6          | 325.7 |
| 2004                 | 182.4     | 104.0         | 286.4 |
| 2005                 | 193.8     | 84.2          | 278.0 |

## Environment continued

### Non-Routine Waste

Non-routine waste is primarily building materials from site demolition and construction activities and from small remediation projects. In 2005, we disposed (via landfill or incineration) of 37 million kg of non-routine waste, and recycled 40 million kg.

### Performance

The amount of waste fluctuates each year depending on plant upgrades and site closures. In 2005 new building at one of our vaccine plants accounted for nearly half of the non-routine waste

Rather than sending this waste to landfill, the plant was able to provide excavated soil from the building expansion to another company to be used as clean fill.

#### Note to Non-Routine Waste Charts

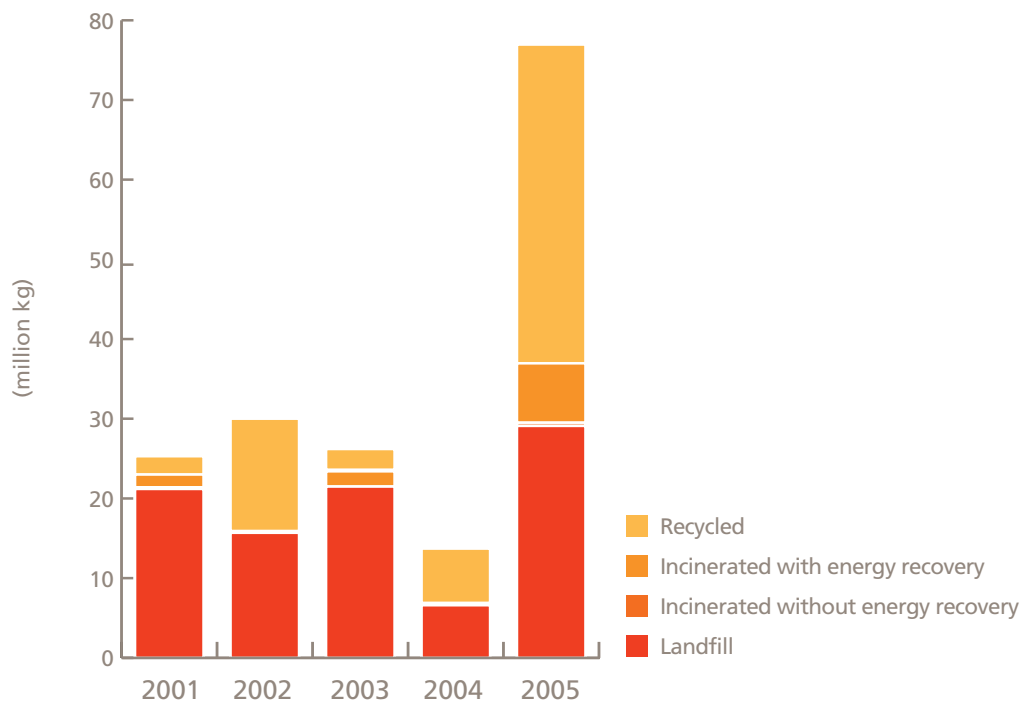
Although the external definition of what constitutes waste varies, for GSK reporting purposes a material is considered a waste if it is no longer fit for its originally intended purpose.

Non-routine waste disposal includes disposal to landfill and incineration either on or off GSK property. Incineration with energy recovery includes processes that result in beneficial energy or resource recovery. We also recycle non-routine waste whenever that is feasible.

# Environment continued



## Nonroutine waste



| Nonroutine waste |          |               |                  |          |       |
|------------------|----------|---------------|------------------|----------|-------|
| Year             | Recycled | With recovery | Without recovery | Landfill | Total |
| 2001             | 2.3      | 1.6           | 0.2              | 21.2     | 25.3  |
| 2002             | 14.2     | 0.0           | 0.2              | 15.7     | 30.1  |
| 2003             | 2.6      | 0.2           | 1.9              | 21.5     | 26.2  |
| 2004             | 6.8      | 0.1           | 0.2              | 6.6      | 13.7  |
| 2005             | 40.0     | 7.5           | 0.4              | 29.1     | 76.9  |

## Environment continued

### OZONE DEPLETION

The ozone layer is essential to human survival because it filters out harmful ultra-violet (UV) rays from the sun. Ozone depleting substances (ODSs) include chlorofluorocarbons (CFCs), hydrochlorofluorocarbons (HCFCs) and halons.

CFCs are the main ODSs we use – as the propellant gas in metered dose inhalers (MDI) for asthma sufferers. The CFC is released when patients use the inhalers.

In 2005, 198 thousand kilograms of CFC propellant were released when patients used our products in the EU. We have stopped making these products in the US and the information on CFC releases from patient use is not compiled outside the EU where this is not required by regulation. A much smaller amount of CFCs – 51 thousand kilograms – were released during worldwide production. We now offer a selection of alternatives to ODS-containing inhalers in most countries and plan to eliminate the use of ODSs from our product portfolio by 2010. See metered dose inhalers.

We also use ODSs in some cooling systems and for other ancillary uses at GSK facilities. We have switched to using hydrofluorocarbons (HFCs) in some cooling systems. HFCs do not deplete the ozone layer but do contribute to global warming. Ozone depletion potential from ancillary use per unit sales decreased by 36% since 2001, meaning we have missed our 2005 target to completely eliminate these emissions. We recognise that the only way to do this is to eliminate CFCs from cooling systems. Our new strategy will focus on installing new equipment to achieve this. We will set a new target in 2006 to eliminate CFC use in line with regulations based on the Montreal Protocol.

#### Ozone Depleting Substances in Manufacturing

A small proportion of the CFC used as a propellant in our Metered Dose Inhalers (MDIs) is released during the manufacturing process. We are working to eliminate use of ozone depleting substances in MDIs by switching to HFC and dry powder inhalers

### Performance

| Ozone depleting substances released from production activities |        |        | Ozone Depletion Potential |
|--|--------|--------|---------------------------|
| Substance  | Kg     | Factor |                           |
| CFC11/R11  | 14,658 | 1.000  | 14,658                    |
| CFC12/R12  | 36,317 | 1.000  | 36,317                    |

Total ozone depletion potential from production decreased by 13% since 2004 (72% since 2001). Ozone depletion potential from production per unit sales decreased by 19% since 2004 (74% since 2001) – meaning we have beaten our 2005 target of a 50% reduction per unit sales since 2001.

As production of CFC-containing MDIs decreases, the amount of CFC lost during production also declines. We will no longer manufacture CFC-containing MDIs in the US after 2005 and in Europe after 2006. We will continue to manufacture them in Bangladesh, China, India and Pakistan until the end of 2010.

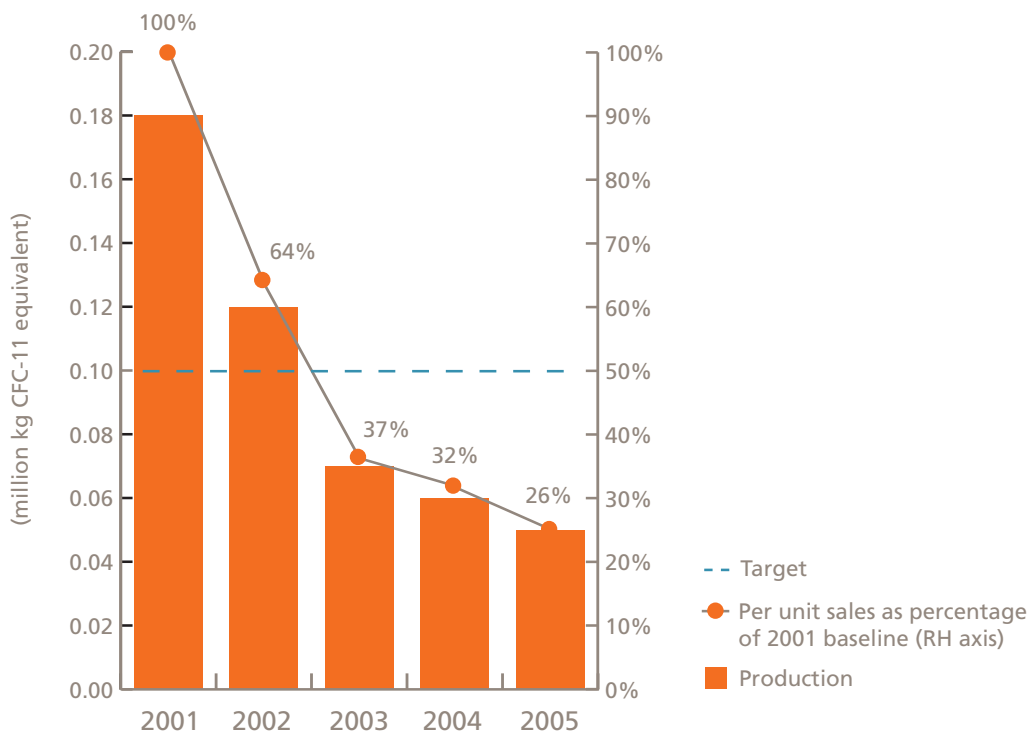
#### Note to Ozone Depletion Potential Charts

We report ozone depletion potential in CFC-11 equivalents as defined by the United Nations Environment Programme (UNEP) Ozone Secretariat

# Environment continued



## Ozone depletion potential from production use

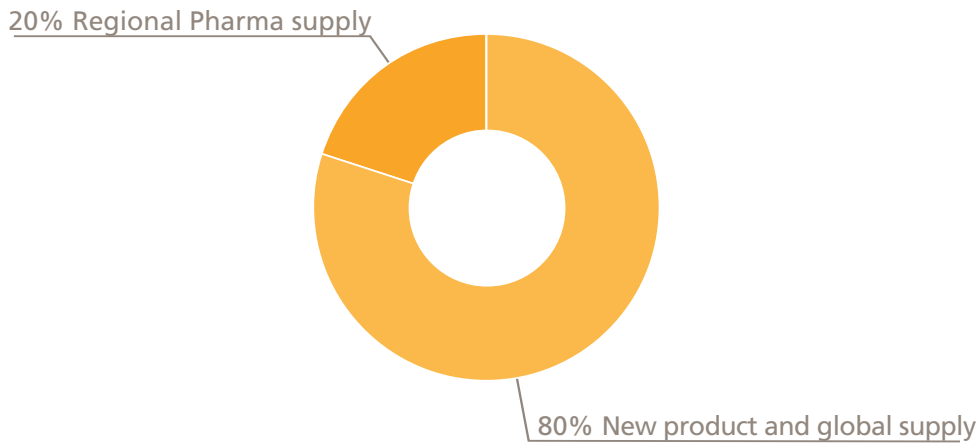


| Ozone depletion potential from production use |            |
|---|------------|
| Year  | Production |
| 2001  | 0.183      |
| 2002  | 0.121      |
| 2003  | 0.072      |
| 2004  | 0.059      |
| 2005  | 0.051      |

# 7 Environment continued



Ozone depletion potential from production use by business



|                                 |             |
|---------------------------------|-------------|
| Primary supply and antibiotics  | 0.0         |
| New product and global supply   | 40.6        |
| Regional Pharma supply          | 10.4        |
| Consumer Healthcare supply      | 0.0         |
| Biologicals                     | 0.0         |
| Research and Development        | 0.0         |
| Commercial                      | 0.0         |
| Other                           | 0.0         |
| <b>Total</b>                    | <b>51.0</b> |
| (thousand kg CFC-11 equivalent) |             |



## Environment continued

### Ozone Depleting Substances in Ancillary Equipment

We use ozone depleting substances (ODSs) primarily in cooling systems. We have switched to using hydrofluorocarbons (HFCs) in some ancillary equipment. HFCs do not deplete the ozone layer but do contribute to global warming.

ODSs – mainly CFCs and HCFCs - are sealed inside cooling systems and are only released in the event of a leak or during maintenance.

We will closely monitor equipment and put in place recommendations on alternative refrigerants and new equipment. We recognise that the only way to eliminate the emissions is to eliminate CFC from cooling systems. Our new strategy will focus on replacing equipment. We will set a new target in 2006 to eliminate CFC use in line with regulations.

Total ozone depletion potential from ancillary increased by 12% from 2004 because of equipment replacement and maintenance at a large site. But the figure has decreased by 32% since 2001. Ozone depletion potential from ancillary use per unit sales increased by 6% since 2004 but decreased by 36% since 2001.

We missed our 2005 target to eliminate ozone depleting emissions from ancillary use. It has not proved possible to eliminate all emissions during servicing and maintenance of cooling equipment. This means that we need to upgrade or replace equipment to use non-ozone depleting gases. New cooling systems that don't use ozone depleting gases are being introduced, in accordance with regulatory requirements. In retrospect we believe the target we set was unrealistic, given the potential for improvement.

### Performance

| Ozone depleting substances released from ancillary activities |        |        | Ozone Depletion Potential |
|---|--------|--------|---------------------------|
| Substance   | Kg     | Factor |                           |
| CFC11/R11   | 1,622  | 1.000  | 1,622                     |
| CFC12/R12   | 212    | 1.000  | 212                       |
| HFC22/R22   | 13,783 | 0.055  | 758                       |
| HFC123/R123   | 898    | 0.020  | 18                        |
| R402  | 96     | 0.055  | 5                         |
| R403a   | 112    | 0.055  | 6                         |
| R408a/FX10  | 473    | 0.055  | 26                        |
| R409a/FX56  | 12     | 0.048  | 1                         |
| R502  | 73     | 1.000  | 73                        |
| Methyl Bromide  | 480    | 0.600  | 288                       |

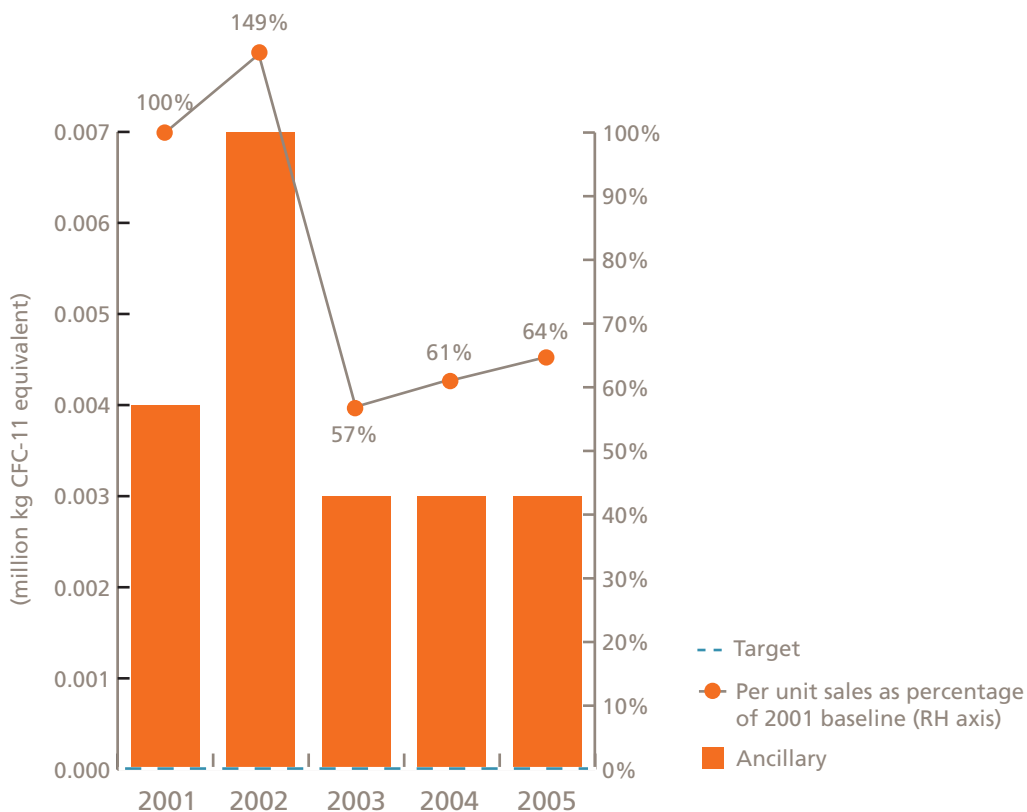
### Note to Ozone Depletion Potential Charts

We report ozone depletion potential in CFC-11 equivalents as defined by the United Nations Environment Programme (UNEP) Ozone Secretariat

# Environment continued



## Ozone depletion potential from ancillary use



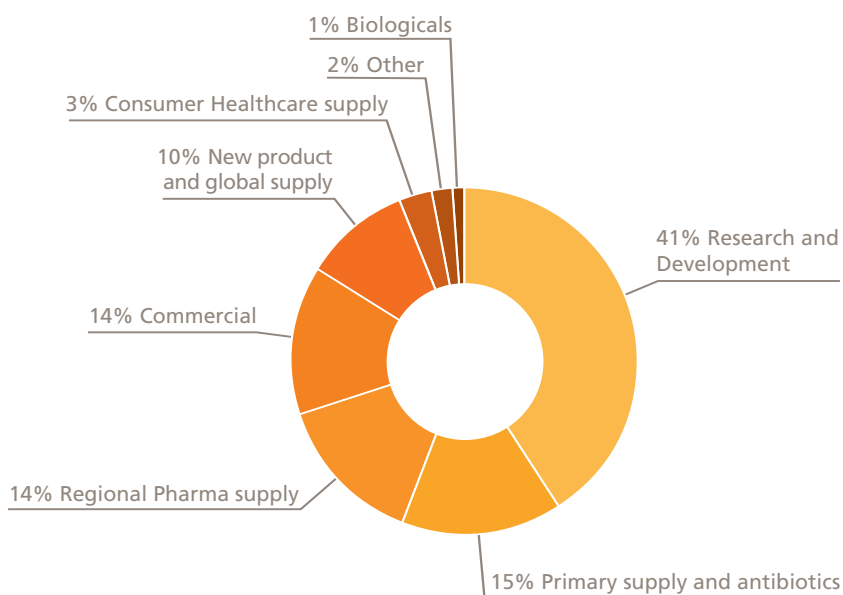
Ozone depletion potential from ancillary use

| Year | Ancillary |
|------|-----------|
| 2001 | 0.0044    |
| 2002 | 0.0069    |
| 2003 | 0.0026    |
| 2004 | 0.0027    |
| 2005 | 0.0030    |

# Environment continued



## Ozone depletion potential from ancillary use by business



|                                 |             |
|---------------------------------|-------------|
| Primary supply and antibiotics  | 0.45        |
| New product and global supply   | 0.29        |
| Regional Pharma supply          | 0.42        |
| Consumer Healthcare supply      | 0.08        |
| Biologicals                     | 0.03        |
| Research and Development        | 1.25        |
| Commercial                      | 0.42        |
| Other                           | 0.06        |
| <b>Total</b>                    | <b>3.00</b> |
| (thousand kg CFC-11 equivalent) |             |

## Environment continued

### VOLATILE ORGANIC COMPOUNDS

We use volatile organic compounds (VOCs) mainly as solvents in our primary manufacturing operations. In 2005, we released 5 million kilograms of VOCs to the atmosphere.

VOCs react with nitrogen oxides in the presence of sunlight, creating ozone in the lower atmosphere. This results in smog, which is a factor in human respiratory illness. Workplace exposure to certain VOCs can also pose a health risk.

#### Performance

Total VOCs emitted to air decreased by 5% in 2005 (24% since 2001). VOCs emitted to air per unit sales decreased by 10% since 2004 (28% since 2001). That means we have missed our 2005 target of a 30% reduction per unit sales since 2001, but we achieved a substantial reduction and only narrowly missed the target.

We achieved reductions since 2001 due to rationalising manufacturing operations following the merger in 2000, as expected when we set the target. The decrease between 2004 and 2005 was due to our site at Ulverston outsourcing some manufacturing. Improved data collection also contributed.

Photochemical ozone creation potential decreased by 7% since 2004 (23% since 2001).

#### Note to VOC Charts

Emissions of volatile organic compounds (VOCs), including fugitive sources such as evaporation and leaks, are measured at GSK manufacturing operations and research and development facilities.

VOCs react with nitrogen oxides in the presence of sunlight, creating ozone in the lower atmosphere. This results in smog, which is a factor in human respiratory illness. We report photochemical ozone creation potential (POCP) in ethylene equivalents. Conversion to ethylene equivalents is based on the European Chemical Industry Council (CEFIC) "Responsible Care HSE Reporting Guidelines" for VOCs (1998).

#### CASE STUDY

##### Reducing solvent use and waste in manufacturing

GSK's R&D site at Research Triangle Park, US, is researching a new drug for the treatment of type II diabetes and metabolic syndrome. The site has developed a new manufacturing process for the drug that reduces waste and solvent use, and eliminates the use of other harmful substances.

Previous manufacturing processes for the drug were time-consuming and inefficient, involving up to eight steps with low production efficiency. The new process developed by RTP has a number of environmental, health and safety benefits.

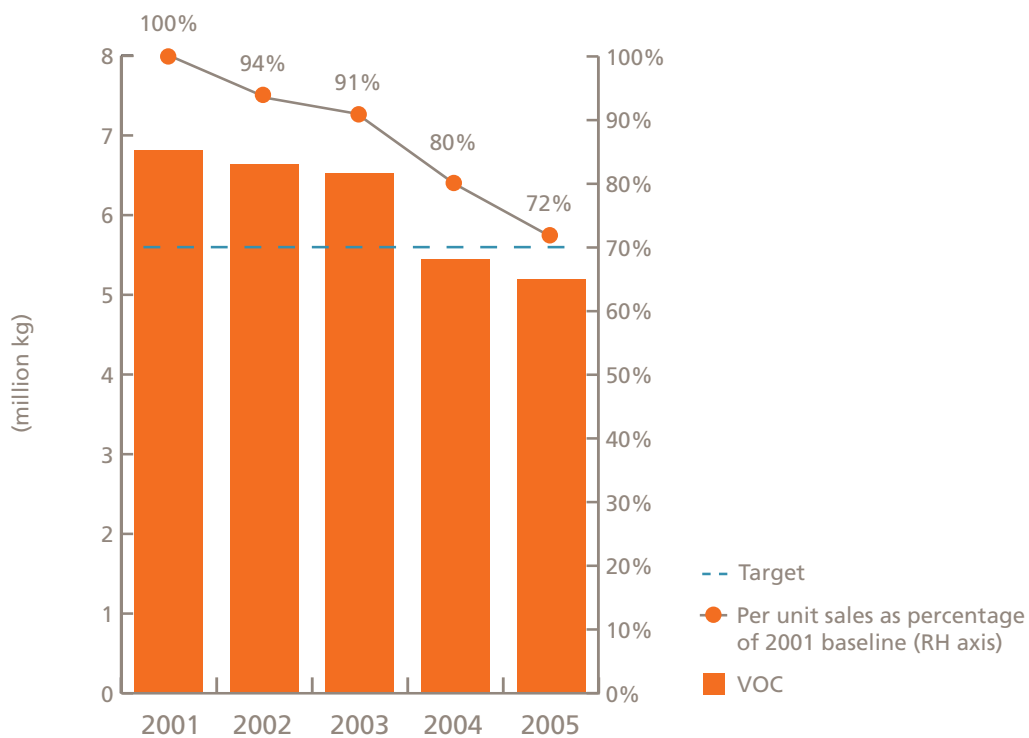
The process is quicker, involving just three steps. Solvents are needed to aid synthesis at each step, so fewer steps mean less solvent is required. As a result, the amount of solvent used (and VOC emissions) has been reduced by 70%. The amount of waste produced has also been reduced by 70%. Importantly, the new process avoids the use of harmful alkylating agents which are hazardous.

RTP was awarded second place in the Green Chemistry/Technology category of our CEO's EHS Excellence Awards for this achievement.

# Environment continued



## Volatile organic compounds emitted to air

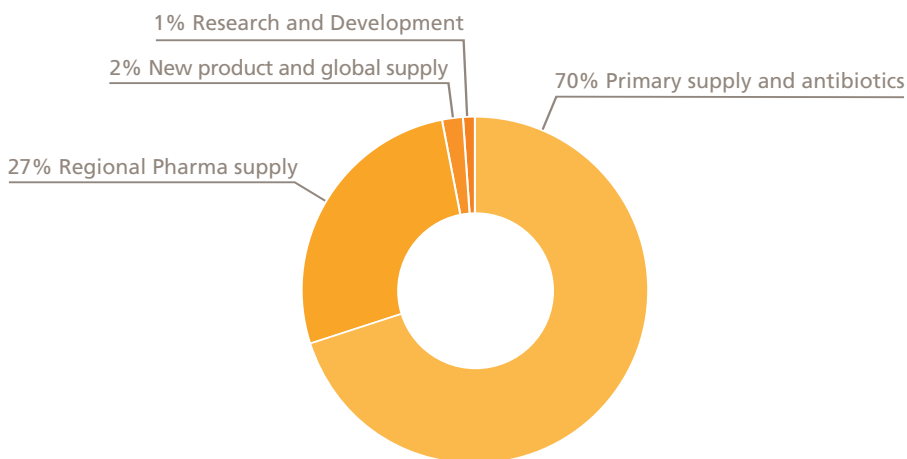


| Volatile organic compounds emitted to air |     |
|---|-----|
| Year                                      | VOC |
| 2001                                      | 6.8 |
| 2002                                      | 6.6 |
| 2003                                      | 6.5 |
| 2004                                      | 5.4 |
| 2005                                      | 5.2 |

# Environment continued



Volatile organic compounds emitted to air by business

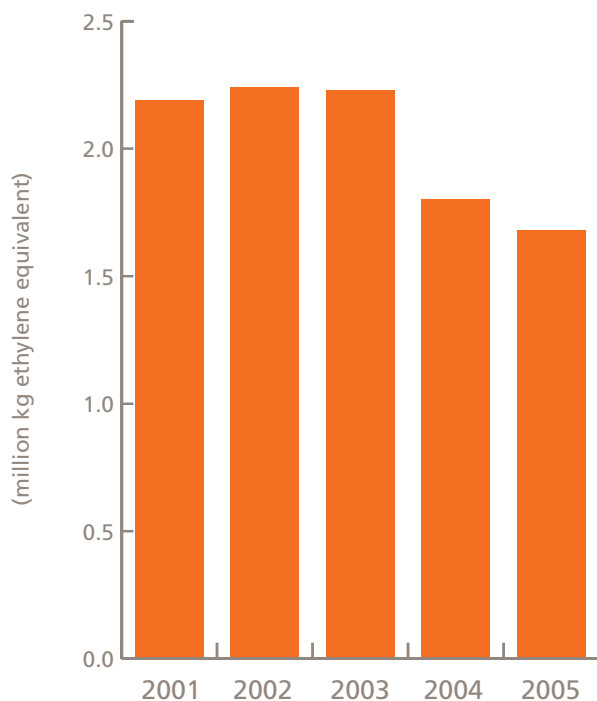


|                                |            |
|--------------------------------|------------|
| Primary supply and antibiotics | 3.6        |
| New product and global supply  | 0.1        |
| Regional Pharma supply         | 1.4        |
| Consumer Healthcare supply     | 0.0        |
| Biologicals                    | 0.0        |
| Research and Development       | 0.1        |
| Commercial                     | 0.0        |
| Other                          | 0.0        |
| <b>Total</b><br>(million kg)   | <b>5.2</b> |

# Environment continued



## Photochemical ozone creation potential



| Photochemical ozone creation potential |      |
|--|------|
| Year                                   | POCP |
| 2001                                   | 2.2  |
| 2002                                   | 2.2  |
| 2003                                   | 2.2  |
| 2004                                   | 1.8  |
| 2005                                   | 1.7  |

## Environment continued

### BIODIVERSITY

Maintaining the diversity of plant and animal species is an important part of sustainability and we aim to make sure our activities do not adversely affect biodiversity. Protecting local habitats and wildlife and improving sites' surroundings are also part of our commitment to local communities.

Wildlife can be threatened by new site developments and by existing operations which affect natural habitats. Habitats can be severely damaged by depletion of water resources so our use of water must be particularly sensitive (See Water for more information on water management)

Any investigation and collection of natural products can also be disruptive and needs to be carefully managed to minimise adverse effects. We make only limited use of natural products in research, but where this happens we aim to ensure that the investigation, collection and use of biological material for the purposes of research or manufacturing does not adversely affect biodiversity.

Biodiversity is managed at site level because the issues and impacts are local. GSK sites are required to:

- identify and assess potential impacts of their activities on local habitats
- act to minimize any adverse effects of their activities on important habitats
- enhance biodiversity where that is feasible
- monitor their impacts to ensure action remains effective in protecting and enhancing local biodiversity

Here are some examples:

**Nabha**, India, has developed a biodiversity management plan to develop "ecoforestry" in 27 acres of land, using the water discharges from the site.

**Memphis**, Tennessee, in the US has teamed up with the North American Butterfly Association (NABA) to improve the habitat and introduce species indigenous to the adjacent President's Island.

**Crawley**, in the UK, has worked with specialist woodland contractors and the local Wildlife Trust to enhance an area

### CASE STUDY

#### Working with our Ribena suppliers to improve biodiversity

GSK, and its heritage companies, have been making Ribena for 70 years. We now buy 95% of the UK's blackcurrant crop, from 45 growers. Many of these farmers are family businesses that have been supplying berries for Ribena for generations.

It takes three years before a blackcurrant bush produces any fruit so it is a big investment. We buy directly from the grower and agree seven year contracts, helping them plan ahead.

Blackcurrant farming is now mechanised with berries shaken from the bushes by harvesting machines, rather than picked by hand. This has enabled us to reduce the number of blackcurrant suppliers – and work more closely with a smaller group of growers.

This close relationship has led to farming and environmental improvements. One such initiative is a partnership with the Wildlife Trust to increase biodiversity.

Helped by the Wildlife Trust, growers are introducing simple changes to improve the habitat for animals

both in the crop and on the field edges. Each farm has drawn up an environmental action plan. Measures include trimming hedges less frequently and only at certain times of the year. Hedgerows are the 'green veins' of the countryside providing food, shelter and breeding sites for many native species. Less frequent trimming, every 2-3 years, allows hedges to grow and produce fruit, providing food for birds, bats, small mammals and insects. Farmers also leave uncultivated margins around the fields, protecting hedges from spraying, adding bat and bird boxes and planting new trees.

Other joint projects with our growers include research with the UK Department of the Environment, Food and Rural Affairs, to increase the vitamin C content in Ribena.

GSK has helped establish a blackcurrant growers group that meets quarterly to share best practice, and the Blackcurrant Foundation, an organisation to promote the health and environmental benefits of blackcurrants.

Similar initiatives are underway with our growers in New Zealand, which supply blackcurrants for Ribena sold in Asia.



## Environment continued

of oak woodland on the site. They have created a pond, thinned the trees and installed 50 bird nesting boxes.

**Dartford**, in the UK, supports a partnership which includes the UK's Environment Agency and is working to safeguard the historic Dartford Marshes – vital in safeguarding Dartford from flooding as well as supporting a host of rare and protected species, including the water vole.

**Rixensart and Wavre-Nord** in Belgium are both close to woodland and have been working on improving biodiversity for several years. They have planted indigenous species of shrub, maximising the use of flowering plants that encourage bees and other insects and established orchards with old varieties of apples, pears and plums. In 2005 Rixensart celebrated the fifth anniversary of a Nature Path employees had created.

### SUPPLIERS

Our supply chain is complex, which means that assuring the EHS performance of our suppliers is challenging. We currently provide oversight and audit of EHS issues centrally for approximately 250 critical suppliers and contract manufacturers of materials that are used exclusively by GSK. They are based primarily in Europe, North America and Asia Pacific.

When selecting, negotiating with and managing key suppliers of materials and products to our manufacturing supply chain, we take EHS and loss-prevention issues into account. This includes providing them with information on the EHS risks associated with the GSK materials they are producing or handling.

We carry out EHS audits before signing contracts with significant new key suppliers, and contracts contain requirements based on our Global EHS Standards.

Subsequent EHS involvement is based on an assessment of EHS risks, focussing on:

- threats to continuity of supply
- hazards associated with manufacturing processes and materials
- environmental impacts
- regulatory requirements
- relevance to the supply of essential medicines

The key suppliers that present the greatest risk to GSK on these issues receive the greatest scrutiny.

Sites are scored based on their performance against GSK's EHS Standards for key suppliers and against a supplementary, quantitative risk assessment scheme. We make recommendations following the audit and monitor progress, with a particular focus on poorly-performing suppliers.

Until they make significant improvements, we curtail or end procurement from sites that do not meet a minimal performance score against the EHS Standards, or that score an "unacceptable" rating on the quantitative risk assessment. For contract manufacturers, the minimum score was 30% until 2006, when we increased this requirement to 50%.

(Supplier audits also cover basic questions on human rights. See human rights and suppliers)

In 2004 we joined the USEPA Green Suppliers Network (GSN) [[www.epa.gov/opptintr/p2home/gsn/program.htm](http://www.epa.gov/opptintr/p2home/gsn/program.htm)]. The Green Suppliers Network is a programme to help small and medium-sized suppliers to reduce their environmental impact. GSK supports this programme through initiatives undertaken under an Operational Excellence theme with specific suppliers.

### Supplier performance

In 2005, we carried out 41 site-based EHS audits, approximately half of which were potentially new suppliers. Of the 41 sites audited, 32 were producers of ingredients and raw materials for our manufacturing supply chain. We found a wide variation in performance, with scores ranging from 28% to 81%. Five suppliers were determined to be unacceptable against GSK's audit assessment standards so we decided not to proceed with these suppliers until significant improvements were made.

The remaining 9 audits were of sites supplying pharmaceutical and consumer healthcare products and materials to Research & Development. Their performance against our EHS standards ranged from 40% to 95%.

In general, suppliers based in North America and Europe performed well. But performance in Asia Pacific was variable, and in some cases there were significant gaps against our EHS standards.

We found no apparent instances of non-compliance with the UN Universal Declaration of Human Rights or the core labour standards set out by the International Labour Organisation (ILO).

## Environment continued

### Reporting EHS performance

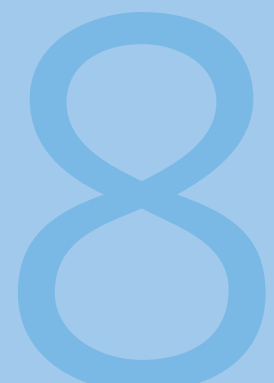
EHS information is collected where possible from selected suppliers. This data is not currently included in EHS performance charts, contained in this report, and has not been subject to verification by ERM.

In 2005 we requested information from 39 suppliers, 20 of which provided data. Some of these had not provided data in 2004 so we do not have comparative figures. These 20 suppliers produced a total of 83 m Kg of material, resulting in the following:

- energy use: 24m gigajoules
- water consumption: 2m cubic metres
- hazardous waste disposed: 51m Kg
- non-hazardous waste disposed: 5m Kg

# Community investment

|          |                               |      |
|----------|-------------------------------|------|
| 1        | Introduction                  |      |
| 2        | Access to medicine            |      |
| 3        | Research                      |      |
| 4        | Ethical conduct               |      |
| 5        | Employment practices          |      |
| 6        | Human rights                  |      |
| 7        | Environment                   |      |
| <b>8</b> | <b>Community investment</b>   | Page |
|          | Value of community investment | 134  |
|          | Humanitarian relief           | 136  |
|          | Community partnerships        | 136  |
|          | Supporting education          | 138  |
|          | Employee involvement          | 138  |
| 9        | Data summary                  |      |





## Community investment

**GSK makes donations of money, medicines, time and equipment to support good causes. The strategy behind our community investment is improving health and education in under-served communities. We support public health initiatives and local community projects around the world and donate medicines to support disaster relief efforts and impoverished communities.**

Community investment is not linked to short-term business benefits and is not intended to create commercial markets for GSK. But it does support our reputation by demonstrating our commitment to tackling healthcare challenges. We believe that using some of our profits to benefit under-served communities is part of being a responsible company.

In 2005, our total community investment was valued at £380 million (\$691million), equivalent to 5.6% of pre-tax profits. Donations are made at group level and by individual GSK sites to support local communities.

Our objective is to ensure that projects are sustainable in the long-term and will continue once GSK funding comes to an end. Most of our community investment is made through non-profit organisations that are experts in the field of healthcare delivery and education. This helps ensure our giving is targeted at the communities that need it most.

Information on our community investment programmes to increase healthcare capacity in developing countries is included in the Access to Medicines section of this report. This covers our major public health initiatives tackling lymphatic filariasis (LF), HIV/AIDS, malaria, and diarrhoea-related disease.

This section provides information on our other community investment programmes in 2005. It covers:

- A breakdown of our charitable donations in 2005.
- Donations of medicines for humanitarian relief including natural disasters.
- Community partnerships – local support provided at corporate level and by GSK sites.
- Our support for science education in the US and UK.
- Employee involvement in communities.

### Awards in 2005

During 2005, we received the first Annual Scrip Award for Corporate Social Responsibility for GSK's role in the Lymphatic Filariasis (LF) elimination programme. We also received a Business in the Community 'Big Tick' for our UK Science Education Programme and our support for Barretstown. We were a finalist in a number of other awards including:

- The Business in the Community International award for the LF Elimination Programme
- The African Investor Award 2005 for GSK's support of the Integrated Management of Childhood Illnesses (IMCI) initiative in Africa
- The US Chamber of Commerce Center for Corporate Citizenship award for our US education programme.

### VALUE OF COMMUNITY INVESTMENT

GSK donations were valued at £380 million (\$691 million) in 2005, compared with £328 million in 2004. This is equivalent to 5.6% of pre-tax profits.

This figure includes medicines worth £255 million (\$464 million) donated to low-income patients in the US through our Patient Assistance Programs, £27 million (\$49 million) of humanitarian product donations for under-served communities around the world and £14 million (\$26 million) in albendazole tablets for the lymphatic filariasis elimination programme.

Our total community investment also includes £61 million (\$111 million) in cash grants and almost £21 million (\$38 million) in management costs.

GSK is a member of the UK's Percent Club for companies which donate at least 1% of their pre-tax profits to charitable causes. GSK is regularly one of the top companies in the UK's Guardian Giving List which lists FTSE 100 companies by the percentage of pre-tax profits

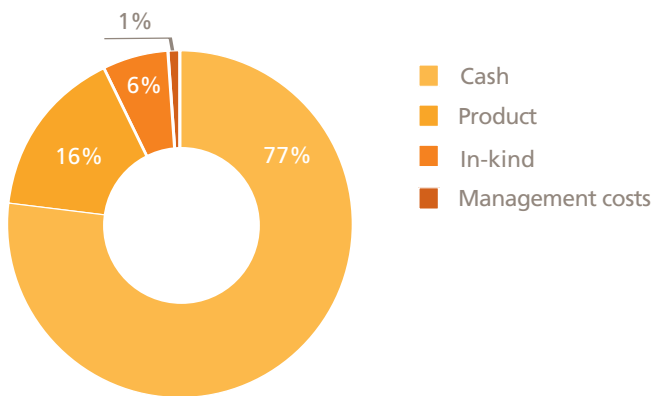


## Community investment continued

contributed to charitable causes. In 2005, we were listed 10th, based on the percentage of our pre-tax profits donated in 2004, but for the fourth year in a row we were the biggest overall giver in the value of our donations.

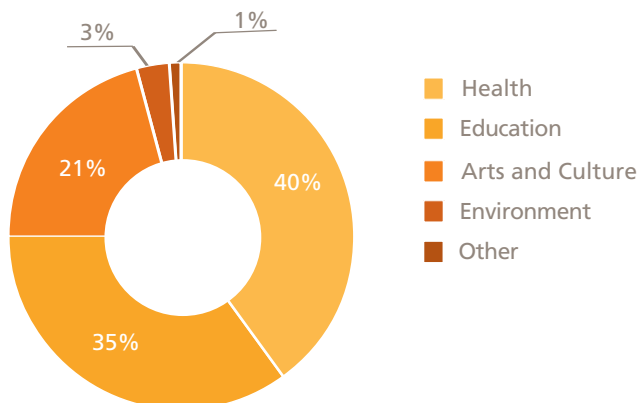
We are members of the UK's London Benchmarking Group (LBG) and the Committee to Encourage Corporate Philanthropy (CECP) in the US. We report our donations in line with the guidelines set by the CECP, which values our medicines at wholesale acquisition cost, in line with other pharmaceutical companies. Wholesale acquisition cost is the wholesale list price, not including discounts.

Method of giving - total £380m



| Method of Giving | £million |
|------------------|----------|
| Cash             | 61       |
| Product          | 296      |
| In-kind          | 2        |
| Management costs | 21       |

% Breakdown of cash giving - total £61m



| Breakdown of cash giving | %  |
|--------------------------|----|
| Health                   | 40 |
| Education                | 35 |
| Arts and Culture         | 3  |
| Environment              | 1  |
| Other                    | 21 |



## Community investment continued

### HUMANITARIAN RELIEF

GSK donates essential products such as antibiotics to help relief efforts in disaster areas and support basic healthcare provision in impoverished communities.

Donations are made at the request of governments and major charitable organisations and may be manufactured specifically for these partners. This enables charities to hold a range of medicines in stock so they can respond promptly in an emergency. We work in partnership with several relief charities including AmeriCares, Direct Relief, InterChurch Medical Assistance, MAP International and Project HOPE.

There is a limit to the amount of products we can give away, so donations must be carefully managed. We rely on the expertise of our partners to ensure that available medicines are targeted at the communities that need them most. GSK general managers must approve donations destined for their country to avoid any conflict with our commercial business. Our charity partners are required to track donations to make sure they reach their intended destination and are dispensed appropriately. We do not donate medicines for diseases which require a continuous, assured supply.

GSK follows the World Health Organization Interagency Guidelines for Drug Donations. These state that donations should be made in response to an expressed need, sent with prior consent and must be labelled correctly and have a minimum one year shelf life. We are also a member of the Partnership for Quality Medical Donations (PQMD), an alliance of pharmaceutical companies and charities that encourages best practice in the donation and delivery of medicines.

### Activity During 2005

During 2005 we donated life-saving medicines worth £27 million (\$49 million), to support relief efforts in almost 100 countries. Supplies of antibiotics and basic medicines were sent in response to the South East Asian tsunami, hurricanes in the US and the Caribbean and the earthquake in Pakistan.

In the immediate aftermath of the tsunami we donated more than 3.6 million doses of antibiotics to prevent the spread of infectious diseases in affected countries. We have also committed £2 million (\$3.8 million) to support organisations working on relief and reconstruction operations in the disaster area.

Following hurricane Katrina we donated medicines valued at \$10 million to relief facilities in ten US states. This included antibiotics, vaccines and consumer healthcare products such as toothpaste, antacids and pain relievers. GSK also supplied interim shipments of medicines for diabetes, heart disease, and asthma for patients who had lost their supplies in the disaster. Some of the medicines were distributed to hospitals and shelters by our partner organisations such as Project HOPE and AmeriCares.

GSK is the largest pharmaceutical company in Pakistan and we were able to deliver urgent supplies of free medicines within 48 hours of the earthquake via our local business there. Our product donations, including hepatitis-A vaccines requested by the Ministry of Health, were valued at \$6.5 million and we also gave a cash donation of \$1 million to the South Asia Earthquake Relief Fund.

### COMMUNITY PARTNERSHIPS

We support a wide range of health and education initiatives in the communities where we operate. Donations are made centrally and by GSK sites to support local charities and good causes.

Below are just a few examples of the many community partnerships we supported in 2005:

#### Europe

Barretstown in Ireland and L'Envol in France are residential camps where seriously ill children can have fun and develop their self confidence. GSK gave £250,000 (\$455,000) and £100,000 (\$182,000) respectively to support the camps in 2005. Employees also give their time to Barretstown and L'Envol, with over 40 GSK employees participating in 2005.

GSK is also funding five European programmes, each with a grant of £300,000 over three years. These are:

- Change in Advance, a disease prevention programme that promotes healthy eating and exercise, aimed at Slovakian children living on urban housing estates;
- Childrens' Shelters, a programme in Spain that provides healthcare for homeless and abandoned children;
- Beacon of Hope, a palliative care programme for children in Romania;
- Reading for Growing, a programme in Italy which, through reading aloud, helps children with neuro-functional disabilities and those who have endured long hospitalisation;



## Community investment continued

- Multi Coloured Lives, an interactive education programme to help children with disabilities integrate into Russian society.

### International

GSK's PHASE (Personal Hygiene and Sanitation Education) initiative is providing education to over 270,000 school children in Kenya, Uganda, Zambia, Nicaragua and Peru to improve their health and hygiene to fight infectious diseases. In 2005, we committed three-year funding of £300,000 to extend the programme to Bangladesh in partnership with Save the Children USA, see Major public health initiatives above.

GSK is funding a number of country programmes, each with a grant of £200,000 over three years:

- Pinoy Health Pass, Family Health and Well Being provides health education for families on low incomes in the Philippines
- Attituda Positiva, uses drama in schools to increase awareness and education on HIV and reproductive health for teenagers in Brazil
- '500 Midwives' helps improve mother and child health in rural areas of Vietnam by bringing birth attendants from ethnic minority groups for training in the capital's major hospital.

### UK

In 2005 GSK supported over 80 charitable organisations in the UK. This included over £470,000 (\$855,000) to support medical research undertaken by the charities Meningitis UK, The British Liver Trust, Alzheimer's Research Trust and The Samantha Dickson Research Trust.

We extended our partnership with the British Red Cross, giving £350,000 over three years to their Gateway project in Scotland. Gateway helps young people with disabilities to gain the skills and self-confidence they need to live independently. Since 2001, Gateway has worked with a small group of young disabled people helping them set personal goals and receive individually tailored training and support. More than 150 people with disabilities also visit the centre each year to take part in workshops and use its facilities. The new funding will enable Gateway to extend their service across Scotland and share their experiences with health and social care providers throughout the UK.

GSK is giving £386,000 (\$703,000) over two years to support the British Lung Foundation's Baby Breathe Easy programme. This is funding a pilot scheme in nine regions

across the UK supporting parents and carers of young babies and children under five in dealing with diagnosed and undiagnosed recurring chest problems.

### US

GSK is donating \$350,000 (£192,000) over three years to the Arthur Ashe Institute for Urban Health. The Black Pearls programme provides health education for low-income neighbourhoods by reaching into non-traditional venues, including African American and Afro-Caribbean churches, barber shops, beauty salons, laundromats and tattoo parlours. It provides culturally appropriate information to help promote early disease detection and encourage people in multi-ethnic communities to adopt healthier lifestyles.

We continue to support the Children's Health Fund's Referral Management Initiative (RMI). A new, three-year grant of \$2.6 million (£1.4 million) will help RMI continue and extend its services into Philadelphia, helping high-risk and homeless children receive the specialist medical care they need.

### Foundations

GSK does not operate a single charitable foundation for its community investment programmes but has several country-based foundations in Canada, Czech Republic, France, Italy, Romania, Spain, and North Carolina in the US. Our local foundations support a wide range of charities and healthcare initiatives.

Since 1998 the GSK France Foundation has supported 68 programmes in 13 countries. These focus on people living with HIV/AIDS in developing countries, particularly in Africa, and aim to improve healthcare through prevention, education and training. During 2005, 13 new programmes were implemented in 5 countries with grants of 700 000 euros (£480,000).

The GSK Foundation in Canada focuses much of its support on hospice care helping terminally ill patients and their families. The Foundation is also supporting community programmes in Africa, including AIDS Orphan Uganda, a three-year programme building community support for vulnerable children in the Luweero District.

The North Carolina GSK Foundation in the USA is an endowed, self-funding organisation. It supports initiatives in the areas of mathematics, science and health education in North Carolina. In 2005, this Foundation awarded grants totalling \$2.7 million (£1.49 million).





## Community investment continued

### SUPPORTING EDUCATION

GSK supports education in the UK and US and has a particular emphasis on developing scientific literacy and encouraging the next generation of scientists.

#### Science Education in the UK

GSK is supporting the INSPIRE (Innovative Scheme for Post-doctoral researchers In Research and Education) scheme, developed in partnership with Imperial College London and the Specialist Schools and Academies Trust, with a £1 million (\$1.8 million) donation over four years. INSPIRE aims to raise achievement by placing post-doctoral researchers in specialist science schools to train as teachers and support science teaching.

In the fifth year of GSK sponsorship, a grant of £110,000 (\$200,000) to the Association for Science Education supported Science Across the World, an international education programme that enables school children in more than 115 countries to discuss science issues over the internet.

With a £50,000 grant from GSK, 2,600 UK science teachers were able to participate in 'Active Assessment' training in 2005. This helps teachers improve their pupils' 'thinking skills' and empowers them to take more responsibility for their own learning.

GSK has also committed £1 million (\$1.8 million) over four years to help build the new Darwin Centre at the Natural History Museum in London, to enable better display of the museum's important collection.

#### Education in the US

During 2005, we increased our support for initiatives to improve overall education standards in the US. GSK is a founding partner of the US Chamber of Commerce's Business Education Network. The network will develop partnerships between the business community and education providers to improve educational standards and bridge skills gaps.

We also continued to support a range of science education initiatives:

- Science in the Summer is a free, library-based education programme in Philadelphia, giving children the chance to participate in hands-on experiments and science based courses. In 2005 GSK donated \$300,000 to Science in the Summer, which enabled almost 6000 children to participate. Almost 75,000 children have participated in the programme since it was launched nearly 20 years ago.

- We support Sally Ride Science Festivals which aim to increase girls' interest in science, maths and technology. The festivals feature workshops led by local veterinarians, astronomers, microbiologists and engineers. Workshops are also run for parents and teachers on how they can support girls' interests in science and technology careers.
- A three-year grant of \$300,000 (£165,000) from GSK is helping the National Board for Professional Teaching Standards to increase the number of science teachers in the North Carolina and Philadelphia areas

### EMPLOYEE INVOLVEMENT

GSK employees are encouraged to contribute to their local communities as volunteers.

Hundreds of employees give their time to good causes through our Days of Caring in the US, and to support school science education through our UK Science and Engineering Ambassador Scheme and US Partnership for Educational Discovery.

In the UK and US we also make cash donations to charities where employees have done voluntary work.

During 2005, our GSK Investment in Volunteer Excellence (GIVE) programme gave \$300,000 (£165,000) to over 350 charitable organisations in the US where employees or their partners volunteered at least 50 hours during the year. In the UK, our Making a Difference programme provided grants of almost £300,000 (\$546,000) to over 440 charities where our employees had volunteered.

In many countries we also encourage employees to donate money to charity by matching the money they give or by providing tax-efficient ways for them to make a donation, in accordance with local taxation guidelines.

In 2005 in the USA, GSK matched donations by employees and retirees at a value of over \$5 million (£2.7 million). In addition, GSK gave \$1.35 million (£742,000) to match donations by GSK employees through the annual GSK and United Way campaign.





## Community investment continued

### CASE STUDY

#### The gift of life – GSK product donations

GSK antibiotics fight both common and life-threatening infections. In 2005 we donated antibiotics and other medicines worth £27 million in response to disaster relief efforts, as travel packs for medics on humanitarian missions and to support healthcare provision in impoverished communities.

Three-year old Rosa Angelica Pravia is just one of the thousands of people to have benefited. She was admitted to a hospital in a remote part of South America where the doctor feared her infection could result in meningitis. Her father earns just \$2 a day cleaning pineapples and there are 10 children in the family, so they could not afford medicine to treat her. Fortunately the hospital had just received a donation of medicines from MAP International, including GSK's antibiotic *Ceftin*. Within three days Rosa was out of danger. Her doctor said the *Ceftin* had saved her life.

Many of these products are donated in response to specific requests from relief charities such as AmeriCares, Direct Relief, InterChurch Medical Assistance, MAP International and Project HOPE.

MAP International uses donations of GSK antibiotics such as *Augmentin* and *Amoxil* in travel packs for its medical missions. The packs are compact, fully stocked, portable pharmacies that enable the teams to treat a wide range of illnesses in developing countries. "The antibiotics treated many infections, some of which were life threatening," a MAP team reported recently after a mission to Zambia. "The local doctors told us that they can go to remote villages to see patients who do not have the resources to fill prescriptions. Without GSK's help we would not have been able to see so many patients and help them with medication."

# Data summary

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## Data summary

|  | 2002  | 2003  | 2004  | 2005    |
|--|-------|-------|-------|---------|
| <b>Access to medicines</b>   |       |       |       |         |
| Number of countries supplied with preferentially priced ARVs <sup>1</sup>  | 50    | 56    | 57    | 56      |
| Number of preferentially priced <i>Combivir</i> tablets shipped (millions) <sup>1</sup>  | 6.2   | 10.7  | 32.7  | 45      |
| Number of preferentially priced <i>Epivir</i> tablets shipped (millions) <sup>1</sup>  | 1.7   | 5.2   | 34.4  | 81.3    |
| GSK <i>Combivir</i> not-for-profit price (\$ per day) <sup>2</sup>   |       | 1.7   | 0.65  | 0.65    |
| Voluntary licences granted to generic manufacturers for GSK ARVs   |       |       | 6     | 7       |
| Number of albendazole tablets donated for prevention of Lymphatic Filariasis (millions)  | 66    | 94    | 67    | 136     |
| Number of countries supplied with albendazole  | 31    | 34    | 34    | 36      |
| <b>Research and development</b>  |       |       |       |         |
| GSK animal research facilities accredited by the Association for Assessment and Accreditation of Laboratory Animal Care <sup>3</sup> | 7     | 7     | 10    | 10      |
| Number of trials published on the GSK Clinical Trial Register (cumulative total) <sup>4</sup>  | –     | –     | 143   | 2,125   |
| <b>Ethical conduct</b>   |       |       |       |         |
| Number of employees completing certification to the GSK Code of Conduct  | 700   | 9,000 | 9,600 | >12,000 |
| Number of contacts through our ethics compliance channels <sup>5</sup>   |       |       | 2,580 | 3,644   |
| <b>Employment</b>  |       |       |       |         |
| Women in management grades (%)   | 32    | 34    | 35    | 35      |
| Ethnic diversity – people of colour (US, %)  | 19    | 19.5  | 19.5  | 19.6    |
| Ethnic diversity – ethnic minorities (UK, %)   | –     | –     | 14.8  | 14.9    |
| Lost time injury and illness rate (cases per 100,000 hours worked)   | 0.34  | 0.30  | 0.30  | 0.30    |
| Lost time injury and illness rate for contractors working on site (cases per 100,000 hours worked)                                   | 0.50  | 0.33  | 0.40  | 0.44    |
| <b>Environment</b>   |       |       |       |         |
| Number of contract manufacturers audited   | 16    | 28    | 35    | 41      |
| Energy consumption (million gigajoules)  | 20    | 20    | 19    | 19      |
| Water consumption (million cubic metres)   | 24    | 23    | 21    | 22      |
| Ozone depletion potential from metered dose inhalers (tonnes CFC-11 equivalent)  | 1,500 | 782   | 464   | 198     |
| Ozone depletion potential from production (tonnes CFC-11 equivalent)   | 121   | 72    | 59    | 51      |
| Ozone depletion potential from refrigeration and other ancillary uses (tonnes CFC-11 equivalent)                                     | 7     | 3     | 3     | 3       |
| Volatile organic compound emissions (thousand tonnes)  | 7     | 7     | 5     | 5       |
| Global warming potential from energy sources (thousand tonnes CO2 equivalent)  | 1,844 | 1,833 | 1,747 | 1,759   |
| Hazardous waste disposed (thousand tonnes)   | 62    | 61    | 74    | 68      |
| <b>Community investment</b>  |       |       |       |         |
| Total community investment expenditure (£ millions)  | 239   | 338   | 328   | 380     |
| Value of humanitarian product donations, including albendazole (£ millions)  | 24    | 116   | 57    | 41      |
| Value of products donated through GSK Patient Assistance Program in the US (£ millions)  | 112   | 125   | 203   | 255     |

<sup>1</sup> Includes ARVs sold at not-for-profit and discounted prices. We are unable to collect data for the number of patients treated.

<sup>2</sup> Includes delivery costs. Médecins Sans Frontières June 2005 report showed that the average cost of generic equivalents is \$0.64 a day and the lowest priced generic equivalent costs \$0.50 a day, not including delivery.

<sup>3</sup> We currently have 14 animal research laboratories. In 2004 we had 13 animal research laboratories.

<sup>4</sup> 98% of trials completed since the merger which created GSK.

<sup>5</sup> Includes contacts with line managers, compliance officers, our confidential Integrity Helplines or offsite post office box (in the US).