Value-Based Pricing for Drugs in the UK

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Outline

• The road to value-based pricing
• The government’s proposals
• Issues raised and recent initiatives
• The future
How Did We Get There (UK)?

• Office of Fair Trading Report in 2007
• More flexibility in pricing introduced through *Patient Access Schemes*
• Caution over the *outcomes-based* schemes and perceived success of the *finance-based* schemes
• Government discomfort with the fallout from some of NICE’s recommendations
Examples of Early UK Patient Access Schemes

• b-IFN and glatiramer for multiple sclerosis – 2002
  – Prospective cohort – managed by DH
• Bortezomib for multiple myeloma – 2007
  – Money back guarantee based on response (M-protein)
• Ranibizumab for AMD – 2008
  – Dose capping scheme (<14 injections per eye)
• Erlotinib for SCLC – 2008
  – Cost capping scheme (same overall cost as docetaxel)
• Sunitinib for advanced RCC – 2009 DRAFT
  – First time EOL guidance informed decision
  – 1st cycle of treatment free to NHS patients
• Lenalidomide for multiple myeloma – 2009 DRAFT
  – Dose capping scheme (<26 cycles/2yrs)

Source: Chalkidou (2009)
Value-Based Pricing Proposal (UK)

• Stated objectives are to:
  - improve outcomes through better access to effective drugs
  - stimulate innovation
  - improve the process (eg increased transparency, timeliness)
  - include a wide assessment, alongside clinical effectiveness
  - ensure value for money from NHS resources

• A technical assessment of the costs and QALYs gained from the drug in its various indications will be conducted as at present

• Instead of NICE making recommendations, there will then follow a negotiation between the company and the DH to determine a (maximum) value-based price (VBP)
Value-Based Pricing Proposal (2)

- Would apply to new branded medicines launched from January 1, 2014
- Recognition that new arrangements may be required for already-existing medicines
- The negotiation would consider:
  - the ‘basic’ cost-per QALY threshold
  - the burden of illness and unmet need that the medicine focuses on
  - the extent of therapeutic innovation
  - the wider societal benefits (eg impact on carers)
Value-Based Pricing Proposal (3)

• A full assessment of these factors will be used to determine the VPB

• If the company’s price is higher than the VBP, it would be asked to lower its price, or provide extra justification

• ‘If the company were not prepared to do either of these, it would be the company’s responsibility to explain to the public why it was not prepared to offer that drug at an appropriate price’
Issues Raised by Value-Based Pricing

Defining the dimensions of ‘value’
- health gain only?
- other considerations?

Determining the local decision rule
- explicit cost per QALY threshold?
- general rating (eg 0-5), as a guide for price negotiations?

Dealing with multiple indications
- price/volume agreements?
- weighted price?

Determining the level of transparency
- publication of assessments?
- publication of negotiated prices?
Recent Initiatives

• Estimation of the Cost-Effectiveness Threshold in England

• Estimation of Broader Social Costs from Routinely-Available Data

• Weighting of QALYs
Study commissioned by the National institute for health Research on the suggestion of NICE

Undertaken by the Centre for health Economics at the University of York (Claxton et al, 2012)

The underlying principle is that the threshold for adopting new technologies should be set at a level reflecting the value of the activities displaced in budget-constrained health care system

Econometric analysis of data linking changes in NHS expenditure and outcomes (in mortality) for primary care trusts across 23 programme budget categories, using adjustments to convert outcome to QALYs

Found that, on average across the NHS in England, the threshold is £18,317 per QALY gained
Estimation of Broader Social Costs

• Research undertaken by economists within the Department of Health
• Considered impacts of disease on other public sector budgets and the patient/family
• If these items were to be considered in economic evaluations of new technologies, then the broader social impacts of technologies displaced would also need to be considered
Weighting of QALYs

• Research commissioned by the Department of Health undertaken by the School of Health and Related Research, University of Sheffield (Brazier et al)

• Discrete choice experiment using an on-line general population sample (n=3669)

• Presented respondents with patient groups that differed on 4 attributes: life expectancy without treatment, survival gain from treatment, HRQoL before treatment and gain in HRQoL from treatment

• Strongest preference for survival gains; very small preference for treating those with greater burden of disease, but mainly in relation to improving survival at end-of-life as opposed to improving quality of life

• The implications of these findings for QALY weighing are the subject of further research
The Innovation Debate in the UK

Several reports over the years
- Value-based pricing proposal (2010)

NICE Appraisal Committee can recognize ‘breakthroughs’

Not yet clear how and if innovation will feature in the new pricing scheme
The Future

• Negotiations between the government and the industry are continuing, with an outcome expected soon
• NICE is likely to retain a central role, undertaking many of the assessments, as at present
• How the factors other than cost-effectiveness will be incorporated is still unclear
  - which factors?
  - formal weightings or informally in negotiations
• With the Cancer Drugs Fund probably coming to an end, it is also unclear whether any arrangements will made for patients access to drugs for which a VBP cannot be agreed
• The new commissioning arrangements in the NHS may also have an impact on which drugs are available