UK losing its way on pharmaceutical cost containment?

Increasing rates of metabolic diseases and cancers, populations living longer and requiring more care, high cost orphan drugs, pharmaceutical price gouging and access delays, restricted or decreasing healthcare budgets... so, how to make sure that medical innovation continues and that patients get the treatments they need?

Further imminent changes in NICE policy are also likely to affect patients who have conditions with the highest clinical burden and the fewest treatment options. Here, NICE has announced a cap of £300,000 per quality-adjusted life year (QALY) for recommended therapies in its highly specialised technologies (HST) appraisal criteria. And it’s not just pharma itself that is aghast. A group of 200 patient groups, led by Genetic Alliance UK, has called for the changes to be scrapped, with Doug Henderson, SMA (Spinal Muscular Atrophy) Support UK managing director, arguing that “these proposals will push the UK even further down the global ladder of countries that respond in a timely and efficient way to scientific breakthroughs.”

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When the Association of the British Pharmaceutical Industry (ABPI) appealed for changes to NICE’s one-size-fits-all system and an overreliance on the QALY back in 2015, they could hardly imagine that the preceding changes and a new fast-track process for drugs that have a cost-effectiveness of less than £10,000 per QALY, would be the result.

One is inclined to wonder how much the academy brains of NICE were influenced by Professor Karl Claxton’s suggestion that £13,000 per QALY would make a more appropriate tipping point. An especially galling thought as the mark was later revised to over £18,000 upon criticisms of the methodology.

To what degree this lowering of the bar indicates a permanent direction of travel to lower QALY thresholds is uncertain, but potentially worrying. Yes, there now appear to be more routes to market, but the conditions seem entirely arbitrary and against the proposed accelerated access reforms touted by the government last year, meaning all roads may lead, if not to Rome, then to delays in access.
What can be done?

The raft of changes seems to be going ahead without the opportunity for industry consultation. Pharma companies should continue to voice opposition to the changes through the ABPI, but should also update their UK access strategies to face these challenges head on.

One way to do this is to act creatively – if NICE is so keen on making changes, there may be an open door to facilitate this process on a more balanced footing. Several recent furores regarding excessive pharmaceutical pricing (cf. Turing’s price hikes in the US, and pricing collusion between Actavis and Concordia in the UK, among others) have turned public opinion negatively towards pharma, so they should tread carefully.

Protecting the price point of an innovative treatment is important for an array of reasons, not least given the policy of international price referencing, which can have a profound impact on profitability on the global scale. It is understandable, then, if pharma is averse to slashing prices that were calculated through (hopefully) logical frameworks that ensure both value for the public and return on investment for shareholders. But a high price is worth nothing without access and reimbursement – volume, ultimately, dictates revenue.

And it is here that the £20 million budget cap will bite. A crude oversimplification states that in this instance, pharma will be obliged to sell more drug for a lower price, or less for the same one, depending on the breadth of patient access. In the latter case, some patients will be excluded from accessing the treatments they need.

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Next steps

Though pharma companies may feel on the back foot, and reluctant to come begging to NICE with their own propositions for access, engagement with payers – as early as possible – is key. Embedding innovative contracting arrangements within an innovative treatment’s clinical and economic value proposition is, therefore, a likely way forward.

For more information on UK market access strategy, managed entry agreements, and payer engagement, contact Pope Woodhead: www.popewoodhead.com

Sources

5. https://www.york.ac.uk/media/che/documents/reports/resubmitted_report.pdf