

## Value-Based Pricing in the United Kingdom

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## Outline of Presentation

- Why has VBP become an important policy option?
- What are the main issues in defining and measuring value?
- What are the main practical issues in implementing VBP?

## 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 political fallout from some of NICE's recommendations

## Examples of 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
  - 1<sup>st</sup> 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 in Measuring and Defining Value

- The basic cost per QALY criterion remains
- Discussion of the possibility of different thresholds for different conditions (equivalent to different weights being placed on QALYs)
- Will 'burden of disease' relate to the size of the patient population, or the seriousness of the condition?
- How wide will the consideration of 'wider social benefits' be?
- What reward will be given for 'innovation' beyond the extra QALYs generated by the use of the drug concerned?

## Issues in Implementing VBP

- In general, will the DH use the 'behind-closed-doors' discussion to be tough, or generous, towards companies?
- In the negotiation, what relative weights will be placed on the various factors?
- Will the VBP be public knowledge, or will the difference between the company's price and the VBP be settled through a rebate?

## Issues in Implementing VBP (2)

- For drugs with multiple indications, or in situations where the assessment identifies patient sub-groups, will price-volume agreements need to be developed?
- Will VBPs be revised, if new evidence comes to light?
- What happens when a VBP cannot be agreed?
- Will GP consortia (or hospitals for that matter) be able/be motivated to negotiate prices with companies independently of the centralised VBP negotiation?