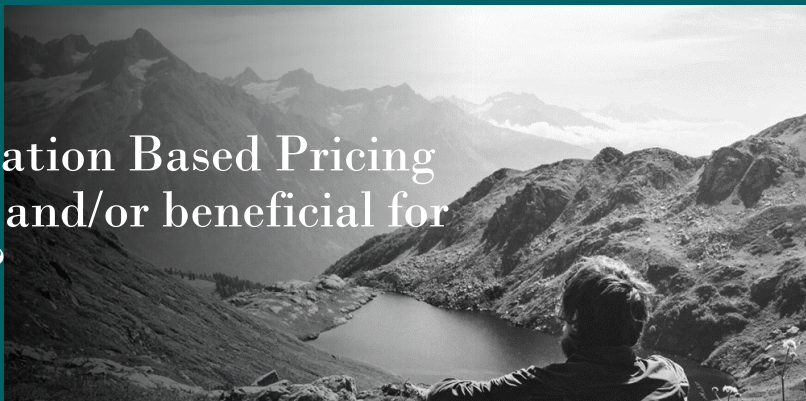


Is Indication Based Pricing feasible and/or beneficial for society?



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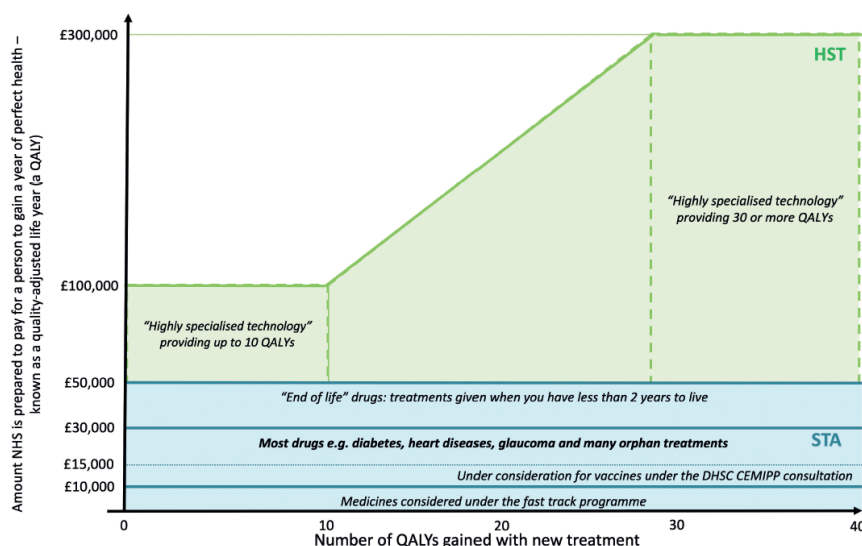
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Is single price stifling INNOVATION?

- Arguments for NO:
 - CEA is only one more criteria
 - Even NICE have different thresholds:
 - Cancer Drugs
 - End of Life
 - (Ultra) orphan drugs
 - The threshold highlights what is reimbursed now
 - Flexibility: list price is not what is reimbursed

Figure 1 – how do the cost-effectiveness thresholds vary between NICE's programmes?



CEA is not the only one criteria

Table 2. Real-world examples of MCDA utilization to support healthcare decision-making (ex-LatAm).

Country	Example(s) of utilization	Source
England/UK	i. Orphan drugs, AGNPS/NICE ii. Respiratory, mental, children's health, cardiovascular, and cancer interventions, NHS/Primary Care Trusts iii. Major capital expenditures, NHS	Devlin & Sussex [13] Adams et al. [14] Airoldi et al. [15]
USA	i. Diagnosis and treatment decisions ii. Clinical trial design	Adunlin et al. [16] Guest et al. [17]
Canada	i. Healthcare priority-setting ii. Budgeting iii. Interventions for chronic non-cancer pain	Diaby et al. [18] Tony et al. [19]
Germany	Incorporation of patient involvement with MCDA quantitative approaches, IQWiG	Danner et al. [20]
Sweden	i. Orphan drug coverage, TLV ii. High-cost biologics, TLV	World Health Organization [21] Deans et al. [22]
Denmark	Orphan drug coverage	Deans et al. [22]
Finland	Obesity research and prevention	Borg & Fogelhol [23]
The Netherlands	i. Orphan drug coverage ii. Publicly funded healthcare priority-setting iii. Ankle-foot repair in stroke	Van Til [24] Devlin & Sussex [13] Baeten et al. [25]
Italy	EVIDEM framework used with medical devices, diagnostic assessments, and pharmaceuticals	Radaelli et al. [26]
France	Screenings	World Health Organization [21]
Norway	Healthcare priority-setting	Defechereux et al. [27]
Hungary	Hospital medical technologies, OEP	Devlin et al. [4]
Scotland	Orphan drug coverage, NHS	Kanters et al. [28]
New Zealand	Algorithmic approach using 1000Minds software used to analyze coronary artery bypass graft surgery, MoH	Devlin & Sussex [13] Hansen et al. [29]
South Africa	Private health plan used for liquid-based cytology for cervical cancer screening	Miot et al. [30]
Ghana	Healthcare priority-setting	Jehu-Appiah [31]
Thailand	Health interventions in the universal health coverage benefit package, NHS	Youngkong et al. [32]
Israel	New healthcare technologies, Health Basket Committee	Devlin & Sussex [13]

● **Table: actual utilization versus research or recommendations for utilization**

Drake JI, de Hart JCT, Monleón C, Toro W, Valentim J. Utilization of multiple-criteria decision analysis (MCDA) to support healthcare decision-making FIFARMA, 2016. *J Mark Access Health Policy*. 2017;5(1):1360545. Published 2017 Oct 12. doi:10.1080/20016689.2017.1360545

Flexibility: List price is not what is reimbursed

Value or reimbursement decided centrally

- **NICE-HTA, SMC, IQWiG**

Access is decided negotiating with budget holders

- **Hospitals, GP, Primary Care**

Even extended practice of reference pricing is being shaken by this divergence

Is single price stifling INNOVATION?

Arguments for YES:

- PPRS (and now VPAS) have slowed down innovation
- A single threshold linked to one indication stifles development of other indications that may require a higher price
- A single threshold per indication complicates pricing for products approved first in combination therapies
- If based on a threshold, it may not reflect any marginal cost of investment

Cost of medicines are under control

Under the PPRS - which covers 85% of new medicines - NHS spend has been flat for 5 years. Any overspend is paid back: industry has given £3 billion over this period.

£3bn
paid back

Potential spend
without the scheme

Actual spend
1.1% flatlined



2013 Time 2018

From PPRS to VPAS

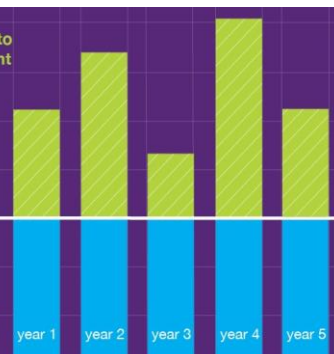
Medicines spend is under control

As agreed with Government, the Voluntary Scheme means the amount of money the NHS spends on branded medicines is controlled. Or pharmaceutical companies refund it.

Paid back to
Government

2%

Branded
medicines
bill growth



HTA/CEA may have stifled innovation in oncology

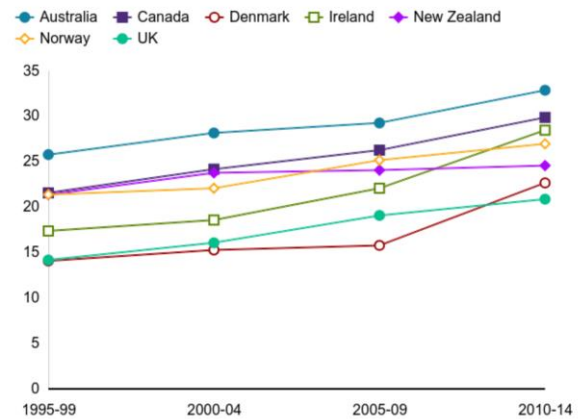
Actual progress in cancer survival in the UK too slow

HOW THE UK'S CANCER SURVIVAL RATE LAGS BEHIND COMPARABLE NATIONS



Stomach cancer survival rates are improving

Patients surviving five years (%)



Source: ICBP/Lancet

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CEA/HTA single price is also problematic in the light of combination therapies

Single price per compound makes it difficult the alignment of payment with value across all treatment uses

- In 2018, 75% of cancer drugs were used in multiple indications (IQVIA, 2018)
- The number of combination therapies in oncology is rapidly increasing (EvaluatePharma, 2017)

Other arguments against current CEA-inflexible threshold

- A single threshold per indication complicates pricing of combination therapies
- If based on a threshold, pricing may not reflect any marginal cost of investment
- Should not price be based on rate of return of investment? But which return?

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Conclusion:
Innovation in UK in the new modified
CEA/HTA framework?