EMAUD
European Market Access University Diploma

Market Access Newsletter

Editorial

by Pr. Mondher Toumi
EMAUD Chairman

Dear Colleagues & Friends,

It is my pleasure to launch the first issue of the Market Access newsletter. Since we launched EMAUD in December 2009, we have continued to pursue our objective to inform all stakeholders of the changing market access environment. For this launch issue I am pleased to welcome two experts to whom I express gratitude for their articles: **Dr. Thomas Müller** from G-BA in Germany, and **Pr. Ulf Persson** from the Institute of Health Economics in Sweden.

The use of QALY in decision making is a never ending discussion. Although the ability of NICE to communicate and promote its view has contributed to suppress, it is emerging again. In reality to date there is no constant, infallible method; however there are tools that should be used in a more intelligent manner and put in a holistic perspective. Considering only strict thresholds is definitely not valid for proper decision support.

The manner in which the TLV in Sweden handles thresholds perfectly illustrates that QALY can be a good instrument to help make reasonable decisions, without substituting for the decision maker. Pr. Persson provides his perspective of the QALY threshold in Sweden and explains how the TLV considers the criteria of human dignity, need and solidarity, and cost effectiveness when making decisions on price and reimbursement. Value pricing is also an important topic in most countries and especially in the UK, as promoted by the Office of Fair Trading. Dr. Müller highlights the difficulties to define value, emphasizing the limitations of QALYs and the aspects that need to be taken into account when making pricing decisions, such as affordability and ethics.

The subject raises contrasting points of view and will be the main topic developed at the 2nd Annual Market Access Day.

Enjoy your reading.

What's new in Market Access?

Market Access evolves in an uncertain environment. The most common regulation of drug expenditure is the price control. The government decides the appropriate price of a medicine after negotiation with the marketing authorization holder. Only three major countries still have free pricing: USA, Germany and UK. However, the last two countries put in place regulatory processes that indirectly regulate prices. If a drug is thought to be too expensive, access is controlled by either negative list recommendations (UK) or a high copayment for the patient (Germany).

Several countries have adopted new rules. **In the UK**, NICE, which does not normally assess drugs outside of their licensed indications, is now able to do so upon request by the Department of Health and is making an ongoing assessment of off-label Roche/Genentech's Avastin for wet AMD. **In Greece**, the Ministry of Economy has announced a new reference pricing law for pharmaceuticals. The struggling Greek economy is looking for opportunities to realize savings in the healthcare sector and has decreed of mandatory price reductions in the order of 25%. **In Spain**, the health minister recently announced a new agreement that will save 1 500 million Euros for the Spanish health system. Much of the savings will come from pharmaceutical spending cuts: a new therapeutic reference price system for drugs more than 10 years on the market; 25% average price decrease for generic medicines, etc. Other changes are being implemented in relation to equality of access and efficiency of the system. **In Germany**, one of Europe's last bastions of "free" drug pricing, firms have until now more or less set the price they like for new drugs. Unsurprisingly, few if any branded companies have engaged in price-centric deal-making. A proposed new plan will require drug firms to submit, in parallel with a new drug application, a benefit-assessment study of their product, showing which patients the product will serve and which comparator drugs, if any, are already available. Indeed, Market Access not only constantly evolves but evolves fast.

Expert Viewpoint

Drug regulation and reimbursement of drugs in health systems: cost-effectiveness-analysis is not a sufficient and adequate basis for fair and reasonable decision making

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Cost-effectiveness-analysis converts all effects of a drug on mortality, morbidity and quality of life into one generic outcome parameter like the QALY, which leads to costs per QALY when all costs for the therapy are calculated and a ratio determined. In combination with an implicit or explicit threshold for the accepted reimbursement level for a QALY within a health system, this methodology can be used to make decisions on inclusion of drugs into the benefit package or on reimbursement levels for drugs. However, when making such decisions, several caveats must be considered.

Economical Caveats

Shift of drug prices to the reimbursement threshold. In health economic cost-effectiveness analysis, the drug price is often taken as a stable and constant input into the analysis and modeling. In fact, the market price is the dynamic result of opposing considerations of the buyer and the seller. In health systems, the preconditions for an ideal market which lead to an equilibrium price are not given, mainly because of the non-elastic need of the buyer (patients with life-threatening diseases) and because of the mono- and oligopolistic structure of the drug market on the buyer's side (health systems) and on the seller's side (patent protection of drugs). If within a health system the maximum reimbursement level is transparent before the negotiation of the price, the seller will automatically raise the price to this maximum limit. The effect is that the health system (or the tax payer) has to pay the maximum price accepted within the system for every QALY introduced by a new drug.

No consideration of scale effects, especially of budget impact and of development and production costs of a drug. If the reimbursement level (and indirectly the price) is set only on the basis of a cost-effectiveness analysis with a monetary threshold for health outcome ("value-pricing"), scale effects on the side of the health system (budget impact) and on the side of the drug company (cost considerations of drug development and drug production) are neglected within the decision procedure. This may lead to unintended effects, for example drugs for rare diseases with small patient numbers and high drug development and/or production costs could be excluded from reimbursement, because the drug company could reach profitability for the small number of customers only by a relatively high price.

Typical examples are drugs for hemophilia or for genetically determined rare (orphan) diseases. On the other side, prices for drugs for common diseases with high patient numbers could be uncoupled from real development and production costs and could lead to high and financially destabilizing budget impacts on the health system.

Asymmetry of expenditures within different sectors in health systems. In almost any health system, the reimbursement and budgets for hospitals, for doctors and for non-drug-interventions are calculated and negotiated on a cost-based approach ("cost-margin-pricing"). To my knowledge, in no health system is the implicit or explicit monetary threshold for a generic health outcome as the QALY a dominant factor for negotiation and/or calculation of reimbursements and budgets for hospitals, doctors and most non-drug-interventions. For example a surgeon will not be paid for an appendectomy with the monetary value of the gained 30 to 50 life years saved for the patient. If the health system regularly reimburses drug therapy at the maximum threshold for a QALY, expenditures for drugs will most likely grow with a higher dynamic than expenditures for non-drug sectors within the health system.

Universal reimbursement threshold: No ethical justification and an unfavorable position for negotiations on price. This is both an economical and ethical argument against the use of implicit or explicit monetary thresholds for QALYs as the basis for drug reimbursement and pricing. It is very difficult, in an ethical view maybe impossible, to set a universal monetary value for health benefits and for life years gained by health interventions. If a health system reimburses drugs only based on health values, the prices will shift automatically to higher levels in an open-end dynamic. One example for this dynamic is the "end-of-life regulation" by the UK NICE with the proposal of an elevated threshold for cancer drugs. At any given monetary threshold will begin a new controversy, if this monetary value reflects in an adequate way the life gain for patients. From an economical view, it is for the buyer (health system) a very unfavorable position when the maximum reimbursement level is already disclosed prior to price negotiations. To avoid this, it is important to introduce additional economic data, especially cost data, into the pricing and reimbursement procedure.

Equity & Ethical Caveats

No consideration of distribution and equity concerns. One key assumption of the QALY concept is that a QALY represents always the same "value", regardless who benefits from the care intervention, and regardless what are the specific health gains. This is in conflict with many empirical findings that most people want to give more priority to patients who are in greater need or in a worse condition.

These value judgments are not reflected by a cost-effectiveness-analysis. It is most doubtful if it is possible to integrate value judgments in a cost-effectiveness-analysis by introducing "ethical weights" into the QALY concept.

Problem of aggregation of QALY-benefits. The result of resource allocation decision making based only on cost-effectiveness-analysis is a maximization of the aggregated health benefits for the population, with the single decision parameter of the monetary value spent on a health care intervention. From an ethical and distributive justice point of view, it is not at all clear if an aggregated QALY-sum of minor benefits is equivalent to the same sum of major or even life-saving health care benefits.

No methodology for valid and consistent determination of quality of life levels in individuals and populations. Humans can adapt to very different levels of impairment of health status, and individuals can have very different perceptions of these impairments, leading to different subjective levels of quality of life for the same disease or disability. This is not only true for different individuals, but also for the same individual who learns to adapt to a health impairment and can gain a high level of quality of life, maybe the same level as prior to the disease or disability. In a very simple example, the loss of one little finger is a very substantial restriction of the quality of life for a piano player, but maybe only of a marginal effect for a football player. The methodology for determination of QALYs is even more insufficient and inadequate, when people prioritize between the loss of their life and different levels of quality of life. In the experience of many clinicians, this trade-off decision is so existential, that it cannot be anticipated by most people, and should not be.

Cost-effectiveness analysis as a single or dominant decision basis is not sufficient or adequate for drug reimbursement and pricing. Cost-effectiveness analysis and calculation of costs and incremental costs per QALY can be an important input for the decision making on drug reimbursement and price finding. The results of the cost-effectiveness analysis must be corrected by additional economic data and by ethical and justice value judgments in a framework of a fair and deliberative process.

Is there a cost per QALY threshold in Sweden?

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The Swedish system for pricing and reimbursement of pharmaceuticals is largely based on the principle of Value Based Pricing (VBP). VBP is a method of setting prices for products based on perceived benefits to the consumer rather than setting prices based on the costs for producing the goods. This could mean that a higher price might be justified for a drug with the same effect as another but which has been documented to improve compliance or quality of life.

In Sweden, it is the pharmaceutical benefits board of the Dental and Pharmaceutical Benefits Agency (TLV) that is responsible for the reimbursement and pricing of pharmaceuticals within the benefit scheme. The TLV was an early adopter of VBP.

TLV's task is to evaluate the cost effectiveness of a pharmaceutical product as well as taking the decisions on price and reimbursement for all outpatient care drugs (prescribed drugs) in Sweden. According to law, the principles of human dignity, need and solidarity, and cost effectiveness are the three criteria that the TLV takes into consideration. The cost-effectiveness principle may be the most prominent principle when TLV makes decisions. For example, reimbursement is denied if TLV considers that the price for the drug that the firm has stated in its application for reimbursement is unreasonably high in relation to the documented benefit and the cost for alternative treatments.
TLV's application of the cost-effectiveness principle is made relatively strictly in accordance with international textbooks in economic evaluation (guidelines at www.tvl.se). However, the applications require that the willingness to pay for an improvement in health is determined, expressed as Quality Adjusted Life Years (QALYs). How much TLV is willing to pay per gained health benefit – QALY – varies since the principles of need, solidarity and human dignity must also be taken into consideration.

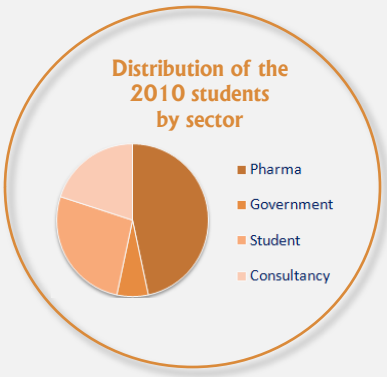
Within the traffic sector, estimates of the utility of traffic security are used in investment decisions. This means that Swedish parliament and the government have indirectly approved €2.1 million (2006 year prices) as the value of a statistical human life. Based on this value and the methodology developed by Persson and Hjelmgren (2003) the willingness to pay could be estimated at €85,000 per QALY. Another pilot study that covered 133 individuals resulted in an estimate of the willingness to pay for one QALY in the range of €40,000 (Hjalte et al 2005). These figures are used as a reference when TLV makes a decision on price and reimbursement of pharmaceuticals, but there are also considerable variations upwards and downwards in order to include the two other decision criteria. The highest value per QALY accepted by TLV is about €90,000. A pharmaceutical for advanced breast cancer (Tyverb) was denied reimbursement because the cost per QALY was estimated to be in the order of €120,000.

References
Hjalte, K, J Hjelmgren, F Johansson and U Persson (2005), "Betalningsviljan för ett kvalitetsjusterat levnadsår – en pilotstudie", IHE, Lund.
Persson, U and J Hjelmgren (2003), "Hälso- och sjukvården behöver kunskap om hur befolkningen värderar hälsan", *Läkartidningen*, Vol 100, pp 3436-3437.

EMAUD News

A flying start for EMAUD!

Started in January 2010, the programme accepted a total of 30 students for its first session. Seen as a great challenge, it has exceeded all expectations. For the first time a complete educational programme was designed and set up around the life cycle of a drug, with a balanced mix of theory and practice. The busy first semester has now come to an end, having provided students with a wide range of market access knowledge. This will be of great value to the students who were searching to jump into the field or simply to enlarge their understanding.



Students from 10 highly diverse countries (Brazil, China, Denmark, France, Switzerland, Sweden, UK, etc.), participated to EMAUD in the first year

To address the subjects of Pricing, Market Access and Health Economics during the programme, "we had the pleasure to welcome over 30 high quality experts and representatives from HAS, IQWIG, G-BA, Catsalut, Ministries of Health of Poland and Hungary, big pharma companies and renowned universities", said Pr. Mondher Toumi. In addition to focusing on national pricing and reimbursement systems, insightful presentations covered subjects such as:

- market access for oncology and vaccinations
- payer landscapes
- price anchoring studies and reimbursability
- stakeholder management
- pricing studies overview
- end of phase II studies
- cost-effectiveness evidence for pricing-reimbursement negotiation strategies
- epidemiology support to market access.

Coming from the industry, government institutions, consultancy or even completing their degree, all students found nourishing ingredients to bring to their daily business. They have reported their appreciation of the programme: what they were looking for when applying was what they actually found during the sessions.

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Student feedback on the first session

A very insightful course.
International Market Access Director, Publicis Healthcare

The content was appropriate for a global vision and to integrate Market Access Thinking.
Marketing Director, Sanofi-Pasteur MSD

It offers both a pure academic teaching and a business oriented perspective through a diversified panel of experienced professionals.
Market Research & Pricing Manager, Ethicon (J&J)

The complexity of the subject gets resolved through the large number of varied case studies. You get hands-on knowledge on top of the theoretical background – excellent!
Commercial Director Dermatology, Wyeth Europe

Announcement

The EMAUD launch meeting welcomed more than a hundred participants and was a real success, allowing the European national agencies to engage and debate with industry. This year, on **3 December 2010**, the 2nd Annual Market Access Day will be organized at Ecole du Val de Grâce to continue the conversation on how to make proper pricing decisions.

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