funcas

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FUNDACIÓ ERNEST LLUCH

INVITACIÓN

Diálogos sobre políticas de salud y buen gobierno

(organizados por Jaume Puig-Junoy, F.E. Lluch y Félix Lobo, Funcas)

Los precios de los nuevos tratamientos oncológicos y la sostenibilidad del Sistema Nacional de Salud

En el acto intervendrán:

Josep Tabernero Caturla, presidente de la Sociedad Europea de Oncología Médica (ESMO), director del Instituto de Oncología (VHIO) y jefe del Servicio de Oncología Médica del Hospital Vall d´Hebron, Barcelona

Beatriz González López-Valcárcel, catedrática de Métodos Cuantitativos en Economía y Gestión de la Universidad de Las Palmas

Beatriz González López-Valcárcel
ULPGC
6 marzo 2019

Grandes avances, grandes sacrificios

Innovación acelerada a precios altos

2. Data

2a. Complete list of included BTDs

Commercial Firms

Sponsor	Ticker	Agent / Alternative Name (Trade Name)	Date of BTD disclosure
Abbvie	ABBV	Elotuzumab (Empliciti)	2014-05-19
Abbvie	ABBV	Glecaprevir + Pibrentasvir (Mavyret)	2016-09-30
AbbVie	ABBV	Ibrutinib (Imbruvica)	2016-06-29
AbbVie	ABBV	Paritaprevir / ABT-450 (Viekira Pak)	2013-05-06
Abbvie	ABBV	Upadacitinib / ABT-494	2018-01-09
AbbVie	ABBV	Venetoclax (Venclexta)	2015-05-07
AbbVie	ABBV	Venetoclax (Venclexta)	2016-01-20
AbbVie	ABBV	Venetoclax (Venclexta)	2016-01-28
Abbvie	ABBV	Venetoclax (Venclexta)	2017-07-28
Alexion	ALXN	Asfotase Alfa (Strensiq)	2013-05-28
Alexion	ALXN	cPMP / ALXN1011	2013-10-24
Allergan	AGN	Rapastinel / GLYX-13	2016-01-29
Amgen	AMGN	Blinatumomab (Blincyto)	2014-07-01
Ariad	ARIA	Brigatinib / AP26113 (Alunbrig)	2014-10-02
Astellas	ALPMY	Enfortumab Vedotin	2018-03-26
AstraZeneca	AZN	Acalabrutinib (Calquence)	2017-08-01
AstraZeneca	AZN	Durvalumab (Imfinzi)	2016-02-17
AstraZeneca	AZN	Durvalumab (Imfinzi)	2017-07-31
AstraZeneca	AZN	Olaparib (Lynparza)	2016-01-28
AstraZeneca	AZN	Osimertinib (Tagrisso)	2017-10-09
Biomarin	BMRN	Valoctocogene Roxaparvovec	2017-10-26
Bristol-Myers Squibb	BMY	Daclatasvir (Daklinza) + Asunaprevir	2014-02-24
Bristol-Myers Squibb	BMY	Elotuzumab (Empliciti)	2014-05-19
Bristol-Myers Squibb	BMY	Fostemsavir / BMS-663068	2015-07-21
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2014-05-14
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2014-09-26
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2015-09-02
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2015-09-16
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2016-04-25
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2016-06-27
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo)	2017-10-16
Bristol-Myers Squibb	BMY	Nivolumab (Opdivo) + Ipilimumab (Yervoy)	2018-03-27
Celgene	CELG	Lisocabtagene maraleucel / JCAR017	2016-12-20
Daiichi Sankyo	DSNKY	DS-8201	2017-08-30

Entre 2012 y 2018, la FDA aprobó **112 'breakthrough therapy designation' (BTD)** (medicamentos distintos)
De ellas, 50 **(45%) son oncológicas**

Fuente:David Hoffmann, Shane Van Dalsem and Frank S. David . Stock price effects of breakthrough therapy designation Nature Reviews. Drug Discovery (Marzo 2019)

OUTLOOK — BIOMARKERS

Stratified medicine: strategic and economic implications of combining drugs and clinical biomarkers

Mark R. Trusheim, Ernst R. Berndt and Frank L. Douglas

Abstract | The potential to use biomarkers for identifying patients that are more likely to benefit or experience an adverse reaction in response to a given therapy, and thereby better match patients with therapies, is anticipated to have a major effect on both clinical practice and the development of new drugs and diagnostics. In this article, we consider current and emerging examples in which therapies are matched with specific patient population characteristics using clinical biomarkers — which we call stratified medicine — and discuss the implications of this approach to future product development strategies and market structures.

Most medicines are currently prescribed empirically. Some work for almost all relevant patients, such as non-steroidal anti-inflammatory drugs (NSAIDs) for pain relief, the proton-pump inhibitors (PPIs) for gastroesophageal reflux disorder or the newly approved Gardasil vaccine (Merck) to prevent human papilloma virus infections. For other therapeutic classes, such as the antidepressant selective serotonin-reuptake inhibitors (SSRIs), although responses are variable, there is at present no way to identify patients who are likely to respond well to a particular agent. In such cases, a number of agents might need to be tried until a satisfactory response is attained.

However, advances in understanding the mechanisms underlying diseases, as well as drug response, are increasingly creating opportunities to match patients with therapies that are more likely to be effective and safe. At the extreme of patient matching are 'individualized' medicines, which vary inherently for each patient. The cancer vaccine Oncophage, which is currently in development, provides an example of an individualized medicine. To produce this vaccine, tumour cells are taken from a patient during surgery[1]. A heat-shock protein and its associated peptides, which represent a unique 'signature' of that patient's cancer, are then isolated from the tumour cells and formulated into a vaccine for administration when the patient has recovered from surgery. This vaccine, which is only suitable for the patient from whom it is derived, stimulates an immune response that attacks tumour cells remaining in the body after surgery. Stem-cell-based therapies could also potentially increase the role of individualized medicine in the future.

Less extreme examples of patient matching to a medicine include therapies for which some form of marker is available to indicate that a given patient is likely to show a response to the therapy. Some call this approach of proactively testing and selecting populations for specific treatments 'personalized' medicine, but we believe a more useful description is 'stratified' medicine. In stratified medicine, a patient can be found to be similar to a cohort that has historically exhibited a differential therapeutic response using a biomarker that has been correlated to that differential response.

Here, we call this special class of biomarkers that links patient subpopulations to treatments clinical biomarkers. An example of a clinical biomarker that is linked to drug efficacy is the BCR–ABL-positive tyrosine kinase genotype, which is used to identify patients with chronic myeloid leukaemia who are likely to respond to imatinib mesylate (Gleevec; Novartis), an inhibitor of this kinase[2]. An example of a clinical biomarker that is linked to drug toxicity is a genetic variant of the UDP-glucuronosyltransfersase 1A1 enzyme UGT1A1, which can be used to identify patients that are likely to experience serious toxicity in response to the anticancer drug irinotecan (Camptosar; Pfizer); the rate of metabolism of the active metabolite of irinotecan by UGT1A1 is reduced in these patients[3]. Beyond genotypes, clinical biomarkers include any diagnostic test or clinical observation that indicates a preferred treatment for a patient subpopulation. Clinical biomarkers can be based on gene-expression patterns, individual proteins, proteomic patterns, metabonomics, histology, imaging, physicians' clinical observations and even self-reported patient surveys. A clinical biomarker is not defined by its technology or biological basis, but rather by its reliable, predictive correlation to differential patient responses.

In summary, we believe that individualized medicine represents one end of a continuum of patient therapy, with empirical medicine at the other end of this continuum, and that in between lies the field of stratified medicine (FIG. 1). The ability of stratified medicine to match a therapy with specific patient population characteristics through clinical biomarkers has important implications for:

- Defining the field for which a drug is used.
- Determining the economic value of the field.
- Establishing the economic barriers to defend the field.
- Allocating the value between the gatekeeper clinical biomarkers and the therapy.

In this article, we highlight selected examples of stratified medicine, and discuss the strategic and economic significance of the points above to the discovery and development of new drugs and associated diagnostics.

Stratified medicine and clinical decisions

Stratified medicine adds a step to traditional clinical practice (FIG. 2). After the differential diagnosis is made on the basis of patient history and physical assessment, and following diagnosis confirmation from laboratory tests and clinical observation, stratified medicine adds a clinical biomarker-assessment step to associate a patient with a specific therapy. Individualized medicines take this process a step further by custom producing the therapeutic — often using the patient's own fluid, cells or tissue to 'seed' production.

Stratified medicine is already practiced in several contexts, albeit often after first-line empirical treatment proves unsatisfactory because of poor efficacy or intolerable toxicity. Antibiotics are matched to specific resistant infections, HIV therapies are tailored to the viral variant present and oncology treatment regimens prioritize agents based on molecular tests. Accelerating clinical biomarker development by both drug developers and diagnostic companies will correspondingly expand the clinical opportunities for stratified medicine.

¡Ya hemos llegado!

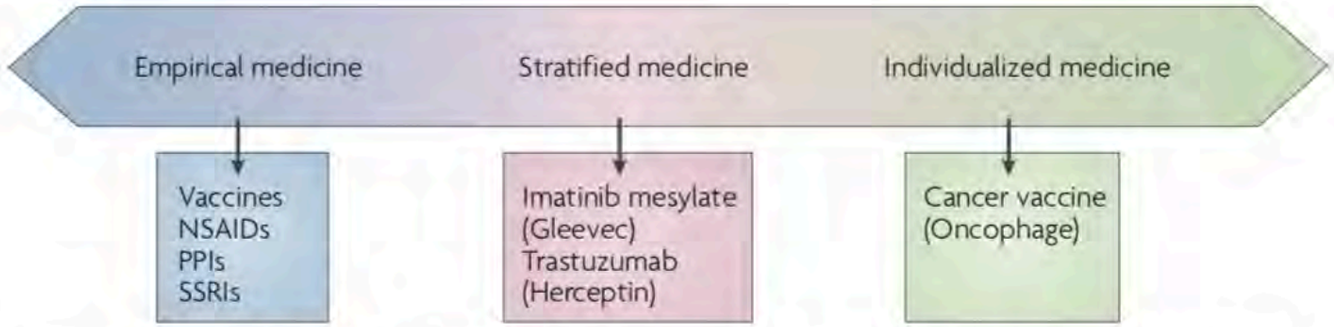


Figure 1 | **The patient therapeutic continuum.** Individualized medicines, such as cancer vaccines that are based on a particular patient's tumour, represent one end of a continuum of patient therapy. Empirical medicine is at the other end of this continuum: some agents work for almost all relevant patients, such as non-steroidal anti-inflammatory drugs (NSAIDs), whereas others may only work for a subset of patients but no method is available to identify these patients, such as with antidepressants. In between lies the field of stratified medicine, in which a patient can be found to be similar to a cohort that has historically showed a differential therapeutic response to a particular therapy using a clinical biomarker that has been correlated to that differential response. For example, the anticancer drug trastuzumab (Herceptin) shows superior efficacy in breast cancer patients with HER2/*neu*-positive cancer. PPIs, proton-pump inhibitors; SSRIs, selective serotonin-reuptake inhibitors.

2

Dos preguntas separadas:
¿Podremos financiarlo?
¿Vale lo que cuesta?

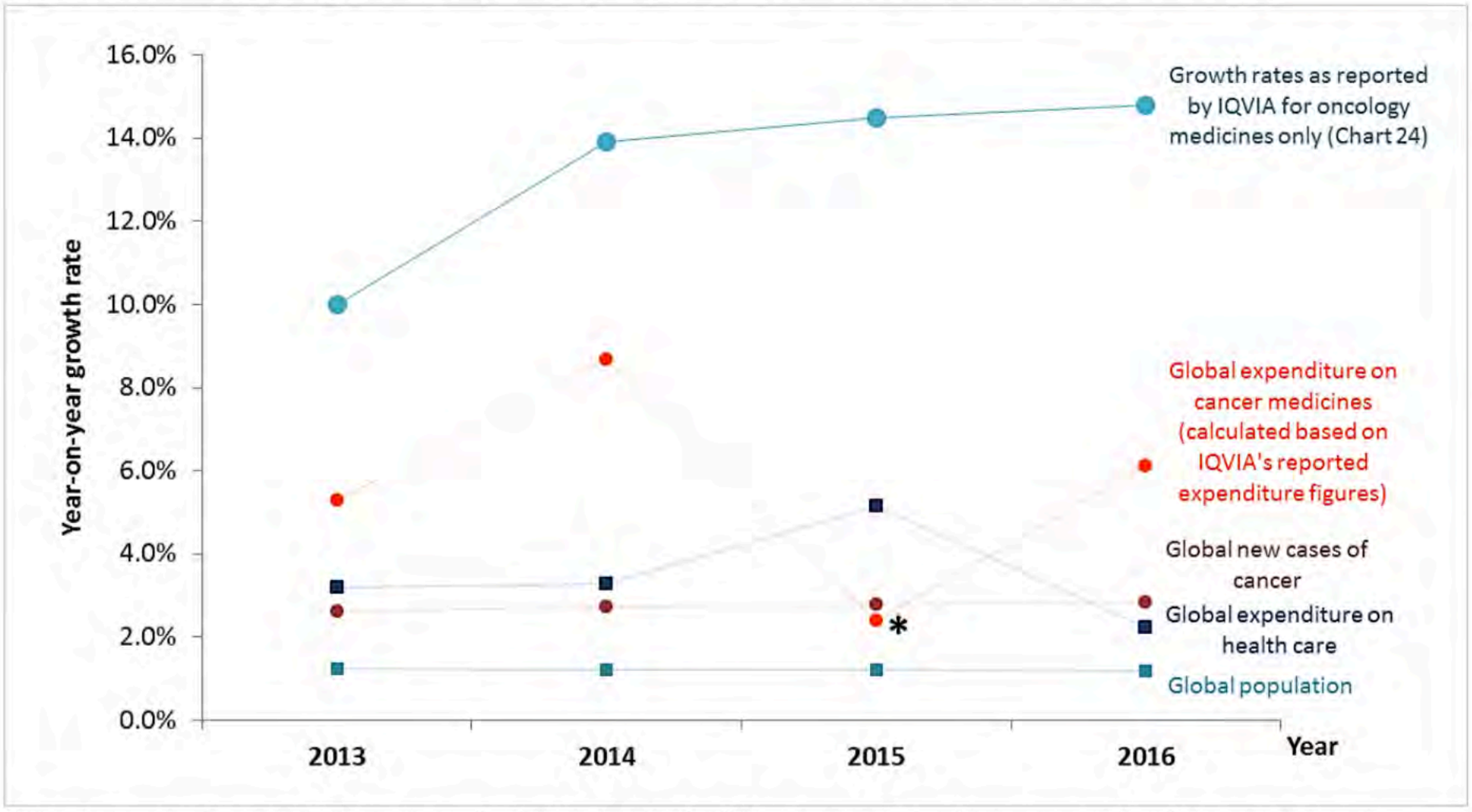
2

Dos preguntas separadas: ¿Vale lo que cuesta? ¿Podremos financiarlo?

2

Dos preguntas separadas:
¿Vale lo que cuesta?
¿Podremos financiarlo?

Fig. 1.1: Year-on-year growth rates of expenditures on cancer medicines and health care



Note: Cancer medicines include medicines for the treatment of solid tumours and blood cancers as well as for supportive care such as anti-emetics, erythropoietins, haematopoietic growth factors, select interferons, bisphosphonates. The growth rates reported by IQVIA Institute for Human Data Science only related to oncology therapeutics, without supportive care.

Source: Author's calculations based on data from the WHO Global Health Expenditure Database (*27*) and IQVIA Institute for Human Data Science (*19*)

La tasa de crecimiento del gasto en oncología es mucho mayor que la del gasto sanitario global

(*)WHO (2018) TECHNICAL REPORT. Pricing of cancer medicines and its impacts

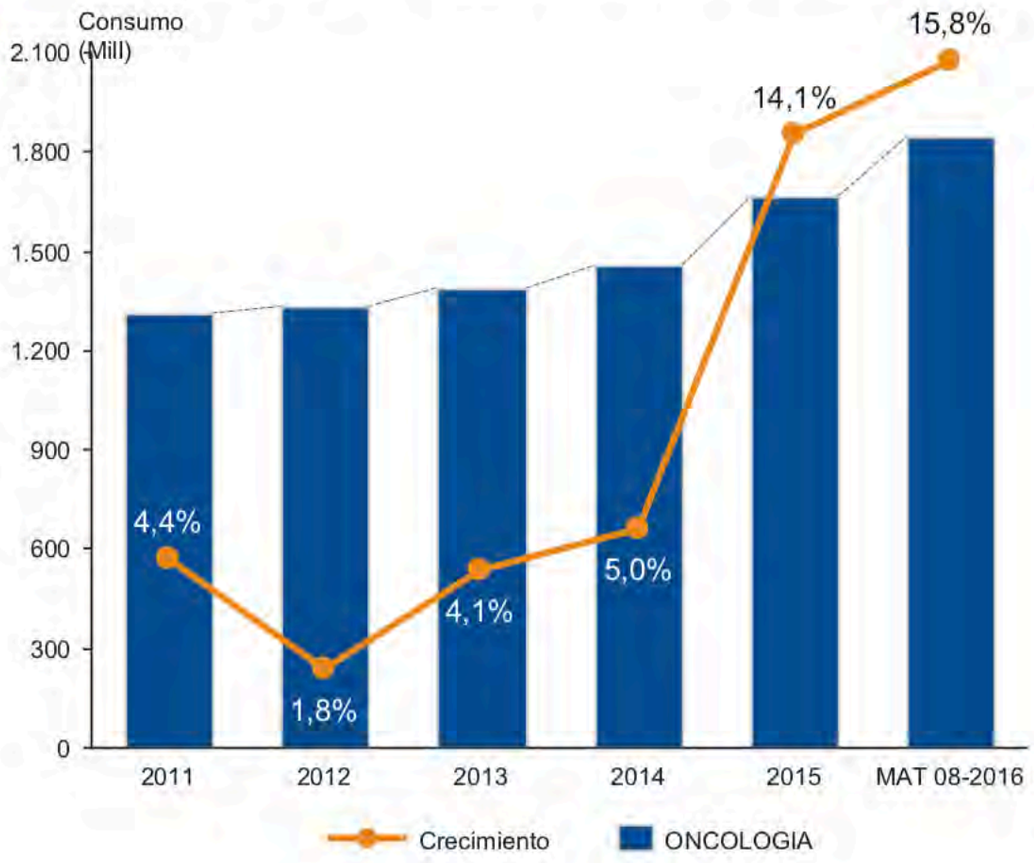
En España, el mercado oncológico es de **2.610 millones de euros** en 2018, **20% del total hospitalario** (*)

MERCADO ONCOLÓGICO

El mercado oncológico presentó una aceleración del crecimiento en 2015, alcanzando el 15,8% MAT8-2016 (PVL)

Se prevé que este mercado siga creciendo en los próximos años como consecuencia de nuevos lanzamientos e indicaciones, pese a la aparición de biosimilares y genéricos

Oncología en Hospitales (Consumo Mill € PVL, España)



Eventos que dirigen el crecimiento

- **Lanzamiento de nuevos fármacos dirigidos a dianas moleculares específicas:**

  Las terapias dirigidas cobran cada vez mayor importancia por su selectividad de acción tanto en **tumores sólidos** (mama, ovario, pulmón, melanoma…) como en **tumores hematológicos** (LLC, mieloma múltiple…)

- **Lanzamiento de fármacos Inmuno-oncológicos:**

  Fármacos dirigidos, en este caso a dianas inmunológicas, que han demostrado resultados exitosos en tumores nicho (melanoma, pulmón, renal) y que actualmente se están estudiando en otros tumores

- **Aprobación de nuevas indicaciones:**

  Aumento de las opciones de tratamiento en cada indicación para los pacientes afectados

- **Aumento de la esperanza de vida y avances que permiten un diagnóstico más temprano:**

  Todo ello incrementa la población susceptible de poder beneficiarse de un tratamiento oncológico

QuintilesIMS™

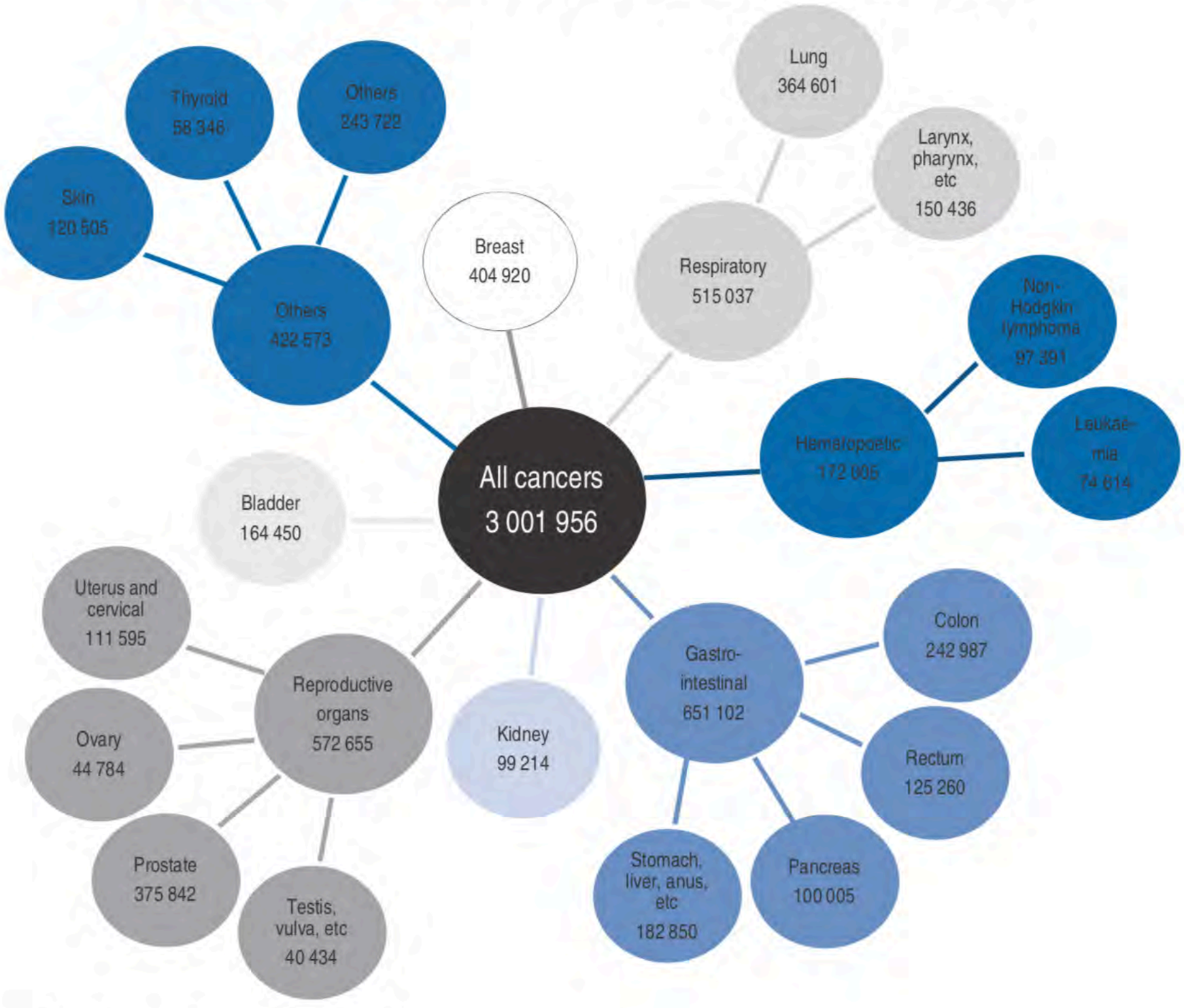
Fuente: Análisis QuintilesIMS, EMH (hospitales). Consumo en M € PVL. Oncología (L1+L2+Revlimid+Imnovid)

33

Concha Almarza (Octubre 2016) Evolución y tendencias del Mercado farmacéutico español

(*) Martinez Jorge (2019): https://www.actasanitaria.com/iqvia-resumen-2018/

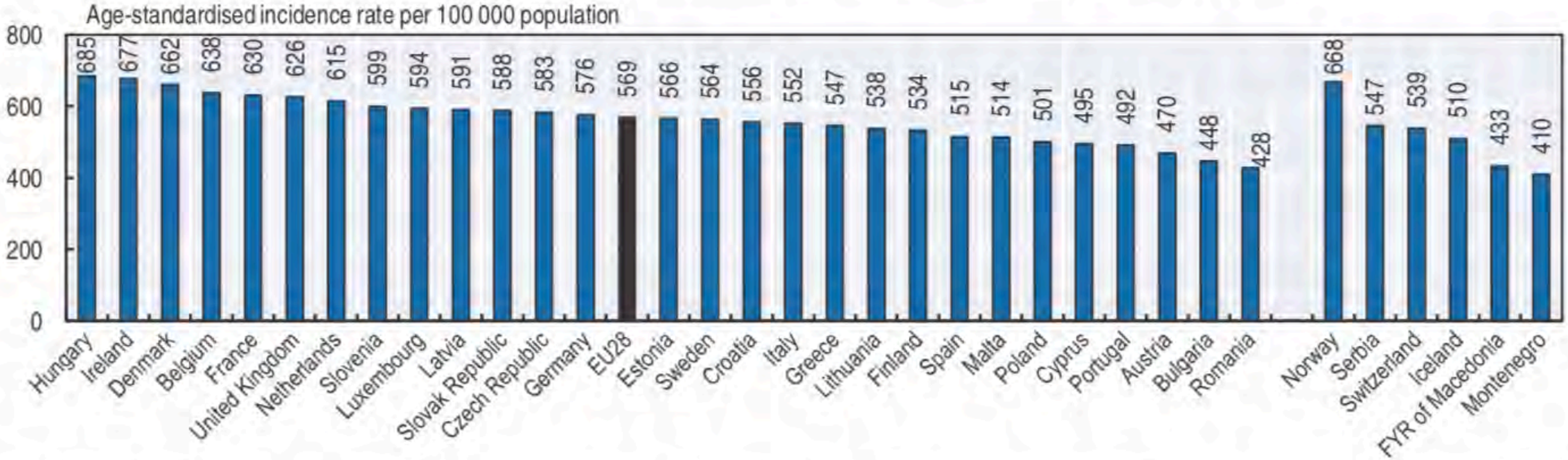
3.28. Estimated number of new cancer cases, all EU countries, 2018



Note: Non-melanoma skin cancer is excluded.
Source: JRC (European Cancer Information System).

OEDC (2018) Health at Glance

3.29. Estimated incidence rate for all cancers, by country, 2018



Note: All cancers are included except non-melanoma skin cancer. Numbers are age-standardised based on the European Standard Population.

Source: JRC (European Cancer Information System).

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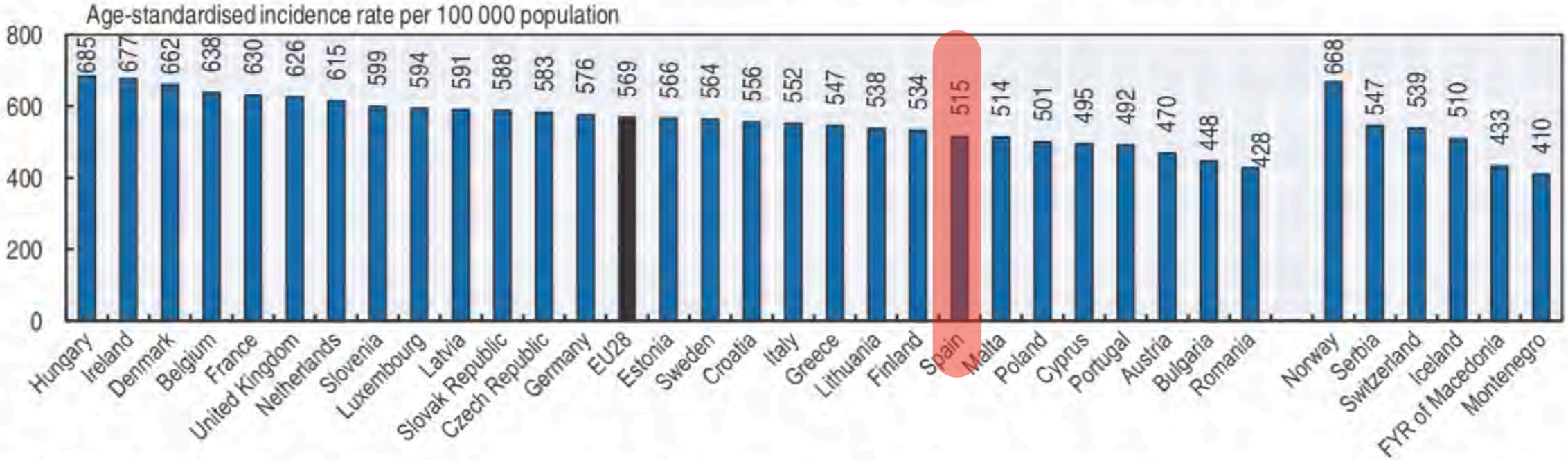


Note: All cancers are included except non-melanoma skin cancer. Numbers are age-standardised based on the European Standard Population.

Source: JRC (European Cancer Information System).

OEDC (2018) Health at Glance

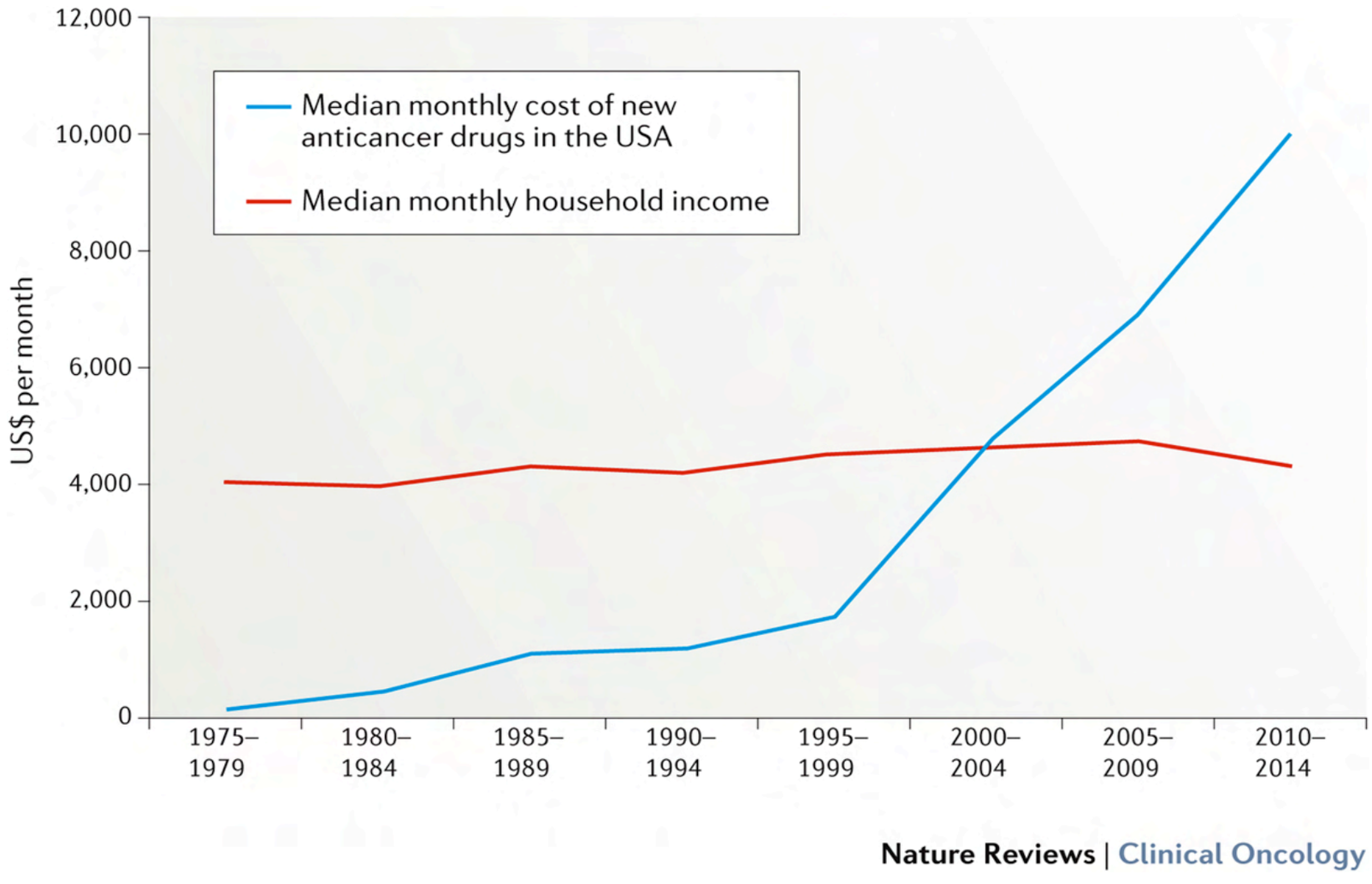
The high price of anticancer drugs: origins, implications, barriers, solutions

Vinay Prasad, Kevin De Jesús & Sham Mailankody

Affiliations | Contributions | Corresponding author

Nature Reviews Clinical Oncology (2017) | doi:10.1038/nrclinonc.2017.31
Published online 14 March 2017

Figure 2 Median monthly launch price of a new anticancer drug, compared with median monthly household income from 1975–2014 in the USA



Prasad, V. *et al.* (2017) The high price of anticancer drugs: origins, implications, barriers, solutions *Nat. Rev. Clin. Oncol.* doi:10.1038/nrclinonc.2017.31

Soluciones de “ingeniería financiera” y fiscales para financiar

(1) Ralph Koijen, Stijn Van Nieuwerburgh . Financing the war on cancer . 01 July 2018. CEPR Policy Portal

Soluciones de “ingeniería financiera” y fiscales para financiar

- Aumentar presión fiscal

(1) Ralph Koijen, Stijn Van Nieuwerburgh . Financing the war on cancer . 01 July 2018. CEPR Policy Portal

Soluciones de “ingeniería financiera” y fiscales para financiar

- Aumentar presión fiscal
- Integrar seguros de vida con seguros sanitarios(1)

(1) Ralph Koijen, Stijn Van Nieuwerburgh . Financing the war on cancer . 01 July 2018. CEPR Policy Portal

Soluciones de “ingeniería financiera” y fiscales para financiar

- Aumentar presión fiscal
- Integrar seguros de vida con seguros sanitarios(1)
- Co-pagos? No en España

(1) Ralph Koijen, Stijn Van Nieuwerburgh . Financing the war on cancer . 01 July 2018. CEPR Policy Portal

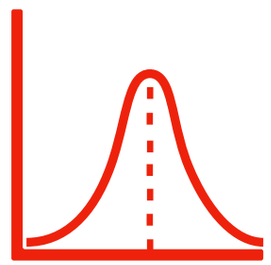
Soluciones de “ingeniería financiera” y fiscales para financiar

- Aumentar presión fiscal
- Integrar seguros de vida con seguros sanitarios(1)
- Co-pagos? No en España
- Coste de oportunidad (otros problemas sociales/otras enfermedades/otros inputs)

(1) Ralph Koijen, Stijn Van Nieuwerburgh . Financing the war on cancer . 01 July 2018. CEPR Policy Portal

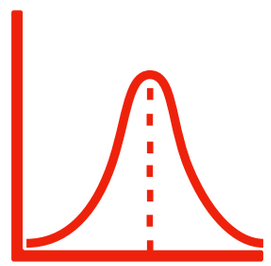
¿Vale lo que cuesta?
¿Cuál es el precio justo?

Beneficio clínico, efectividad, coste-efectividad, otros valores sociales



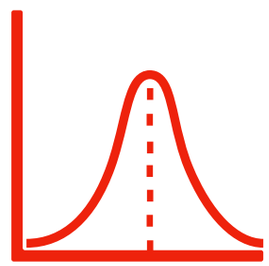
Beneficio clínico, efectividad, coste-efectividad, otros valores sociales

- **Medidas** de valor: AVACs, ASCO, ESMO-MCBS,…



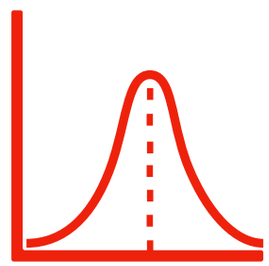
Beneficio clínico, efectividad, coste-efectividad, otros valores sociales

- **Medidas** de valor: AVACs, ASCO, ESMO-MCBS,…
- **Métodos** para evaluar: ACE, MultiCriterio, SROI, …



Beneficio clínico, efectividad, coste-efectividad, otros valores sociales

- **Medidas** de valor: AVACs, ASCO, ESMO-MCBS,…
- **Métodos** para evaluar: ACE, MultiCriterio, SROI, …
- **Incertidumbre** “intrínseca”. Comprar billete de lotería



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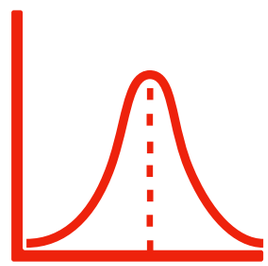

Journal of Economic Perspectives—Volume 29, Number 1—Winter 2015—Pages 139–162

Pricing in the Market for Anticancer Drugs[†]

David H. Howard, Peter B. Bach, Ernst R. Berndt, and Rena M. Conti

In 2004, Genentech introduced the drug bevacizumab—brand name Avastin—for patients with late-stage colorectal cancer. The drug cost $50,000 per treatment episode and was associated with an incremental increase in life expectancy of five months. Following Genentech's pricing announcement, newspapers ran stories with titles like "Cancer Weapons, Out of Reach" in the *Washington Post* (Wittes 2004) and "Price of Cancer Drugs Called 'Mind-Boggling'" in *USA Today* (Szabo 2004). Some Wall Street analysts worried that bevacizumab's pricing would prompt the US Congress to regulate drug prices (Anand 2007). By 2011, the backlash against bevacizumab was a distant memory. Bristol-Myers Squibb set the price of its newly approved melanoma drug ipilimumab—brand name Yervoy—at $120,000 for a course of therapy. The drug was associated with an incremental increase in life expectancy of four months.

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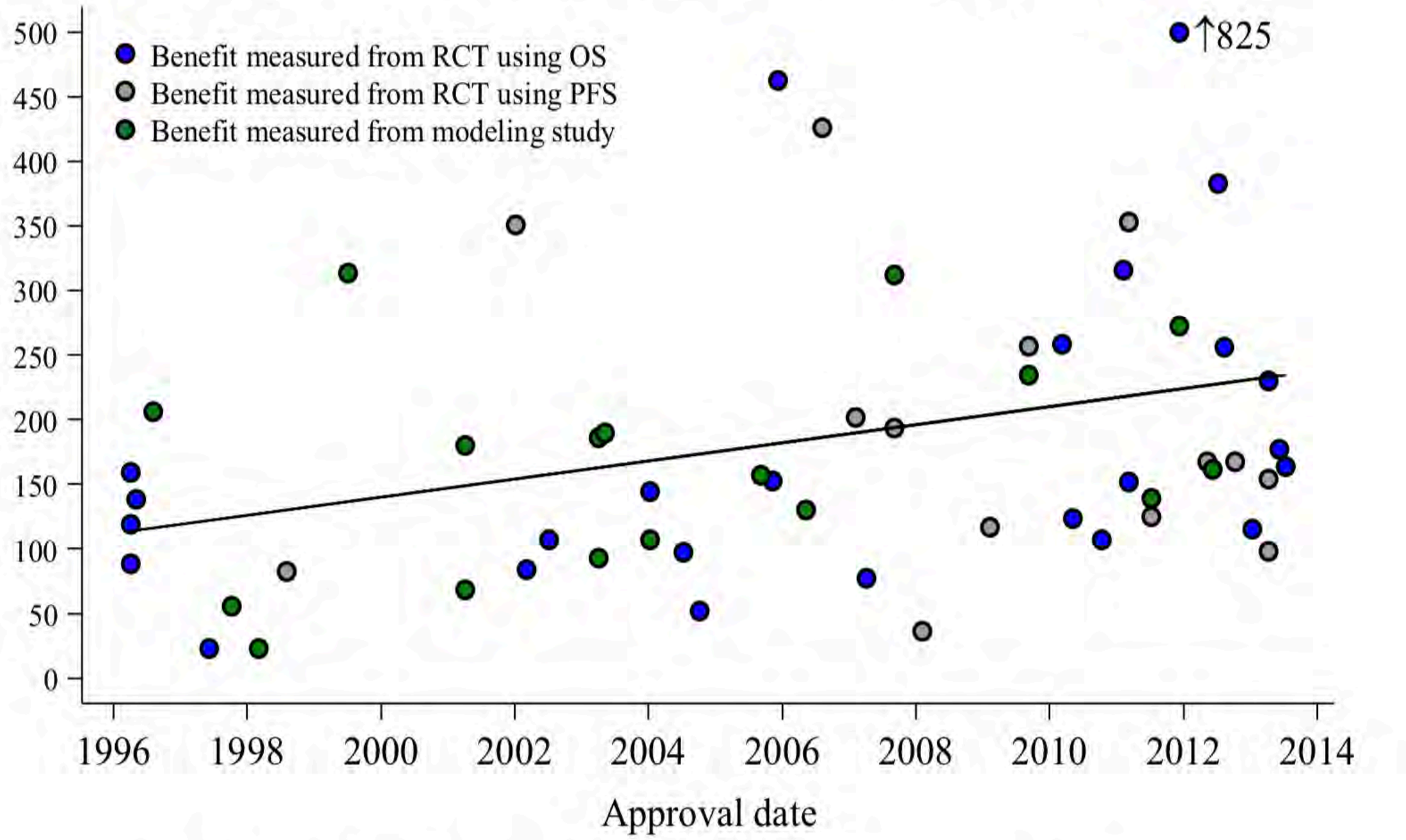
Figure 2: Price per year of life gained versus approval date



The best fit line is: Price per year of life gained = $101,077 + $7,396 × Approval year.
For purposes of display, we re-coded one value from $825,000 to $500,000.
RCT: randomized controlled trial. OS: Overall survival. PFS: Progresion-free survival

Howard, David H., Peter B. Bach, Ernst R. Berndt, and Rena M. Conti. " Pricing in the Market for Anticancer Drugs ." Journal of Economic Perspectives 29, no. 1 (February 2015): 139–162

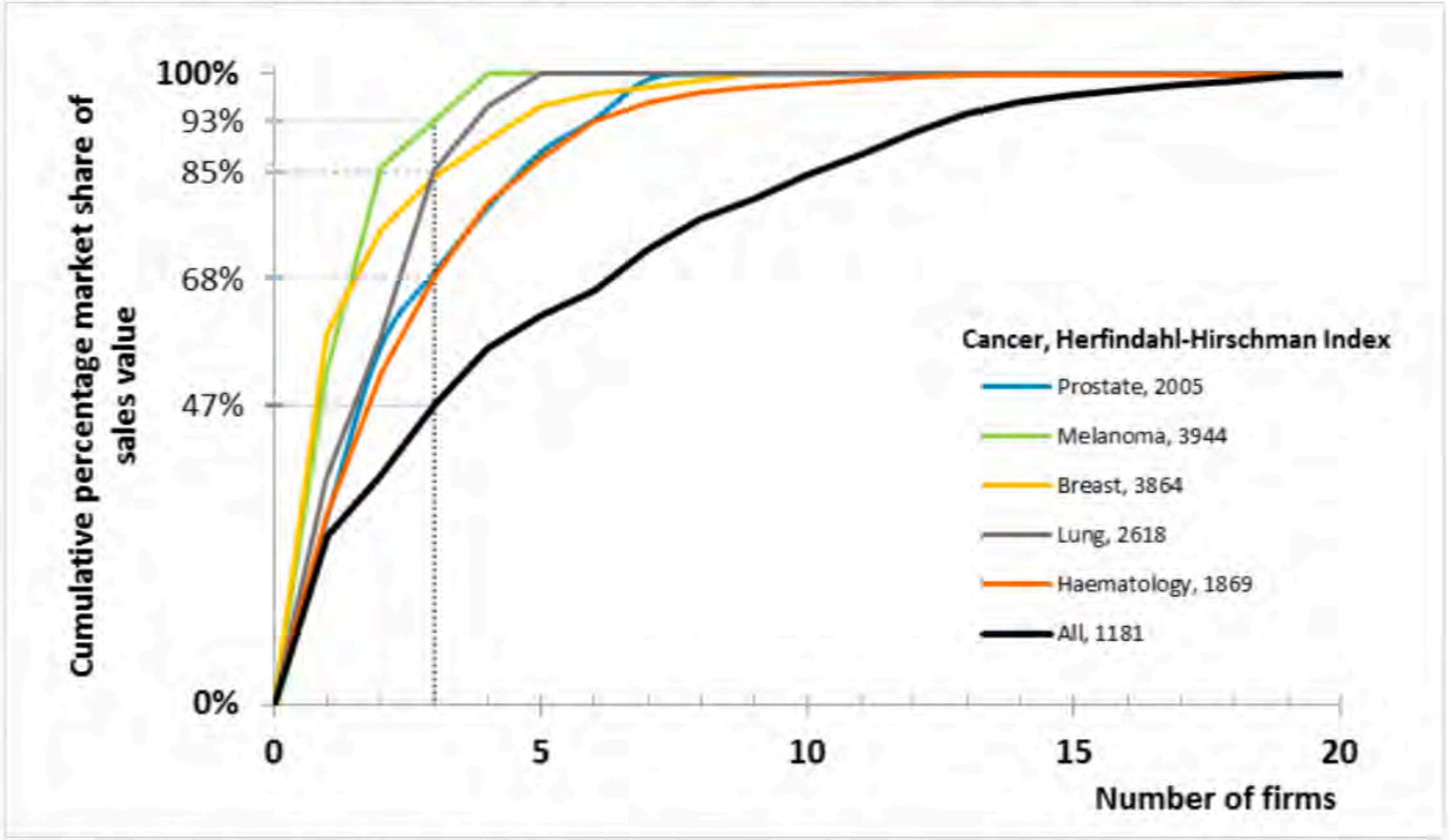
4

Los precios altos son un efecto secundario de las patentes y de la disposición a pagar de los países ricos (demanda inelástica)

5

Mercado más concentrado lleva a precios más altos

Fig. 3.6: Distribution of market share by 2017 sales value and Herfindahl-Hirschman Index



Source: Author's calculation based on 2017 sales figures of products presented in companies' annual reports

(*)WHO (2018) TECHNICAL REPORT. Pricing of cancer medicines and its impacts

6

La regulación de precios basada en costes y/o beneficios NO es socialmente conveniente.

Asimetría de información

Contents lists available at ScienceDirect

Journal of Health Economics

journal homepage: www.elsevier.com/locate/econbase

Innovation in the pharmaceutical industry: New estimates of R&D costs☆

Joseph A. DiMasi[a,*], Henry G. Grabowski[b], Ronald W. Hansen[c]

[a] Tufts Center for the Study of Drug Development, Tufts University, United States
[b] Department of Economics, Duke University, United States
[c] Simon Business School, University of Rochester, United States

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O31

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Pharmaceutical industry
Discount rate
Technical success rates

ABSTRACT

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¿Cuánto cuesta lanzar un nuevo medicamento?

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Innovation in the pharmaceutical industry: New estimates of R&D costs☆

Joseph A. DiMasi[a,*], Henry G. Grabowski[b], Ronald W. Hansen[c]

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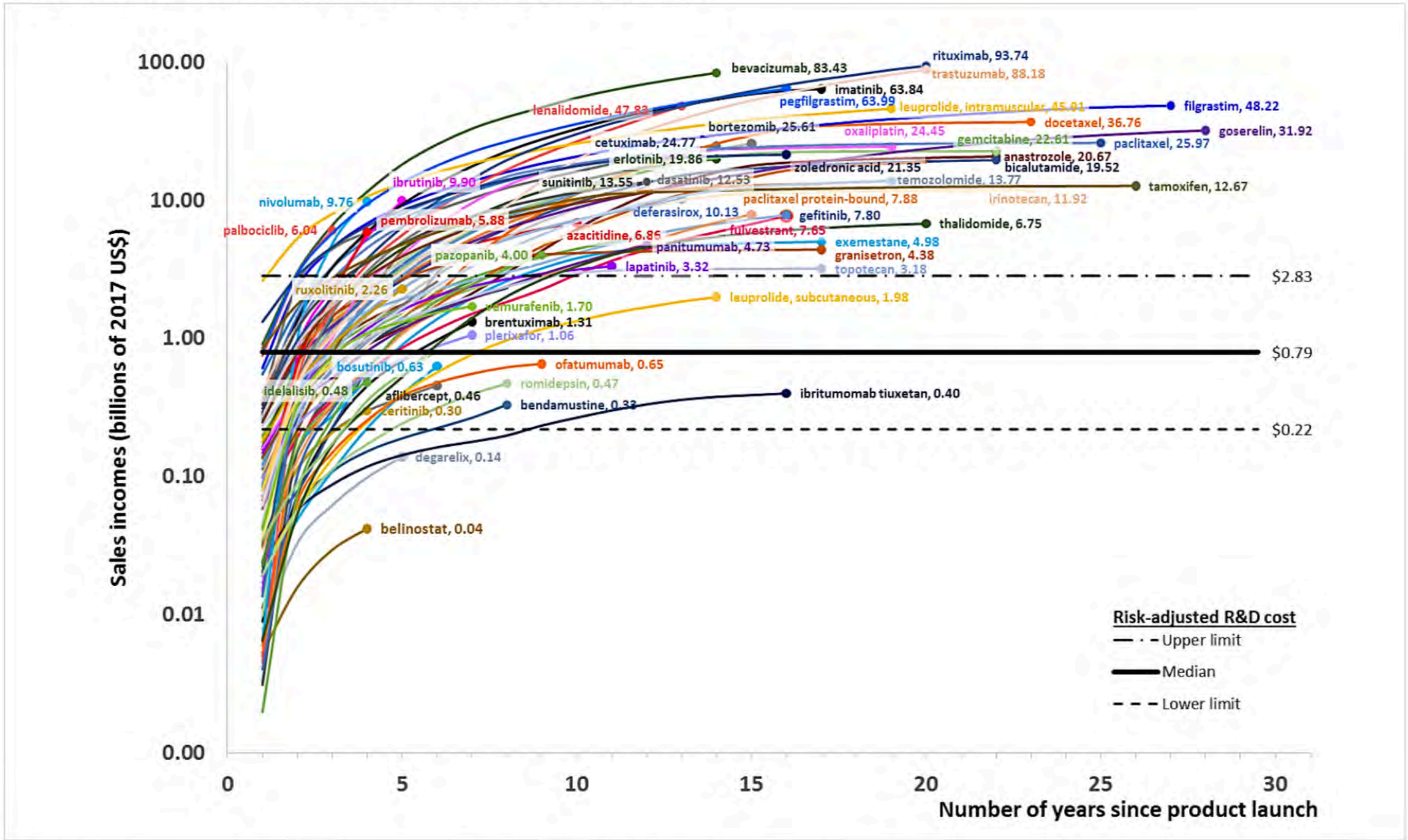
Hay suficiente evidencia de que el cancer genera beneficios extraordinarios

Fig. 3.5: Cumulative sales incomes of cancer medicines in 2017 US dollars, by molecule



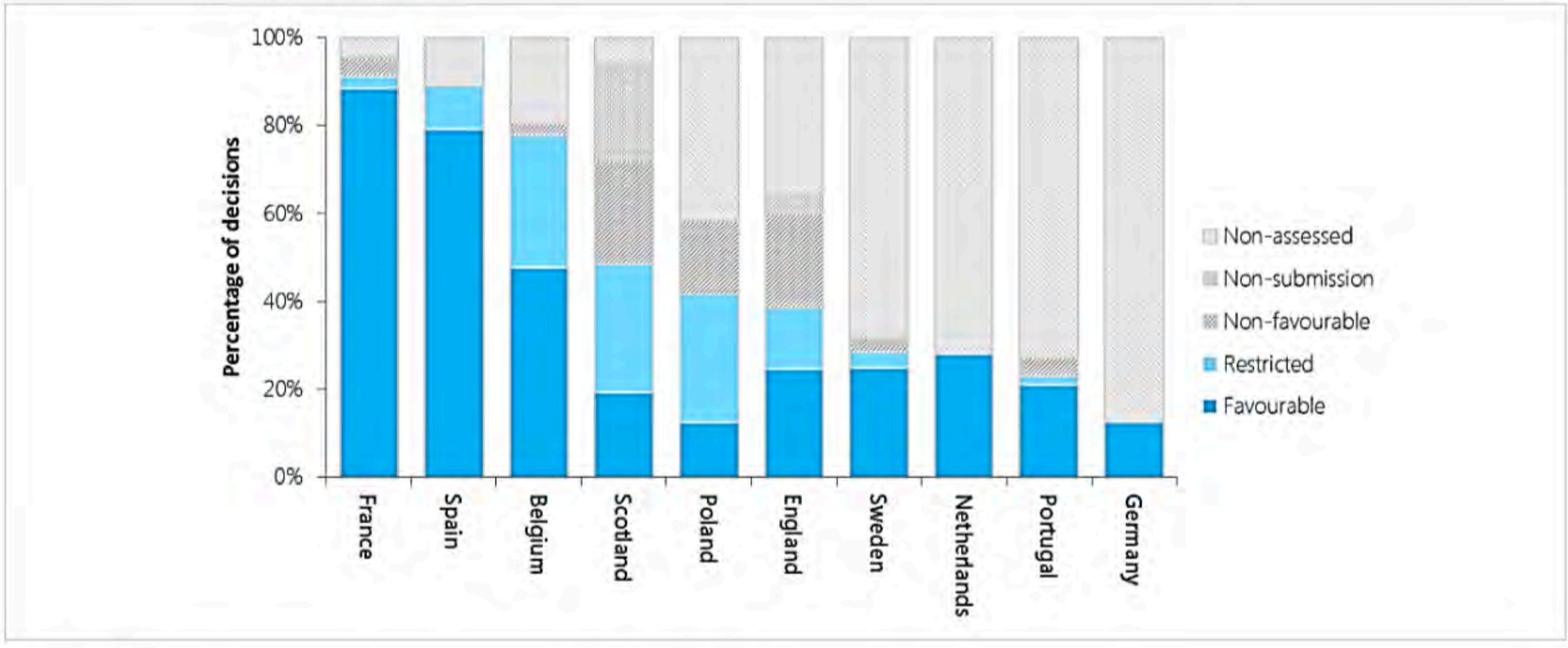
Source: Author's analysis based on sales figures of products from 1989–2017 presented in companies' annual reports and public reports (*117*)

(*)WHO (2018) TECHNICAL REPORT. Pricing of cancer medicines and its impacts

7

No priorizar = priorizar mal (MBS, MBC, FIFO,)

Fig. 4.10: Decision outcomes on the coverage of cancer medicines (2002–2014) in 10 European countries or areas



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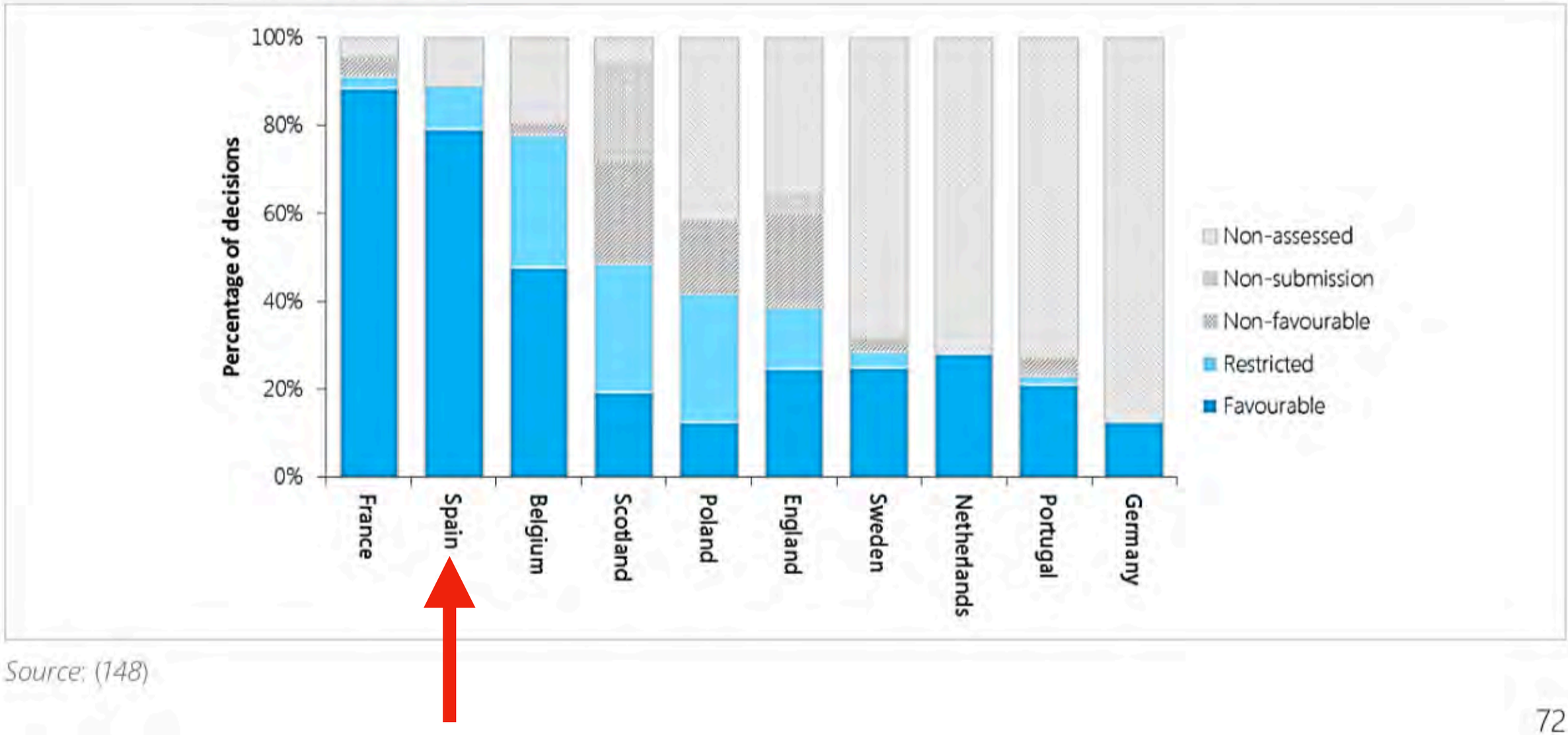

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El paradigma del Precio Basado en el Valor (expresado a través de la disposición a pagar) corresponde al comportamiento clásico racional del monopolista

Piensa globalmente, actua localmente: discriminación de precios

Table 4.3: Estimated costs of cancer pharmacotherapies, by cancer type and country

Cancer	Standard regimen[a]	Estimated annual cost of cancer medicines[b] Nominal value[c] (with adjustment for purchasing power)			
		India	South Africa	Australia	USA
Breast cancer Early stage HER2 positive	doxorubicin, cyclophosphamide, docetaxel, trastuzumab [Adjuvant AC-TH]	$ 18 500 ($ 67 900)	$ 33 900 ($ 74 400)	$ 41 800 ($ 37 000)	$ 71 700 ($ 71 700)
Colon cancer Stage III	capecitabine, oxaliplatin [Adjuvant CAPOX or XELOX]	$ 2 200 ($ 8 100)	$ 1 300 ($ 2 900)	$ 1 200 ($ 1 000)	$ 7 300 ($ 7 300)
Liver cancer Advanced	sorafenib	$ 700 ($ 2 700)	$ 12 700 ($ 27 800)	$ 28 700 ($ 25 400)	$ 90 800 ($ 90 800)
Prostate cancer Castration-sensitive metastatic	goserelin, bicalutamide docetaxel [ADT plus DOCE]	$ 3 600 ($ 13 300)	$ 3 300 ($ 7 200)	$ 4 100 ($ 3 600)	$ 7 100 ($ 7 100)
Lung cancer Metastatic non-small cell	vinorelbine, cisplatin	$ 1 800 ($ 6 600)	$ 800 ($ 1 900)	$ 1 200 ($ 1 000)	$ 500 ($ 500)
	erlotinib for EGFR positive	$ 1 700 ($ 6 200)	$ 27 300 ($ 59 800)	$ 13 400 ($ 11 900)	$ 76 700 ($ 76 700)
Lymphoma Non-Hodgkin – diffuse large B-cell	rituximab, cyclophosphamide, doxorubicin, vincristine, prednisolone [R-CHOP21]	$ 6 700 ($ 24 600)	$ 20 000 ($ 43 900)	$ 17 800 ($ 15 700)	$ 48 100 ($ 48 100)
Leukaemia Chronic myeloid	imatinib	$ 800 ($ 2 800)	$ 13 300 ($ 29 100)	$ 23 200 ($ 20 600)	$ 96 700 ($ 96 700)
	dasatinib	$ 800 ($ 3 100)	$ 20 000 ($ 43 800)	$ 40 200 ($ 35 600)	$ 109 400 ($ 109 400)

Note: [a] Please refer to the WHO Essential Medicines List and clinical guidance for specific details of the treatment regimens.

[b] Costs were estimated for a full course or 12-month treatment. Cost calculations were based on body surface area of 1.8 m^2 or body weight of 75 kg where necessary. Please note that the cost estimates are indicative only. [c] Numbers represent US$ in 2016.

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Piensa globalmente, actua localmente: discriminación de precios

Precios óptimos de Ramsey: el precio del mismo medicamento será menor en países de demanda más elástica al precio (“pobres”)

9

Discriminar precios por indicación responde a la lógica del comportamiento racional óptimo del monopolista

Piensa globalmente, actua localmente:
discriminación de precios

The Economics of Indication-Based Drug Pricing

Amitabh Chandra, Ph.D., and Craig Garthwaite, Ph.D.

Pharmaceutical treatments and medical devices often have varying effectiveness depending on the indication for which they're used: in oncology, for instance, response to a treatment varies with the type of tumor and stage of disease. The advent and proliferation of precision medicine in which biomarkers — whether genomic, proteomic, or structural — identify patients likely to receive greater treatment benefits only increase the range of variability in the effectiveness of the same product.

Yet manufacturers traditionally charge the same price for all indications. Recently, there have been calls for "indication-based" pricing systems, in which manufacturers are paid more when treatments are used for indications for which they have higher value ("high-value indications") and less for indications for which they confer less benefit ("low-value indications").[1,2] Supporters hope that such a system will reduce prices for low-value indications but that prices for high-value indications will not increase.[1]

This expectation arises from a belief that manufacturers currently set uniform prices according to the value generated for high-benefit indications and somehow get patients who receive lower value to pay the same price.

If that were true, it would mean that manufacturers have convinced insurers and patients to consistently pay prices exceeding their products' value. But simple economics makes it clear that relative to uniform pricing, indication-based pricing results in higher prices for patients who benefit

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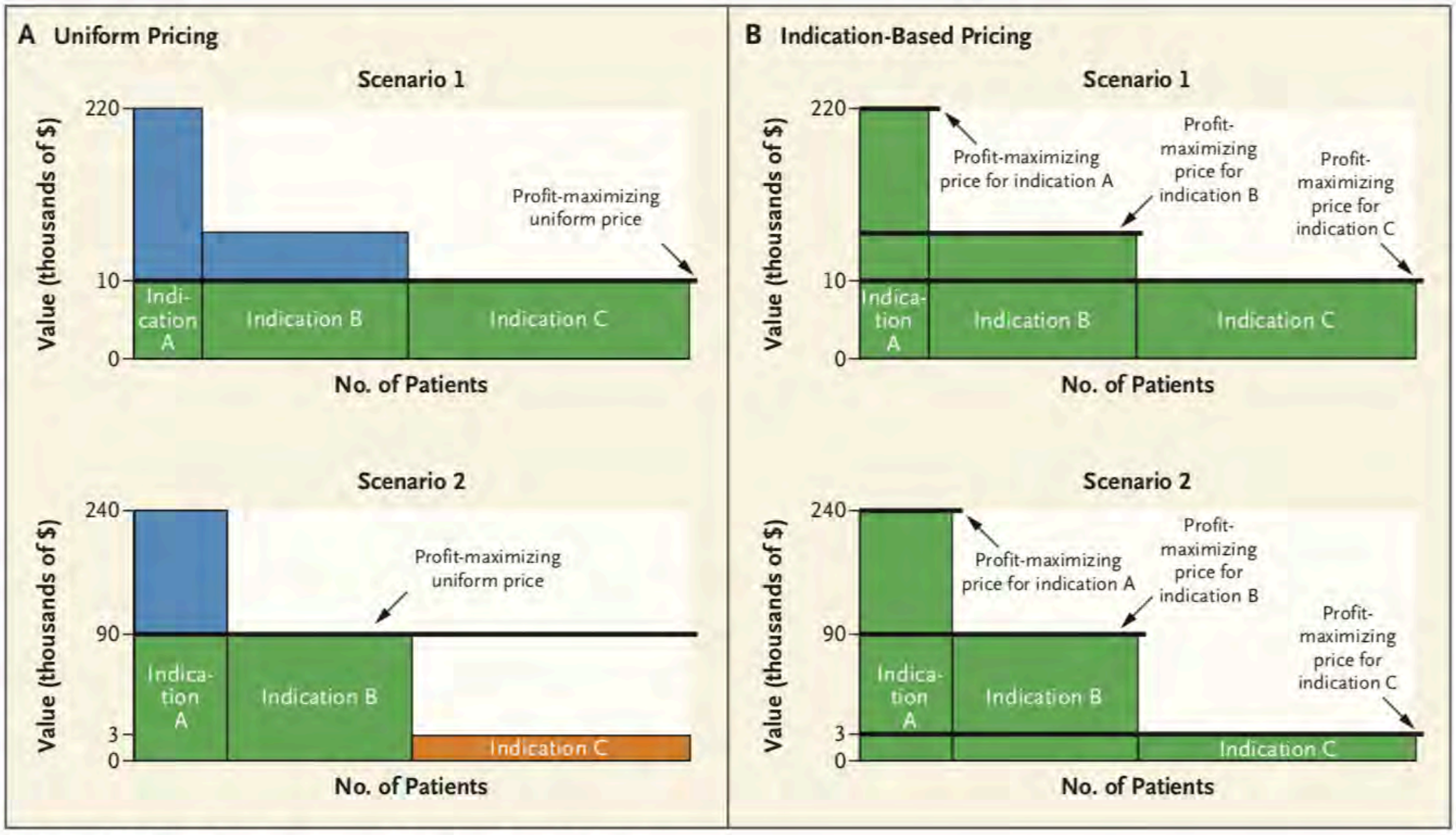

Effects of Uniform Pricing versus Indication-Based Pricing.

In scenario 1, the value of the treatment is relatively retained across indications; in scenario 2, the value is low for indication C, which affects a relatively large population.

PharmacoEconomics
https://doi.org/10.1007/s40273-018-0716-4

CURRENT OPINION

Multi-Indication Pricing: Nice in Theory but Can it Work in Practice?

Jorge Mestre-Ferrandiz[1] · Néboa Zozaya[2] · Bleric Alcalá[2] · Álvaro Hidalgo-Vega[3,4]

Precio *personalizado*

Abstract

For medicines with different valued indications (uses), multi-indication pricing implies charging different prices for different uses. In this article, we assess how multi-indication pricing could help achieve overall strategic objectives of pricing controls, summarise its advantages and disadvantages (vs. uniform pricing) and estimate the hypothetical impact on prices of moving towards multi-indication pricing for specific oncologic medicines in Spain. International experience shows that multi-indication pricing can be implemented in real practice, and indeed a few initiatives are currently in use, albeit mostly applied indirectly through confidential pricing agreements that offer a way to discriminate prices across countries without altering list prices. However, some more sophisticated systems are in place in Italy, and more recently in Spain, where the objective is to monitor usage per patient/indication, and ultimately pay for outcomes. Based on the existing experience, we also outline six conditions required for multi-indication pricing. Multi-indication pricing is a useful tool to determine the relative prices of a drug for multiple (different-valued) indications, but by itself will not offer the 'solution' to what the absolute price should be. That will be driven, among other things, by cost-effectiveness thresholds, if they exist. Overall, we argue multi-indication pricing is nice in theory and it could work in practice, although changes in the manner in which medicines are priced, procured and monitored in clinical practice need to be applied.

Hi Beatriz,

It's a familiar issue in the pharmaceutical industry:

You know Indication Based Pricing (IBP) can deliver real benefits to those who rely on your products. But you're struggling to drive IBP implementation with payers.

Get the support – and evidence – you need to build a winning pitch and help turn the tide.

Don't miss your chance to engage with the experts and grow IBP advocacy across your organisation.

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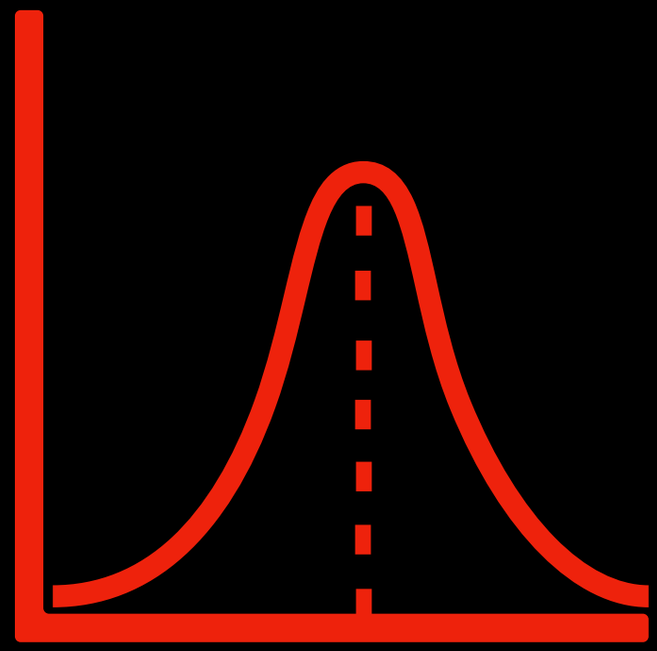
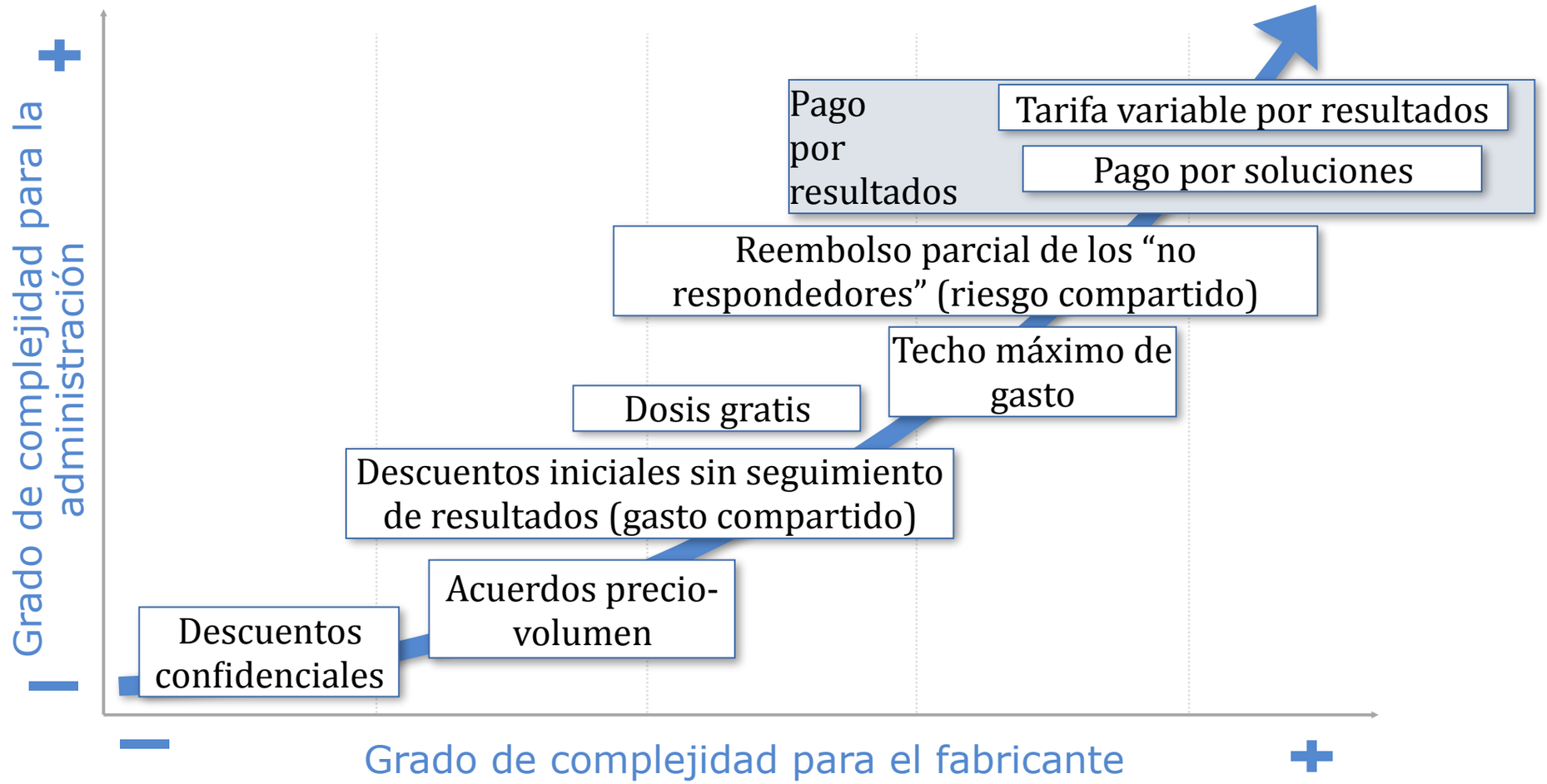


Para afrontar la incertidumbre sobre el valor creado (efectividad) los contratos de riesgo compartido son una buena idea

Instrumentos de financiación cada vez más sofisticados



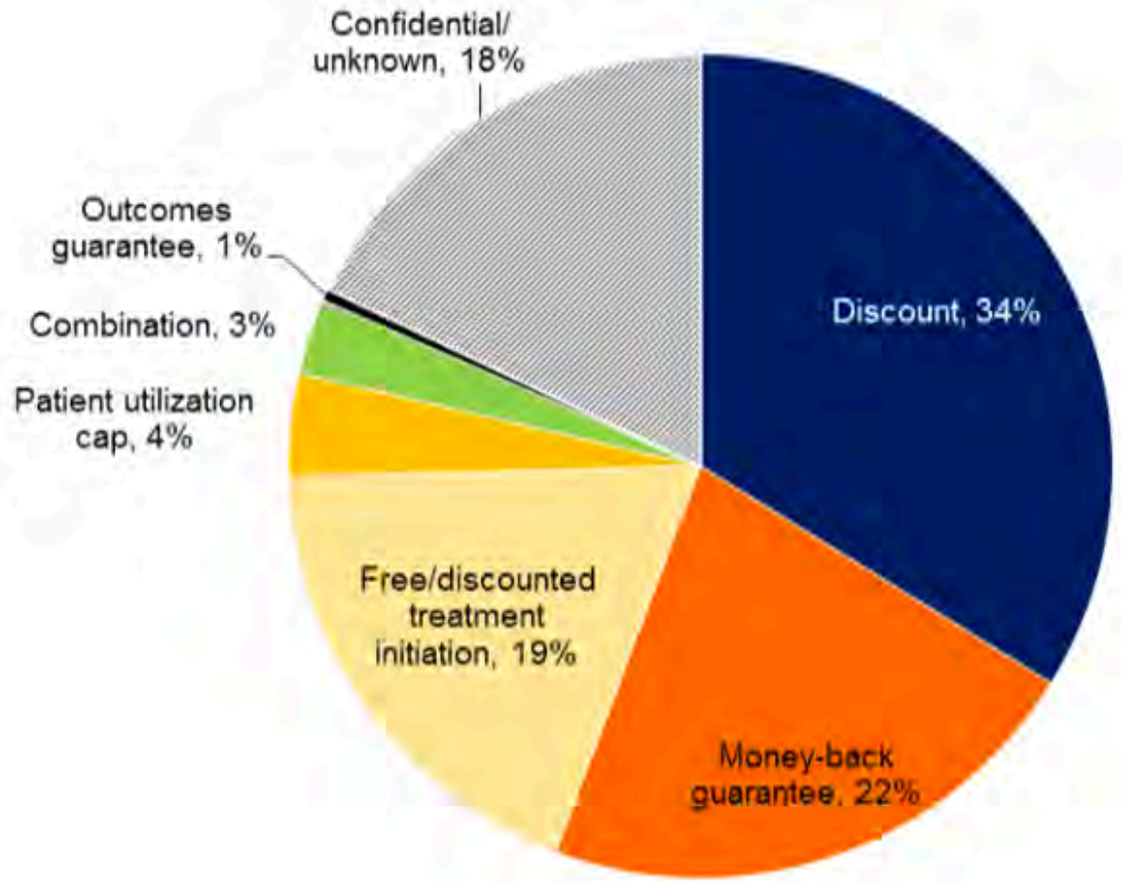
Alvaro Hidalgo. Presentación Septiembre 2018

MEA: Managed Entry Agreement

(*)WHO (2018) TECHNICAL REPORT. Pricing of cancer medicines and its impacts, pag.42

MEA: Managed Entry Agreement

Fig. 3.10: Types of MEA applied for cancer medicines in European countries



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Efectos secundarios benéficos del comprador público: inequidades territoriales de acceso

12

Dinámica de precios: fomentar competencia y revisión precoz (biosimilares)

13

Transparencia vs opacidad: ventajas de la transparencia

Y el último:

14

No olvidemos ni la prevención ni los cuidados paliativos

Muchas gracias

beatriz.lopezvalcarcel@ulpgc.es