

Govt cautioned over risk-sharing schemes

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The risk-sharing schemes now being used as a way of increasing access to medicines are very much in their infancy and should not form the basis for more widespread use in the NHS, a new report warns.

The UK government must re-assess such schemes before making the National Institute for Health and Clinical Excellence (NICE) “redundant,” says the study, which is published by the Stockholm Network, a European pro-market think tank.

The news that NICE “will no longer deny patients access to new medicines is a welcome move away from centralised rationing,” says the Network. “Even at a time of austerity, the British public does not want or accept rationed healthcare. But it would be a shame if the NICE experiment was replaced by an equally unpredictable and misguided means of allocating resources,” adds chief executive Helen Disney.

The study examines 27 risk-sharing schemes in operating in various countries, and concludes that the results have been too varied to be relied upon. Moreover, in most instances, these arrangements have been used as a “fig leaf” for imposing price cuts rather than for widening access or increasing innovation, it adds.

In its examination of risk-sharing schemes in the NHS, the report says that such arrangements have only ever really been resorted to in response to the rejection of drugs for reimbursement by NICE and are not yet a part of the original drug approval process, despite calls from NICE chief executive Sir Andrew Dillon for them to be included. Instead, implementation of such a scheme is “mainly an afterthought prepared at the last minute to save the drug approval process from collapse,” it notes.

While the schemes involving Johnson & Johnson’s multiple myeloma drug Velcade (bortezomib) and Novartis’ Lucentis (ranibizumab) for wet age-related macular degeneration (AMD) have shown that they can give patients access to drugs that would ordinarily have been unavailable because of NICE guidance, the UK experience is still by no means encouraging, says the study. In particular, the continuing criticisms and controversies involving the UK’s first such scheme, involving four drugs for the treatment of multiple sclerosis (MS), suggest that “it is probably safe to say that it has not gone to plan for the UK government,” it adds.

Nevertheless, the researchers forecast that risk-sharing programmes and value-based pricing (VBP) are set to become an integral part of pharmaceutical pricing strategies in the UK. Given this likelihood, they urge the government to accept that risk-sharing is still in its infancy and that current experiences are by no means a basis for widespread use. When drugs are rejected for reimbursement, such schemes can act as band-aids over the damage, but this is not a sustainable system for the future, they warn.

Also, while risk-sharing schemes need to address adequately both price and performance concerns, current examples seem to suggest that the former is dictating the mechanisms by which the schemes work and that, to this extent, such arrangements aim to control the issue of cost rather than to deal with the issue of risk.

Risk-sharing agreements should reflect a true commitment to serve the needs of patients, to allow for greater individual choice while securing the most effective methods of treatments, says the study, adding: “this means that the risk may be at the expense of payers, or manufacturers or both, but never at the expense of patients.”

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