

Gesundheit!

Stockholm Network Health and Welfare Newsletter



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COMMENTARY

Helen Disney, chief executive of the Stockholm Network

Apart from assessing and critiquing existing reforms, one of the roles of a think tank is also to try to stay five to ten years ahead of the game and predict which policies and societal changes may be coming down the line. In this issue of *Gesundheit!* we attempt to do just that by taking a forward look at the future of European healthcare.

Our senior researcher, Paul Healy kicks off by giving us an overview of where healthcare systems have come from and where they are likely to go in future, ending with an assessment of what this means in terms of the need for system reform.

Meanwhile in our book review, we analyse a new publication by Richard Barker on the future of medicines, which presents some of the exciting new innovations that healthcare systems will be enhanced by but also challenged by in the next 20 years – be it the development of brain-enhancing drugs, e-health or the impact of our greater understanding of the human genome. His insights make for fascinating reading for

policymakers as well as for us all as potential future patients and users of healthcare systems.

Last but not least, we introduce a new section of *Gesundheit!* entitled “Health of the Nation”, which will profile policy reforms country-by-country, as well as providing some brief snapshots about healthcare news in the EU member states. The UK’s proposed healthcare reforms have attracted much controversy and debate and in this issue we examine what they may mean for patients in a period when the government is consulting and pausing to reflect on whether the reforms can still go ahead in their current form or whether greater input from professionals and other experts is needed to fine-tune them before the *Health and Social Care Bill* can make it successfully through parliament.

Star-gazing is never easy and we are unlikely to be able to predict all of what the future holds but we hope this issue provides some useful insights and analysis of where healthcare may take us into the future.

FUTURE OF HEALTHCARE

Paul Healy, senior researcher of the Stockholm Network

Healthcare systems today are more adept than ever at keeping patients healthier for longer. Since 1961, life expectancy at birth in the OECD has increased by over 11 years on average, which means that a person born in the OECD can now expect to live beyond 80 years of age.

The main cause of this has been the modernisation of healthcare, which has been driven by an explosion of medical advancements and relatively peaceful societies that have allowed patients to take advantage of such progress.

Healthcare systems are now much more sophisticated creatures, which encourage the development of complex innovations. The evolution of research into molecular biology between the 1940s and 1960s showed just how rapid progress can be made and the adoption of genetic engineering from the 1970s onwards has showcased how such progress can be translated into significant benefits to people's lives. Even on a global scale, more sophisticated healthcare systems were able to eradicate life-threatening diseases, such as small pox in the 1970s.

Yet, such successes have also created some problems of their own. Diseases that are greatly influenced by environmental factors, such as cancer and heart disease, have been compounded by the fact that people have been living longer and are more prone to develop such conditions in line with their ageing. Such diseases dominate the list of top ten causes of death in developed countries, whereas people in the developing world are more likely to die from infectious diseases, such as HIV-AIDS, diarrhoea and malaria.

Nonetheless, this is not to say that patients should now accept that later life diseases are an insurmountable consequence of society's progress in healthcare. In fact, patients can now reasonably demand even further advancements that allow more diseases to be overcome.

Fortunately for patients, medical innovation has not reached its end and the famous quote in 1899 by the

US Office of Patents that "everything that can be invented has been invented" should teach us all not to lose faith about the potential for ingenuity in the future. If necessity is indeed the mother of invention then we should now ponder where medical innovation could lead us in the future.

More accessible healthcare

Modern consumer habits mean that today's patients are much more demanding of easy-to-access healthcare treatment. No longer are patients willing to accept long waiting lists for operations, time-consuming booking systems for family doctors or an inability to access medical opinion at the touch of a button. This inclination is not necessarily because patients are unacceptably insistent today but because they recognise that such obstacles are no longer necessary.

More accessible healthcare systems in the future will inevitably need to make strides in the field of eHealth, which has up to now been surprisingly slow in its uptake. The development of eHealth sees healthcare treatments combined much more with information technology, allowing for electronic health records, telemedicines and consumer health informatics. Such developments can improve healthcare treatments for patients, as well as making healthcare more efficient and dynamic. Yet, it is still unclear how long it will take policymakers to overcome concerns about the initial cost of implementing such measures.

More personalised healthcare

If eHealth can be rolled out further then this would certainly fulfil another demand of patients: the desire for more personalised treatment. No longer do patients want to be treated as a homogenous mass, primarily because they have realised that medical evidence proves that they in fact are not all the same. Whilst one-size-fits-all healthcare can have its advantages in areas of public health, such as immunisation, the reality is that most diseases are much more complex. Semashko healthcare systems during the Cold War, which were entirely socialised, proved woefully

inadequate in dealing with individually treating patients and life expectancy, as a result, lagged far behind Western healthcare systems by 1990.

Yet whilst progress has been made in the West, many treatments are still being administered simply on the basis that the patient is human. Most medicines in Brazil, for example, are the same pills that are consumed in the United Kingdom, whilst often the only difference between medicine for a five year old and an 85 year old will simply be the dosage. This is why more research is now being now into personalised medicines, which are designed to tailor treatments towards specific subsets of a population.

More effective healthcare

Personalised medicine aims to create more effective medicines and reduce the side-effects for patients. Such benefits often drive medical innovation, as research is very often targeted towards filling gaps in treatment needs. In the future, therefore, it can be expected that even greater investment in research and development will generate further advances in the effectiveness of healthcare treatments.

Scanning technologies, which constantly improve the effectiveness of treatments, have continued to develop. Whether it is x-ray, computerised tomography (CT), magnetic resonance imaging (MRI) or newer positron emissions tomography (PET) scanning, medical innovations have persistently been providing added benefit to the treatment of patients.

More expensive healthcare

Yet in truth, the price that will surely be paid for more accessible, personalised and effective healthcare is likely to be larger healthcare budgets. Innovation, after all, does not come for free and developing more sophisticated treatments in new disease areas requires

heavy incentives and investment. Such rises in health costs, however, are likely to further compound the notion that healthcare systems are currently unsustainable. We should therefore also think about how we can modernise these systems to combine 21st century healthcare treatments with 21st century healthcare policies.

On average, current health spending per capita in the most developed countries is 19 times the amount that it was in 1970. As a percentage of GDP, health spending has also grown considerably since 1970. Certainly, this is no new premise and plenty of studies have contended as much, calling for greater urgency from policymakers in tackling such challenges.

Conclusion

So it becomes increasingly obvious then that healthcare systems are likely to change. Whilst it is encouraging that such developments are going to be designed to keep people alive for longer, such progress will inevitably come at a cost. Therefore, policymakers should be looking to pre-empt changes in healthcare and aiming to install reforms that will better accommodate such changes.

The best way to prepare for more accessible, effective and personalised treatments would be to implement reforms now that make the current healthcare system more accessible, effective and personalised. To do this, patients need be empowered.

In financing healthcare, there needs to be a greater balance between private and public funding, allowing for more flexibility and choices. Furthermore, there needs to be a reform of the relationship between patients and their health services, which could turn the emphasis towards what patients want. Last but not least, further competition in health services will increase accountability of such services to patients.

BOOK REVIEW – 2030: THE FUTURE OF MEDICINE (DR RICHARD BARKER)

Helen Disney, CEO and Founder of the Stockholm Network

What will medicine look like in twenty years' time? How is science going to reshape our quality of life and what impact will this have on how we organise and pay for our healthcare systems? These fundamental questions are the subject of a concise new booklet by Dr Richard Barker entitled *2030 The Future of Medicine: Avoiding a Medical Meltdown*.

While the title sounds rather pessimistic, this neatly-organised 100 page 'think piece' in reality provides a great deal of optimism about what the future of medicine holds. Via a series of case studies, recounted through the lives and illnesses of a fictional family, The Carters, Dr Barker shows how new advances in medicine will be able to transform our lives and enhance patient care. There are many coming innovations from the so-called \$1000 genome, which will help us predict the likelihood of future disease and thus adapt our behaviour, through to even more controversial developments such as the creation of 'nootropic drugs' to enhance brain function. Perhaps all policymakers should be given a prescription for these?

What all of these treatments have in common, however, is the increasing personalisation of medical care. As the physician Oliver Sachs is quoted as saying "Don't ask what disease this patient has, ask what patient the disease has". Yet Dr Barker argues that talk of personalised medicine is currently over-ambitious, partly because of the cost and also because it is often unnecessary from a medical point of view. Instead he prefers to talk more realistically of 'stratified medicine' meaning the use of targeted therapies which can save money as well as save lives.

Innovation will also come from the IT sector, not just from medical science, and again this promises some revolutionary changes for both patients and professionals. Cutting-edge technologies already in use in parts of Europe include Denmark's national Patient Health Portal and France's 'Diabcarnet' which monitors diabetics via the first large-scale electronic logbook for a disease, enabling patients to partner with doctors to manage their own care. There is a great deal for patients to look forward to.

Yet while such new technologies are all very well, is there much point in discussing them if our future health

systems are unable to afford them? Our insatiable demand for healthcare does indeed put us at risk of the medical meltdown referred to in the book's title, unless we act rapidly to change the way we organise and pay for healthcare. Growth in health expenditure is rapidly outpacing GDP growth in all advanced economies. So what is the solution?

The book identifies 10 key 'levers' which we need to use to prevent the medical meltdown. Chapter 3 outlines each of these levers in detail arguing for an overall approach of prevention rather than cure: "the only viable long-term option is to proactively tackle demand growth, make new technology more affordable and turn the patient into a consumer, making informed choices and actively participating in the funding equation. We must also make unprecedented strides in healthcare productivity, to close the gap between a fast-rising healthcare spending curve and what our society can afford."

These are the key points which must drive future policymaking and Dr Barker makes an effective case for change. He points out some hard truths that we need to face including the words of a senior British doctor who estimated that one-third of health spending in the NHS is wasted – no business would survive with this level of waste. The other major system referred to in the book – the US health system – fares little better with a 2009 survey of young Americans showing that 96% agree 'the health system is broken and needs fundamental change'.

Neither the top-down tax-funded NHS nor the US private insurance model currently fulfils the criteria needed to sustain the healthcare needs of the future. So does Dr Barker have a preference for state or market-based solutions? In the final analysis he does not come down on one side or the other, recognising perhaps the need for both elements to play their part in the system and concluding that: "the key thing is not the amount of market-making or central structuring [but] whether the system...can use the 10 levers effectively. Most of these levers are in the hands of others and wise governments recognise this".

We can only hope that governments of the next twenty years are indeed as wise as this important book.

HEALTH OF THE NATION – UNITED KINGDOM

This new section of Gesundheit! explores individual healthcare systems throughout Europe and analyses the landscape for reform. It begins by looking at the United Kingdom and assesses the National Health Service in light of radical proposals for change by the UK coalition government.



Since 1948, patients in the United Kingdom have had free access to the National Health Service (NHS) – a fully public, single payer, universal healthcare system. Upon its introduction, its chief architect, UK minister of health Aneurin Bevan, argued powerfully that “money ought not to be permitted to stand in the way of obtaining an efficient health service” and thus established the founding principle of the NHS: that it should exist free at the point of use.

Despite some early challenges to this notion, most notably in the introduction of prescription charges for dental care and spectacles, over which Bevan resigned from the government, there has been very little fundamental reform of the complimentary nature of the NHS.

THE NATIONAL HEALTH SERVICE

The NHS is financed through mandatory payroll taxes that are paid by employees, whilst employers also contribute through national insurance payments. All citizens working in the UK are required to make these contributions if they are calculated as earning over a certain level per annum, currently set nationally at around £7,000 upwards for income tax. However, payment of such taxes is not a prerequisite for treatment in the NHS.

In fact, anyone who is a resident in the UK can access NHS services free at the point of use. One of the few exceptions to this, in addition to dental and optometry services outlined above, exists only in England for prescribed pharmaceuticals. English patients in the NHS are sometimes required to pay a fixed co-payment or prescription charge (currently £7.40), although this affects only around 10% of all pharmaceuticals prescribed in the NHS once a host of exemptions are taken into account.

In England, contributions made through payroll taxes are collected centrally and distributed to ten regional Strategic Health Authorities (SHA), who set priorities and budgets for individual Primary Care Trusts (PCTs),

which commission health services for their given population (on average around 340,000 people). In total, there are just over 150 PCTs, through which 80% of the total NHS budget is spent. In Scotland and Wales, services are commissioned through NHS Boards and Local Health Boards respectively.

Most patients' experiences with the NHS begin with an appointment with their general practitioner (GP). These primary care physicians, of which there are 36,000 in the UK, act as gatekeepers for secondary care, to which patients are not permitted direct access. Patients must obtain a referral, subject to consultation, from their GP in order to be able to visit a hospital or specialist. The logic behind the gatekeeper system, also common in Scandinavian countries, is that costs can be controlled by reducing unnecessary interventions. In addition, GPs are also generally believed to have a greater knowledge of the quality of care available from secondary care providers thus allowing for secondary care to be used more efficiently.

CHALLENGES

Healthcare funding

Over the next year, £126 billion will be spent on healthcare by the UK government, which accounts for around 18% of all public spending in total. This public funding usually accounts for around 83% of all health spending in the UK and compares unfavourably with its European neighbours. For example, both France and Germany spend more on health through public means per capita than the UK. In addition, health spending through private means also accounted for more of the total spending on health. Furthermore, the United States spends \$1,000 of public money more per person on health than the UK, yet this public spending accounts for only 46.5% of the total spending on health.

A major contributing factor to this discrepancy is the low level of private health insurance in the UK. Only around 10% of the UK population currently has voluntary health insurance, provided privately, and most

are either individual insurance plans that supplement NHS care or corporate plans offered by employers as part of their benefits package for employees. It had previously been the case that patients were prohibited from supplementing an NHS treatment with private care, for example paying for private diagnostic tests that can put them further along a waiting list, with the logic being that this would create a two-tier system. Yet, increasingly controversial examples of cancer patients privately purchasing medicines too expensive for the NHS and subsequently being denied basic NHS care, forced a government review and finally, in November 2008, a lifting of the ban.

Patient access

The decision by the NHS to deny certain treatments from being made available has become a controversial aspect of UK health policy over the last decade, ever since the establishment of the National Institute for Health and Clinical Excellence (NICE). NICE is tasked with performing cost-effectiveness assessments on pharmaceuticals and deciding if they are likely to cost more than £30,000 per quality-adjusted life year (QALY), in which case they will usually not be made available.

Such decisions, along with the longer than usual period of time it takes to make them, are the main reason that UK patients have a relatively low level of access to new and innovative medicines, in particular to cancer drugs. In fact, lack of access to such medicines was deemed such an important issue that the Conservative Party campaigned in the 2010 general election for the creation of a Cancer Drug Fund, which would provide patients with expensive treatments on a case-by-case basis. In government, this commitment was honoured, though it will only be in place temporarily until 2014.

“Postcode lottery”

Another prominent feature of the NHS in recent years has been the perception of a wide variation in the quality of health services across the UK. Much of this has spawned from an often inflexible arrangement that prevents patients from accessing services outside of their residential area, thus creating a notion of being forced to endure inferior services.

Whilst in theory patients have a choice of which GP they register with, in practice most surgeries operate a catchment area system where only those within the area are able to register. Whilst patients do have the right to choose which hospital they are treated in for secondary care, the distance between “competing” hospitals, as well as a lack of information, often means that most patients go to whichever provider their PCT designates.

Postcode lotteries are also even seen to create a variation in patients accessing medicines, which have been denied by NICE, but which can be provided on an “exceptional basis”. Research has shown that appeals against the decision to deny an individual patient treatment can widely vary between PCTs within just a few miles of each other.

THE CURRENT CONTEXT FOR REFORMS

In January 2011, the UK coalition government presented a bill to parliament which proposes radical reforms to the NHS. Many of the reforms had been formulated long in advance by the Conservative Party shadow health team whilst they were in opposition.

GP commissioning

Key to the government’s plans are measures that will abolish both PCTs and SHAs, creating in their place consortia that would be managed by GPs. This would give GPs more responsibility for spending the health budget, allowing them to control almost 80% of total health spending.

This practice-based commissioning would be an extension of the GP fundholding scheme that was introduced by the Conservative Party in the early 1990s. Health secretary Andrew Lansley believes that commissioning by GP consortia will allow the NHS to be more responsive to patients.

Any willing provider

In addition to moving commissioning powers to GPs, the planned reforms of the NHS will also introduce the principle that commissioners should be able to buy services from “any willing provider” so as to create greater competition between services. The idea is to

facilitate a greater range of accredited providers, including those from the private sector, as opposed to formal tendering processes that can often restrict competition.

Value-based pricing

For pharmaceuticals, a value-based pricing system is set to be introduced that would alter how medicines are paid for by the NHS. It would work by determining a range of maximum thresholds that would be set to reflect the values that different medicines offer. In doing so, the government believes it can create greater incentives for the pharmaceutical industry to invest in unmet needs and for treatments for more severe conditions.

CONCLUSION

In truth, the plans to restructure the NHS are far from finalised and the government has recently decided to pause the legislative process, in the face of a wide range of criticism over their plans. In particular, opposition from key health professionals, such as the British Medical Association and the Royal College of Nursing, has created the impression that reforms are being undertaken without bringing key stakeholders onside.

Furthermore, the promise to increase health spending in real terms until 2015 will also be difficult to maintain given current fiscal constraints and high inflation, although it is likely that this pledge will be honoured even at the expense of other priorities.

RECENT DEVELOPMENTS



EUROPEAN UNION

The European Parliament has approved the Cross-Border Healthcare Directive, which will make it easier for EU residents to seek medical treatment anywhere within the Union.



AUSTRIA

Austria, which has one of the highest smoking rates in Europe, has installed a new law that will require most restaurants to set aside partitioned seating areas for non-smokers.



BELGIUM

Prolonged coalition negotiations could see healthcare devolved to regional authorities, as part of a concession to the New Flemish Alliance – the largest party in Belgium.



BULGARIA

The Bulgarian government has decided to delay any further radical reform to health services, in line with its recently published National Health Care Map, because it is concerned that they may prove unpopular.



CYPRUS

Despite a 2013 deadline imposed by the EU Cross-Border Healthcare Directive, the Cypriot government has had to postpone the design and implementation of a National Health Service because of cost concerns.



CZECH REPUBLIC

Doctors in the Czech Republic may soon be required to prescribe cheaper generic medicines from mid-2012, according to the Czech health minister.



DENMARK

Proposals by the Danish government, which are designed to make foreign residents "earn" access to public services, could see foreigners pay to visit a doctor in their first two years of residence.



ESTONIA

Recent official figures have shown that 6% of Estonians (82,000) have no health insurance, which is 30,000 residents more than last year.



FINLAND

New laws will give patients the right to choose any public health clinic in their municipality, creating more competition and consumer choice.



FRANCE

The discarded umbilical cord of a healthy French baby has been used to help cure his sibling of a genetic blood disease, sparking a bioethical debate in France over the use of stem-cell research.



GERMANY

€700 million has been put aside by the German finance ministry to help lower-income citizens pay their health insurance premiums.



GREECE

The terms of an EU-IMF bailout will inevitably see cuts to the Greek healthcare budget, at a time when healthcare professionals have already been striking to protest austerity measures.



HUNGARY

The Hungarian health ministry has announced plans to consolidate most of Hungary's state health care institutions into a single organisation, Gyemszi.



IRELAND

Doctors in Ireland have complained that over-regulation is undermining their relationship with their patients, as new rules require GPs to maintain up-to-date medical knowledge and quality standards.



ITALY

A influx of immigrants from North Africa has triggered fears of a health epidemic in Italy and a conference is planned with the European Commission to discuss the issue.



LATVIA

Latvia's health ministry is encouraging GPs to prescribe more medications, in order to prevent costly hospitalisation for the elderly and those with chronic conditions.

**LITHUANIA**

A recent report into the price of health and dental services has shown that treatment in Lithuania is the cheapest in the EU.

**LUXEMBOURG**

The number of health professionals in Luxembourg has increased by 77% since 2000 yet, despite this, parliament continues to debate whether Luxembourg's medical workforce is sufficient.

**MALTA**

A recent report has found that 70% of immigrants in Malta have encountered difficulty in accessing health services, whilst Maltese law is still unclear on immigrants' rights to health care.

**NETHERLANDS**

The nationwide adoption of electronic medical dossiers has been delayed by the Dutch Senate, because of concerns over privacy and effectiveness.

**POLAND**

The Polish government has proposed a tax deduction on private health care premiums, which the government estimates would see up to 10% of patients purchase private health insurance.

**PORTUGAL**

Prime Minister Jose Socrates has argued that the healthcare system should be preserved from tough austerity measures generating from the EU/IMF bailout negotiated recently.

**ROMANIA**

The Romanian government has announced plans to build a network of six emergency hospitals under private-public partnerships.

**SLOVAKIA**

Slovakia's Constitutional Court has struck down a 2007 law that prohibits private health insurers from paying dividends to shareholders

**SLOVENIA**

The European Commission has referred Slovenia to the ECJ due to concerns that complementary health insurance rules could lead to distortions in the Single Market for insurance and less choice for Slovenian consumers.

**SPAIN**

Government austerity measures have placed further pressure on the research budgets of Spanish biotech companies.

**SWEDEN**

Sweden's National Board of Health and Welfare currently faces a backlog of 3000 medical malpractice complaints, after it took over processing of malpractice cases from the Medical Responsibility Board.

**UNITED KINGDOM**

A report by the Institute for Fiscal Studies has suggested that a guarantee made by the UK coalition government to increase health spending in every year over the next four years may not actually be realised, due to rising inflation.

STOCKHOLM NETWORK EVENT

THE WELFARE STATE AFTER THE CRISIS

Since its inception, the Stockholm Network has set out to debate the way public services are provided in Europe and to argue for greater efficiency and consumer choice. Britain has experimented with aspects of market-oriented reform and with ideas from other countries but such reforms are nevertheless still viewed with suspicion. Yet a new government and a new economy makes a revolution in the way public services are provided in the UK unavoidable. No longer just the territory of think tanks, the debate about the role of the state in public services is now leading the news agenda.

This half-day seminar looked at realistic options for public service reform which will attempt to contain the impact of cuts. It offered examples from other European countries and argued that a rethink of how services are provided and what government does may be unpopular but is now the only practical way forward.

Participants included:

Lord Freud is the Parliamentary Under Secretary of State (Lords) for the Department for Work and Pensions. He was appointed the shadow Minister for Welfare Reform in February 2009 and was also a member of the Economic Recovery Council advising David Cameron from February 2009 to May 2010. Between January 2008 and February 2009 he acted as adviser on welfare reform to the UK Government.

Hans Ouwehand is director of Calder Holding, a group of companies specialising in delivering a range of services associated with welfare to work, citizenship, occupational and mental healthcare and debt counseling. Prior to moving to the private sector, Hans was the executive director of the disability department of the

Dutch social security carrier UWW and responsible for the implementation of the Gatekeepers legislation and the re-assessment for the disabled population.

Gavin Poole is the Executive Director of the Centre for Social Justice (CSJ). The CSJ is an independent think tank established by Rt Hon Iain Duncan Smith MP in 2004 to seek effective solutions to the poverty that blight parts of Britain. Gavin joined the CSJ having completed 23 years of military service in the Royal Air Force where his final appointment was as a Ministerial Private Secretary within the MoD.

Nick Timmins has been the Public Policy Editor of the Financial Times since 1996. He was a founder member of The Independent and before that he worked for The Times. He is author of *The Five Giants: A Biography of the Welfare State*.

Jason Turner served from 1998-2001 as New York Mayor Rudy Giuliani's welfare commissioner. During his tenure, Turner created the largest work program in the country. Prior to his work in New York, Turner was well known as one of the chief architects of the Wisconsin welfare-to-work program.

Helen Disney is the chief executive and founder of the Stockholm Network. Helen is formerly an editorial writer for The Times and an editorial writer and commentator for the Daily Express. From 1996-2000, she worked at the Social Market Foundation, an independent pro-market think-tank, where she was deputy director and editor of its quarterly journal.

The event was featured in a number of publications, including the *Financial Times*, *Money Marketing* and *Public Service Europe*. Videos from the event can be viewed in full at: <http://tinyurl.com/5wspfrm>.

STOCKHOLM NETWORK PUBLICATIONS

KEEPING MEDICINES SAFE – EXTENDED

By Paul Healy and Dr Meir Pugatch

The Stockholm Network Patient Safety Series puts patients' wellbeing and better quality of care at the heart of all our policy recommendations. As part of this, this paper is a follow-up to our *Keeping Medicines Safe* paper, which looks at the spread of substandard medicines and highlights the regulations used in the approval, manufacture, sale and use of medicines.

Our last paper, *Keeping Medicines Safe*, looked at substandards in Argentina, Brazil, China, India and Turkey. This new paper, *Keeping Medicines Safe - Extended* provides a complement to this with case studies of Egypt, Peru, Russia and Thailand.

It concludes that the four countries studied in this paper all have flaws in how they regulate against substandard medicines reaching the market, the proof of which is in the scale of inferior products that are consumed within their healthcare systems today. The reasons why these countries suffer from high incidences of substandard medicines vary, yet there are a few common themes that present themselves in all four countries:

- Ineffective legal and regulatory frameworks;
- Ongoing gaps between the "text book" legislation and practices on the ground; and
- Lack of transparency, rule of law and even exposure to corruption.

The paper also offers constructive policy recommendations generally, in regard to tackling the spread of substandards, as well as specifically, in regard to what each individual country should do to best protect their citizens from harm.

A NEW VALUE-BASED APPROACH TO THE PRICING OF BRANDED MEDICINES

By Paul Healy, Dr Meir Pugatch and Helen Disney

The Stockholm Network has made a submission to the Department of Health consultation on the decision to move to a new system of drug pricing for branded pharmaceuticals in the National Health Service (NHS). The reforms would see branded pharmaceuticals which were launched after 2014 being priced using Value-Based Pricing (VBP) and not by the Pharmaceutical Price Regulation Scheme (PPRS), the current price control mechanism used in the NHS.

The submission argues that whilst the Stockholm Network supports the reform's proposed aims and their emphasis on better patient access to effective and innovative medicines, it has concerns about whether a move to VBP is the best way to achieve this. In particular, it notes that the proposals have the potential to be counterproductive and could, in fact, hinder pharmaceutical innovation in the UK as well as restricting patient access to medicines in the future. There is also unease at the imposed nature of these reforms, which have been formulated in opposition without adequate consultation with relevant stakeholders, and the seemingly top-down nature with which they are likely to be implemented.

The Stockholm Network hopes that this consultation will allow a more open dialogue to emerge and that the government is willing to revise the reforms to allow changes to be made to make them more practical and implementable.