

# Multi-Indication Pricing: Pros, Cons and Applicability

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## 1. BACKGROUND

- Many medicines currently available, and many more in pharmaceutical industry pipelines, are likely to be effective in multiple indications – oncology prime example
- Assessment of value for oncology products more complex
- Prices paid for branded medicines should aim to reflect their value – thus, for multi-indication medicines, prices should be different across indications to reflect their different values
- Yet current pricing and reimbursement systems are not equipped to handle this
- There tends to be one single (uniform) price across all indications => price and clinical value will rarely match up across multiple indications
- A single, uniform, price across indications has negative consequences
- Some current pricing models do allow for what is termed as “blended” pricing – mostly volume driven

## 2. AIMS

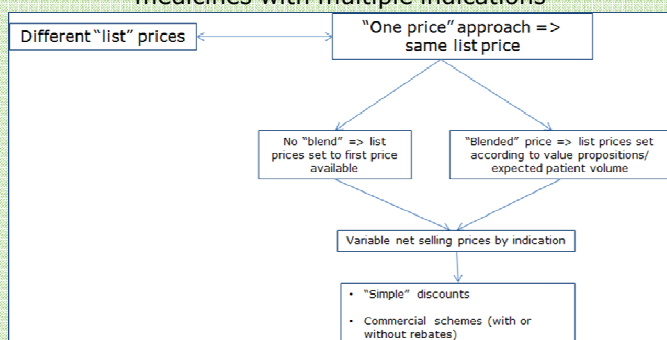
- ‘Multi-indication pricing (MIP) involves setting a different price for each indication approved for the medicine
- Two questions:
  1. Can MIP be a flexible pricing scheme that delivers a sustainable solution?
  2. If it does, can MIP be implemented in the UK, and how?

## 3. METHODS

1. Desk research on MIP and set up conceptually the effects of MIP versus uniform or flat pricing (i.e., same price across all indications)
2. Workshop (held on the 26 January 2015 at The Royal Society, London) with healthcare system stakeholders to discuss the pros and cons of MIP and the practicalities of implementing MIP in the UK

## 4. RESULTS

Framework to outline possible MIP schemes for medicines with multiple indications



Is MIP possible in the UK? Two operational challenges:

1. Whether the NHS can handle MIP schemes involving variable net selling prices by indication, requiring monitoring of volume usage per patient per indication, and undertake any financial reconciliation ex post to ensure that the correct funds flow across the necessary stakeholders, be it at national or local level
2. Data availability: are there data sets which allow such monitoring of volume usage per patient per indication, and is the necessary data being generated routinely or requiring ad hoc intervention?

Examples of MIP in some countries administered through different brands of the same molecule for very different conditions

## 5. DISCUSSION

- All stakeholders present at the workshop were interested in the potential use of MIP but many were sceptical of the ability of the NHS to get good value from its use.
- There was general support on the notion of relative prices reflecting relative value, but it was important that price did not exceed value in any indication.
- There is a need to ensure collaboration across all stakeholders (NHS, industry, patients, doctors, nurses and other health care professionals) if the NHS were to benefit from any future pricing scheme(s) that allow different prices across indications.
- If MIP were pursued, there was interest in using either (i) “blended” pricing (at list level) or (ii) schemes that might generate variable “net” selling prices.
- NHS’s Systemic Anti-cancer Therapy (SACT) data can in principle support the implementation of MIP, albeit with challenges. The current UK collaboration will help us understand whether the SACT dataset could in practice underpin such pricing systems

## 6. CONCLUSION

- Handling multiple indications within the same disease area – including different potential lines of treatment and/or combination regimens – is a challenge
- Innovative pricing schemes require potential to track the specific utilisation of the drug in its different indications, regimens and patient sub-populations
- The (limited) international experience shows that certain health systems have already accumulated significant experience in the form of indication-specific net selling-price arrangements, both at the national and at the sub-national levels
- There is also a need to consider the dynamic-pricing case, given the interest in adaptive pathways

### (Selected) References

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