Practical Issues in Making Funding Decisions A Private Funder Perspective

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Can We Fund The Un-fundable?

Practical view in current reimbursement environment

Private Heath Sector Enquiry

Single consistent outcome is: **regulatory failure** in all aspects allowing or even protecting, perversity in services and pricing

Aim: To highlight Practical Implications of HTA in current Funder Landscape

- Who uses it?
- What is it used for?
- Is it worth it and does it matter?
- Does it influence decision making?
  - Funding vs not funding?
  - Benefit design?
- Can we afford to have HTA or should we just look at price like always?

Who Uses HTA?

- Majority of funders in SA require HTA submissions for adjudication process for funding
  - Outcome from funders are inconsistent and often very superficial in response
  - Lack of insight is alarming
  - Inconsistent application of same “tool set”
  - Patient perspective is seldom part of the outcome or feedback received

What is it Used for?

- Formulary listing of medicines: however this is mostly a **budget impact analyses (Silo based approach as that is the reimbursement model of administration)**
  - **Premium impact is the holy grail**
- When true HTA and multicriteria decision processes are encountered these are reserved to high cost items only.
- Often new items are considered for addition and not for replacement; thus adding cost
- Retrospective analyses of ingrained, costly and ineffective interventions are seldom if ever revisited but perpetuates due to supply and demand pressures (“at least we are doing something”)

HTA: Is it worth the effort and does it matter? Does it influence decision making?

- Most new interventions are submitted to funders with international HTA analyses adapted for SA market with local values
- The problem is that the “black box” of decision making inside the funder is not available to the receivers of the decision – the patient!
- Over the years little has changed and each fund make their own decision with their own criteria and the main criterium is set by the actuaries and that is: “medical inflation”: upward pressure on the cost to treat.

HTA: Is it worth the effort and does it matter? Does it influence decision making?

Oncology example: The cost of chemotherapy drugs have declined significantly over the last 10 years with most of the earlier molecules being genericised. The problem is that the introduction of a newer and life saving therapy is hampered due to the perception of cost with limited appreciation of full impact on contributing society. Cost drivers are: futile care, unnecessary care, and in-appropriate care (ICON analyses)

Can We Afford Not to Have and Official Independent and Collaborative HTA body?

- HTA of treatment (all) should follow the same principles of access and equity
- Pronounce on cost effectiveness in different settings
- User of analyses should have to demonstrate in a transparent way why they accept and implement vs oppose to adopt
- Displacement of costly (low value) care should be a systematic process
- Differential pricing is a global reality even inside countries

Int. J. of the Economics of Business, 2015
Vol. 22, No. 2, 263–275, http://dx.doi.org/10.1080/13571516.2015.1045747

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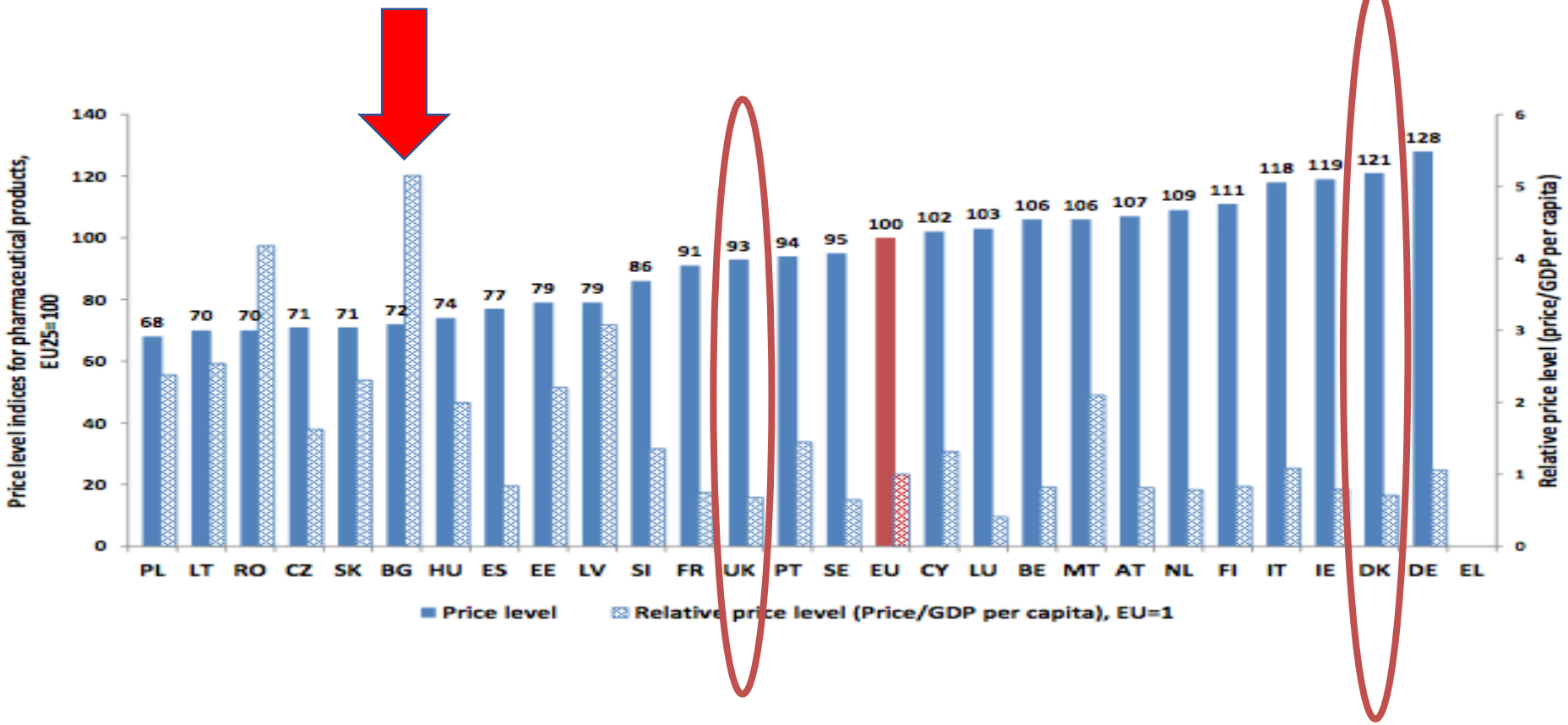
European Union Pharmaceutical Markets: A Case for Differential Pricing?

ADRIAN TOWSE, MICHELE PISTOLLATO, JORGE MESTRE-FERRANDIZ, ZEBA KHAN, SATYIN KAURA and LOUIS GARRISON

ABSTRACT *Differential pricing has been considered extensively for its potential to increase access to medicines in low- and middle-income countries. A differential pricing system applied within an economic union (such as the European Union [EU]) comprising high-income and middle-income countries would also increase access and provide stronger incentives to invest in the R&D of innovative medicines. Access to innovative medicines is limited in EU markets with relatively low GDP per capita, indicating that the current pricing system does not promote efficient access. This article looks at how theory could be put into practice suggesting ways to implement a differential pricing system in the EU that can enhance overall welfare.*

Price level index for pharmaceutical products in 2005, EU25=100

Low GDP economies cannot sustain innovation



Source: European Commission Directorate-General for Economic and Financial Affairs (DGECFIN);
Cost-containment policies in public pharmaceutical spending in the EU By Giuseppe Carone et al 2012

Drug Development Costs

- Biopharmaceutical companies have incentives to develop new innovative medicines **only if they can profitably recoup investment costs**. c 2 – 2.6 billion US$ per successful drug
- Pharmaceutical R&D is a global joint fixed cost meaning that costs cannot be causally attributed to specific countries, and sunk at launch.
- **This has significant implications for the prices that different groups of buyers, with different abilities and willingness to pay, should efficiently be charged.**

- Towse et al Int. J. of the Economics of Business, 2015 Vol. 22, No. 2, 263–275, http://dx.doi.org/10.1080/13571516.2015.1045747

Willingness to Pay

Health Systems & Reform, 2(1):32–38, 2016
Published with license by Taylor & Francis Group, LLC
ISSN: 2328-8604 print / 2328-8620 online
DOI: 10.1080/23288604.2015.1124172

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Research Article

Using Cost-Effectiveness Evidence to Inform Decisions as to which Health Services to Provide

John Cairns*
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1. Multiple thresholds may be considered based on burden of disease and trade-offs/opportunity costs
2. GDP based calculations may be unsustainable

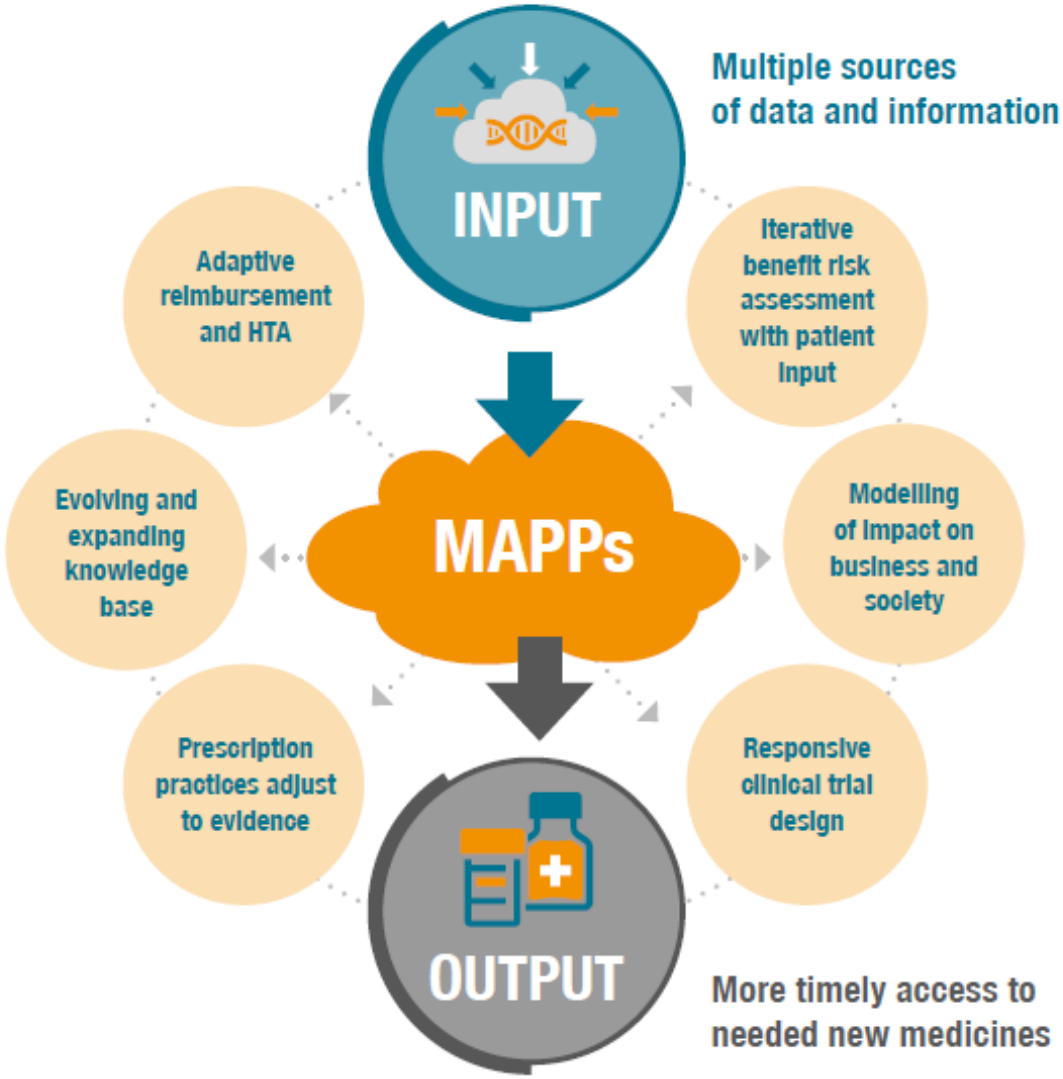
What about faster access to more sophisticated/expensive treatment

MAPPS

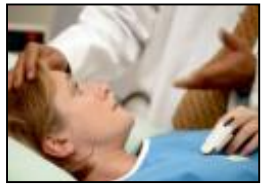
Wats new: Medicines Adaptive Pathways to Patients (MAPPs)

- Luxembourg, EFPIA Annual Meeting, June 2015
- Faster access and benefit with in regulatory frame work
- Should South Africa bother?

…To Industry, Patients, Payers, Providers, Regulators



How Will MAPPs Benefit Stakeholders?*



For patients and providers

- Earlier access to promising new medicinal products
- Lower *realised* harm

For regulators

- Continuous reduction of uncertainty throughout the lifetime of the product
- New risk management paradigm that may restore public confidence

For payers

- Adaptive reimbursement plan to align value with price and utilisation
- Continuous risk/benefit information flow to better support (follow-on) coverage decisions

For the pharmaceutical industry

- Earlier revenue stream; staggered development costs
- Decrease risks of (costly) late stage failures and post-market withdrawals

** Based on HG Eichler's presentation of 4 June 2015*

What will change with adaptive pathways?
Achieved for identified “orphan drug”

- Transition from …
- Magic moment → life-span management (RWE)
- Prediction → monitoring (RWE intent and claims data)
- RCT only → toolkit for evidence generation
- Big populations → small populations (small cohort exposed)
- Focus on licensing → focus on patient access (SAHPRA to be consulted)
- Open utilisation → managed utilisation (continuous measurement)