

Suitability of value based pricing implementation

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Therapeutic benefits will give NHS poor value for money. According to the Department of Health consultation which happened in 2017, they suggested that Levothyroxine Sodium should not be routinely prescribed in primary care, since of the huge increase in cost. Their decision was that any new patients must be referred to an endocrinologist to ask for a trial. Yet, some patients' GPs and endocrinologists are, however, prescribing Levothyroxine Sodium on a private prescription which they can then use to obtain from outside of the UK at a much cheaper cost.

NHS and manufacturers

Although the NHS spending was not mentioned a lot in this research, it is worth to mention the relationship between the prices under VBP and the NHS. As Keyworth and Yarrow (2007) argued previously that the VBP might not necessarily reduce the NHS spending, if new and valuable pharmaceuticals are developed that command higher prices. This can be considered true, taking the example of Simvastatin, the therapeutic value of this drug remarkably exceeds its best alternative value by 0.55 QALYs. And looking at their prices, Rosuvastatin is sold at a much higher price by the same companies that produce Simvastatin. If the NHS were to implement the VBP, and change the price of Simvastatin at a higher rate to be able to represent the added benefit, then this will raise the NHS spending on prescription cost. While, the other way around would reduce the manufacturer's revenue from supplying the drug, hence fewer incentives for innovation.

Also, the report notes what Claxton et al. (2008) and Towse (2007) mentioned in their report, the VBP fails to take into consideration the price of a medicine throughout its total lifecycle, where the initial price of a drug changes significantly to its price following patent expiration. This contradicts with what Pauly (2017), Sussex, Towse and Devlin (2012) mentioned that, the VBP policy would relieve the NHS from financial distress on the long-term. However, if drug prices were at a standard range to represent the value it produces, then even after the patent expiration companies producing generics will be forced to comply with the value price standard range.

Future Research and Limitations

To investigate further, several areas where information is lacking were highlighted in the literature review and methodology. Future research needs to take into account the uncertainty shocks. Uncertainty shocks such as the burden of new disease or an economic crisis/ uncertainty, for example the case of Brexit, any unforeseen event which might cause inflation or market fluctuations in the supply and demand. These can also increase the value of a medicine in a period of time, which as a result may not be efficient to either the NHS spending, consumer's cost or manufacturer's revenue.

Another area to investigate is the suitability of the VBP on generic drugs. Another calculation method might be useful to look at is the incremental cost-effectiveness ratio (ICER), the ratio of change in costs to the change in effects. It represents the cost of the intervention to a relevant measure of its effect. Also, looking at the ex-ante and ex-post. QALY only takes quality of

life, The conclusion and limitation section should reflect the issues raised in the literature.

Conclusion

To conclude, this research has examined the suitability and feasibility of implementing the value-based pricing instead of the PPRS policy using the top three prescribed drugs in England. The aim of this research was to inspect, if prices based on value provides benefits to the manufacturers and the consumer, or it outlines a negative cost. The study used the top three prescribed drugs according to the NHS net integrated cost between 2014 and 2017. Data used was mainly secondary data and official statistics by several sources. They were all analysed using the secondary analysis approach, and the results were mainly descriptive analysis.

The findings comparison between prices under the PPRS and VBP showed noteworthy differences. In overall, Levothyroxine Sodium and its best alternative were the significant finding. Both had the same added benefit, yet completely different prices. This can be one of the reasons the cost of Levothyroxine Sodium has cost the NHS poor value for money. If the drug was taken under the VBP then it would be priced much lower than it is at present. The second finding is under the PPRS, Simvastatin and its alternative Rosuvastatin are also priced completely different. Simvastatin has a much lower price than Rosuvastatin, whereas Simvastatin has much higher value added benefit to consumers than Rosuvastatin. Looking at both of these drugs under the prospective of VBP, Simvastatin would be price higher due to its higher therapeutic value.

Finally, Atorvastatin and its alternative Pravastatin were not very much different in their added benefit and their prices only differed by 2 pence. All in all, further investigation on other drugs such as generics might lead to different conclusions. This research does not criticize the current pricing policy, it takes both the PPRS and VBP into discussion for further enlightenment. Future research might yield other findings that could help policymaker's choices.