Bringing medicines to life
Scotland

Lewis Macdonald MSP
Convener
Health and Sport Committee
T3.40
Scottish Parliament
Edinburgh
EH99 1SP

26th February 2020,

Dear Mr Macdonald,

Thank you for your letter and follow up questions in relation to product licensing and outcomes-based payment schemes.

In response to your first two questions regarding licensing, the industry is committed to playing an important role in influencing the further evolution of the regulatory process in order to ensure it is suitable for new types of medicines. However, it is also important to state that the licensing of medicines is a reserved power, and the current UK-wide system works well for all four nations.

Licensing

During the committee session there was discussion over licensing amid concerns that some manufacturers would not seek a license in smaller indications or for off-patent medicines where there is no incentive to expand an existing license.

Before responding to those points directly, I think it would be helpful to clarify the current licensing process.

Medicines are developed and licenced for specific treatment indications. The process by which a licence (or 'marketing authorisation') is granted and maintained involves a robust review and ongoing scrutiny of the medicine by a competent regulatory authority. The license holder may, over time, apply for a licence extension for additional treatment indications. These additional licenses are granted following extensive data collection.

However, sometimes the clinical need of an individual patient maybe such that it requires healthcare professionals to consider the use of an unlicensed medicine or a licensed medicine outside of its licensed indications (this is termed 'off-label 'usage). In these circumstances, the regulatory authorities will not have reviewed and approved data relating to that medicine to ensure it meets the standards for efficacy, safety and quality, either at all, or for that particular use. The ABPI code of practice prohibits the promotion of off-label treatments by pharmaceutical companies.

"Repurposing" is a concept used to describe a new use for an existing medicine which is already licenced for another treatment indication(s). The new use will usually be supported by some level of clinical data, and this may or may not, be planned to be submitted to a competent regulatory authority for licensing. In cases where the data is submitted to a regulator and is approved, the medicine will be granted a licence extension for that use as a new treatment indication.

Repurposing is perhaps of most interest to the committee and developing incentives is an issue that the wider life sciences community is exploring.

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Most recently, the AMRC (Association of Medical Research Charities) produced a report in collaboration with industry, NICE, the MHRA and various Royal Colleges to investigate how this process can be improved. The full report can be read here. The report notes that the primary route for establishing a new indication for a medicine is through the medicines licensing system.

The report made several recommendations to incentivise repurposing and some of these include:

- Extending the scope of HMRC Research & Development Tax Credits to include the repurposing of generic medicines.
- Exploring the creation of a UK Catalyst Fund to establish the UK as a leader in medicines repurposing.
- Educating clinicians to understand what prescribing resources exist to support the use of repurposed medicines.
- Empowering the MHRA to proactively communicate clinical trial protocol advice, scientific advice sessions and the Innovation Office to medical research charities, academic research groups and other stakeholders looking to conduct work into repurposing.
- Enabling the Accelerated Access Collaborative to horizon scan to ensure that repurposed medicines are included in the Accelerated Access Pathway.

More generally, the European Commission has been working on this issue through their Safe and Timely Access to Medicines for Patients (STAMP) working group. Rather than call for specific incentives, this work aims to encourage new licenses through optimising and de-risking the pathway which currently exists. ABPI have been working with the commission on a draft framework that will be deployed in a pilot.

This framework operates by improving communication between academia (who are often the first to identify medicines for repurposing), the regulator and industry partners. The process would enable an academic to contact the regulator for advice around the eligibility of a molecule, this advice would then enable the "academic champion" to take this project to an industry partner who can subsequently evaluate the risks and opportunities involved. A lack of awareness and communication between academia, the regulator and industry is often the first and largest barrier which prevents older drugs from being repurposed. This framework provides a template to de-risk and improve the process. Further reading about the STAMP project can be found here.

Finally, it is worth covering the emerging issue of "adaptive licensing". Adaptive licensing predominantly applies to new treatments where 'drug candidates' that meet a serious unmet medical need can be initially approved for use in a restricted patient group. This is then gradually expanded to broader patient populations as additional safety and efficacy data is generated. Whilst this doesn't apply to older molecules or those in limited indications, it does demonstrate that flexibility is required to ensure patients continue to benefit from fast access to new medicines.

Outcomes-Based Payment Schemes

The committee's interest in outcomes-based payment (OBP) schemes is welcome as both the industry and patients believe this represents the future road of travel when it comes to ensuring patient access to innovative medicines.

Outcomes-based payment schemes can be useful where medicines are curative but there is uncertainty about long term outcomes. In such cases, linking the price of a medicine to the outcomes achieved in the real world, over time, can expediate the access pathway. Ultimately, as treatments target smaller patient populations a degree of risk-sharing between the industry and the NHS will be necessary to ensure patients continue to benefit from new treatments.

Recommendation 21 of the Montgomery Review on Access to New Medicines called for the exploration of managed access arrangements in order to support the early adoption of a medication, and we understand that the Scottish Government is currently testing a proof-of-concept outcome-based pricing approach.

However, whilst this action is welcome, other areas of the UK are further ahead in both their collection of data and the ability to offer outcome-based payment arrangements. The current approach to negotiating Patient Access Scheme's is limiting the willingness of companies to engage with NHS Scotland, which is not true in the rest of the UK. Only once Scotland has evolved its medicines access policy environment will it be able to fully benefit from the opportunities afforded by the new voluntary scheme.

In practice, there are a number of ways outcomes-based payment schemes can work. For example, in the scenario you highlight, where a patient outcome fails to match trial performance, a variety of rebate mechanisms can work. These include:

Cost-Sharing arrangements: Price reduction for treatment cycles until patient response.

Payment-by-results: Outcomes are tracked during real-world use and payments, rebates or free stock are offered relative to a medicine's performance versus their trial performance. This type of scheme represents genuine risk sharing between both the NHS and the company.

Coverage with Evidence Development: Evidence is collected in a real-world setting to address an aspect of uncertainty. This type of arrangement is similar to the current "ultra-orphan" pathway where a manufacturer has three years to collect data relative to a product's efficacy before re-submitting to SMC.

Risk sharing: Manufacturers reimburse a proportion of the cost when the patient fails to respond.

Outcomes guarantees/ pay-for-performance: Manufacturer provides rebates or price adjustments if the drug fails to meet pre-agreed outcome targets at the individual patient level.

Conditional treatment continuation: Continued use of the drug and associated payment is based on intermediate endpoints at the individual patient level.

Hopefully, this gives you a flavour of some of the ways in which industry can help manage uncertainty through flexible arrangements. It is also worth noting that the improved outcomes achieved in clinical trials are often as a result of the additional support offered to patients. The inquiry has touched upon poor patient adherence as not only a source of waste, but a factor in poorer outcomes, and the NHS would be wise to understand why trial performance is often better than the outcomes achieved in the real world.

Furthermore, in instances where the real-world performance of a medicine exceeds its trial performance, mechanisms must exist for a manufacturer to secure reimbursement that correctly matches cost with value.

Finally, we would like to clarify one area which was raised during the oral evidence session on consumption relating to instructions for patients on what to do with unused medicines. It is currently regarded as good practice to include a statement on the Patient Information Leaflet to encourage patients to consult their pharmacist on how to dispose of their medicine.

If there are any other areas that you believe ABPI Scotland can provide additional insights and information, please do not hesitate to get in touch.

Yours sincerely,

Alison Culpan

Director ABPI Scotland