Opinion

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Caving to Trump and pharma on drug prices will cost lives, not save them

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Increasing NHS drug costs would cause thousands of preventable deaths, widen health inequalities and harm the British economy – whilst doing nothing to encourage genuine life sciences investment, argues health economist Karl Claxton.

The UK government is currently contemplating how much more it should be paying for new drugs in order to avoid painful tariffs imposed by the Trump administration – and ostensibly to encourage inward investment in life sciences and ensure the UK pays its fair share of the costs of pharmaceutical innovation.

This summer, UK ministers rejected a proposal by the pharmaceutical industry to **effectively increase costs by £2.5 billion**. A proposal reported on **by *Politico* last month** would have seen the quality-adjusted life year (QALY) measure that NICE uses to evaluate the cost-efficiency of new medications increase by 25%. That proposal stalled out for not going far enough to increase spend.

As another, likely more costly, deal is now being negotiated, it's worth evaluating just how much is at stake for the NHS – and for the health of British citizens.

The true costs of paying more

For the sake of this analysis, let's say the government agrees to spend an additional £1 billion on new drugs (not yet available as generics).

That would lead to at least 4,500 additional deaths and a loss of almost 120,000 years of life in good health each year, according to analyses developed over the last decade by myself and colleagues based on 16 years of **NHS expenditure and outcome data**.

Why such a negative impact? Simply put, because increasing the NHS bill for newly approved drugs means that the money is not available for treatment of other NHS patients. It is by now well established by a substantial body of evidence that **increasing NHS expenditure is extremely cost-effective**.

> **Both NHS and US patients are victims of long-term political failure, on both sides of the Atlantic**

Our work, together with previous evaluations, **offers causal estimates** of the health and other benefits of **changes in NHS expenditure across a range of disease areas**. With this huge increase in spend on drugs, we would see the greatest impact on reduced survival for patients with cancer, circulatory, respiratory and gastro-intestinal diseases and **significant impacts on the quality of life** for patients suffering from respiratory, gastro-intestinal, endocrine, neurological, muscular skeletal and mental health problems. On top of reducing health outcomes for NHS patients, we can also expect an **increase in health inequality**.

There would also be considerable damage to the economy, for a number of interwoven and complex reasons – among them, the fact that worse health outcomes would reduce productivity and participation in the workforce. A conservative estimate would be a loss of £6 billion with **larger long-term effects**. We also know that this will have an **impact on the adult social care sector**, increasing local authority costs by over £100 million each year. If local authorities are unable to cover this additional expenditure, we can expect a **further increase in mortality** for NHS patients, **reduced quality of life** and **increased anxiety and depression** among service users and their informal carers, and a further reduction in economic growth.

Does the NHS pay enough for drug innovation?

The argument **made by some** that these prices and the harm done to the public health objective of the NHS is **necessary for the UK to pay its fair share** to stimulate further innovation is, to be blunt, entirely false. The most recent evidence suggests that the harm done by diverting funds from other services while a new drug is on patent **is not compensated** once the patent expires and prescribing switches to cheaper generics or biosimilars.

The NHS is already paying much more than its fair share and commonly more than 100% of the very long-term benefits, incentivising more unaffordable innovations, which will

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the very long-term benefits, incentivising more unaffordable innovations, which will compound the harm done. The evidence of how innovation responds to increasing payments suggests that a fair share would be closer to 20% of the long-term value, which is much lower than **the NHS is currently paying**. However, the current pressure is for the UK to unilaterally pay more for new drugs, which will have no measurable effect on innovation as the UK makes such a small contribution to the global market.

Nonetheless, it is quite understandable that there is a real concern about unaffordable domestic prices of drugs in the US. However, the fact is that the current policy of the US administration, to negotiate reduced domestic prices in return for pressure on the rest of the world to pay more, through threats of tariffs, trade deals and the type of orchestrated pressure we have seen recently in the UK, is **unlikely to make medicines affordable for most Americans either**.

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Indeed, evidence is starting to emerge that **US citizens**, just like NHS patients, **are also paying substantially more than their fair share** for the benefits of innovation. So, this is not an issue of NHS vs US patients. Both are the victims of a long-term political failure, on both sides of the Atlantic, to ensure pharmaceutical pricing and the incentives offered reflect how much we can afford to pay for the benefits of innovation. This includes establishing mechanisms that allow different prices to by paid by different health care systems that **reflect how much they can afford to pay** for the benefits new drugs offer.

As to the claim that higher UK prices are required to incentivise investment in the UK, this is also **demonstrably fallacious**. The research and development of new drugs is for a global not domestic UK market. What determines where investments are made depends on tariffs or threats of tariffs, costs, the business environment and most importantly the research environment. If we wish to support the life sciences sector and encourage inward investment to the UK, rather than pay higher prices, we should invest in our research environment and research infrastructure.

It's also worth noting that all this evidence underscores that increasing expenditure on the NHS is very good value: improving health outcomes and reducing health inequality, while reducing social care costs and stimulating economic growth. Based on how the UK Treasury values the health and other benefits of NHS expenditure we can confidently say that **the NHS is underfunded to some considerable extent** and that the scale of underfunding has grown, especially since 2010. Asking the NHS to pick up the bill for any deal that might be done, especially if it increases the threshold used by NICE would be, to quote a **beloved 1980s British political satire**, to do a "damn silly thing in a damn silly way."

Footing the bill

Whatever amount the NHS has to pick up, in all likelihood, the bill will be for substantially more than £1billion. **Lord Patrick Vallance**, the former president of research and design GlaxoSmithKline and now our Minister for Science and previously the government's Chief Scientific Adviser, has pressed for increasing the share of health expenditure devoted to new drugs **from 9% to 14%** – which amounts to £10 billion each year.

Similarly, Tomas Philipson, President Trump's former chair of his Council of Economic Advisors, has said the UK should **increase expenditure to 0.8% of GDP per capita**, an increase of £2.5 billion. The US ambassador is also reported to be **pressing for substantial increases** prior to trade talks later this month.

Even if the money comes from somewhere other than the NHS, paying these potentially huge sums still remains a "damn silly thing" as any additional public expenditure would offer greater benefits if it was devoted to the NHS, social care or other public services. Some of any extra money could also be used to invest in the research environment for life sciences. For example, it could include investing in research infrastructure, where adaptive clinical trials could be conducted more quickly and cheaply, attracting investment in the UK, but also improving the evidence base for clinical practice, delivering health benefits for future NHS patients.

There is no denying that the UK government is in a difficult position ahead of US trade talks later this month. It can either back the NHS but risk tariffs for the UK pharma sector or hope to avoid them by conceding to these mounting pressures.

As they grapple with that choice, here are some final data points to consider: when we apply the treasury's own valuations to the impacts of an additional £1 billion bill, the loss to the UK would be the equivalent of 77% of the value of all UK pharmaceutical exports or nearly half the total contribution the sector currently makes to GDP. At £1.5 billion, the loss would be more than the total value of all UK pharmaceutical exports or more than 60% of the contribution UK pharma makes to GDP.

In other words, at the huge amounts currently being discussed, the economic self-harm would far exceed the potential hit to pharmaceutical exports or GDP we would expect from even the highest tariffs. So, by all accounts, it is time to stand up and back the NHS.

References are linked to throughout the body of this article.

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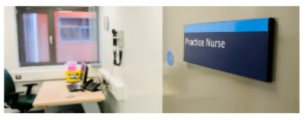

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