have a crucial role as incentives for research. Thus, drug prices are essential to support an intertwined academic–industrial system of biotechnological research, with intense competition for talents, ideas, and venture capital. As patents inevitably end, companies must constantly renew their pipeline. This cycle, although far from flawless, nevertheless shows impressive progress for patients.

Calculating the ideal price equilibrium for companies versus societal benefits is difficult. However, in our political experience, commercial investments in drug development are connected to societies' decision to protect intellectual property and pay a premium price for innovation. The difference between QALY thresholds shown by Naci and colleagues[1] might reflect this political decision. In 2022, the average price of a daily dose of generic drugs in Germany was €0·35, compared with €8·74 for patent-protected drugs.[2,3]

Drug prices can become a hurdle for equal access, and governmental regulation is needed to balance interests. Nonetheless, societies do not only face opportunity costs by investing in premium prices for drug innovations, but also when not investing in innovations, by losing advances in research for future patients. Societies might even lose momentum in technology overall. Although allocation decisions for drug spending remain difficult, politicians and citizens must recognise the multifaceted challenges of drug pricing.

We declare no competing interests.

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1 Naci H, Murphy P, Woods B, Lomas J, Wei J, Papanicolas I. Population-health impact of new drugs recommended by the National Institute for Health and Care Excellence in England during 2000–20: a retrospective analysis. *Lancet* 2025; **405:** 50–60.

2 Wissenschaftliches Institut der AOK. Drug prescription report. 2023. https://www.wido.de/publikationen-produkte/buchreihen/arzneiverordnungs-report/ (accessed Dec 15, 2024).

3 Wissenschaftliches Institut der AOK. The statutory health insurance pharmaceutical market. 2023. https://www.wido.de/forschung-projekte/arzneimittel/gkv-arzneimittelmarkt/ (accessed Dec 15, 2024).

Huseyin Naci and colleagues[1] estimated a net loss of approximately £1·25 million quality-adjusted life-years (QALYs) in the National Health Service (NHS) due to the adoption of new drugs, with costs per QALY exceeding £15 000.[1] In an accompanying Comment,[2] Victoria Charlton stated the Article[1] contributes to existing evidence that decisions by National Institute for Health and Care Excellence (NICE) might not be ethically justified, implying that the cost-effectiveness thresholds used by NICE might be too high.

Naci and colleagues provide new quantitative information within the paradigm of the extra-welfarist logic of cost-effectiveness, assuming that the sole objective of the NHS is to increase the sum of QALYs produced, given the politically determined budget (ie, allocative efficiency) of the NHS. However, both the Article and the Comment rely on controversial assumptions.[3–5]

For the estimation of QALY loss to be ethically decisive, assumptions must be made: that QALYs capture all the value generated by health interventions, every QALY is equal in worth, and QALY maximisation is the sole goal of the NHS.[3] If agreement is not reached for all those assumptions, there is no ethical problem in some QALYs being more expensive than others.

The NHS is a social institution with fairness as a core value, implying trade-offs between allocative efficiency and distributive concerns.[4] Fairness considerations include providing quality health care in sparsely populated areas and to patients with severe and rare disorders, even if entailing an increased cost per QALY. Citizens have strong fairness preferences,[5] and NICE is correct in attempting to take these preferences into account.

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1 Naci H, Murphy P, Woods B, Lomas J, Wei J, Papanicolas I. Population-health impact of new drugs recommended by the National Institute for Health and Care Excellence in England during 2000–20: a retrospective analysis. *Lancet* 2025; **405:** 50–60.

2 Charlton V. What price is society willing to pay for new drugs? *Lancet* 2025; **405:** 3–5.

3 Dolan P, Shaw R, Tsuchiya A, Williams A. QALY maximisation and people's preferences: a methodological review of the literature. *Health Econ* 2005; **14:** 197–208.

4 Olson JA. Concepts of equity and fairness in health and health care. In: Glied S, Smith PC, eds. The Oxford Handbook of Health Economics. Oxford: Oxford University Press, 2011: 814–36.

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Analysis by Huseyin Naci and colleagues[1] overlooks the broader policy context influencing the National Health Service expenditure on branded medicines. The Department of Health, through the Voluntary Scheme for Branded Medicines Pricing and Access scheme and the commercially equivalent statutory scheme,[2] ensures the branded medicines budget growth rate (2%)[2] remains below the overall health-care budget growth rate (5·9%).[3] If the National Institute for Health and Care Excellence (NICE)'s decisions lead to expenditure surpassing the agreed amount, the pharmaceutical industry covers the excess via rebates—estimated to be 22·9% of branded medicine sales revenue in 2025.[4] Therefore, the branded medicines budget is effectively ring-fenced.

Even if NICE approves medicines at a suboptimal threshold, there should be no adverse effect on population health,