TRANSPARENT, TIMELY AND HIGH QUALITY HTA EVERYWHERE IN THE EU IN OUR INTEREST

9th European Conference on Rare Diseases

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EURORDIS's arguments in favour of the proposal

- *EU citizens demand EU to take action in health policy. 70% of people would like the EU to intervene more, while 49% feel current EU action is insufficient (Eurobarometer June 2017)*
- *Decision-making based on scientific and medical evidence, everywhere in the EU: "evidence is global, decision is local"*
- *Solidarity between Member States is a funding principle of the European Union*
- *HTA cooperation on a voluntary basis has its limits*
- *The proposal introduces fairness, high scientific standards and efficiency in the evaluation and subsequent decision-making process, in the interest of the patients*
- *The objectives are complementary with the European policy to create and develop European Reference Networks*

Transparency and HTA cooperation as proposed by the Regulation are the only real antidote to secrecy and political games

A constructive change

- A Regulation that obliges MS to base their decisions on facts:
  - scientific and medical evidence on one hand
  - healthcare budget they decide upon on the other hand
- In other terms, a Regulation that ensures TRANSPARENCY in the provision of the clinical aspects of Health Technology Assessment
  - The relative effectiveness
- More clarity on the final decision
  - MS can't afford it*, difficulties to negotiate an affordable price
  - MS don't agree with the joint report (requires justification - transparency)
  - MS sometimes make their decisions on other grounds (industrial policy, corruption, political games…)

* health is not awarded the same budget priority in all MS: across EU Member States, the healthcare expenditure varies from 5.9 to 11.9 % of Gross Domestic Product (GDP)

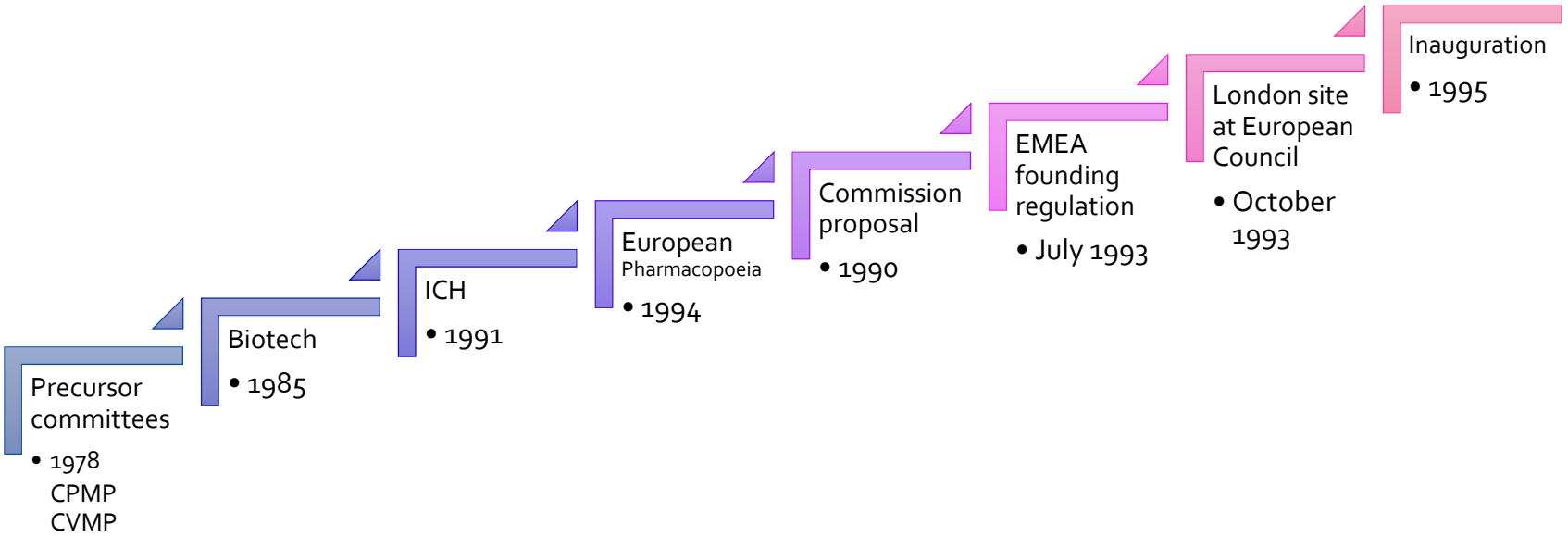
Voluntary cooperation has its limits (1)

Different countries, different HTA practices

Data requirements in 8 countries + EUnetHTA for a diabetes product

From the Commission's Inception Impact Assessment

Voluntary cooperation has its limits (2)
Creation of the EMA: timelines (17 years)



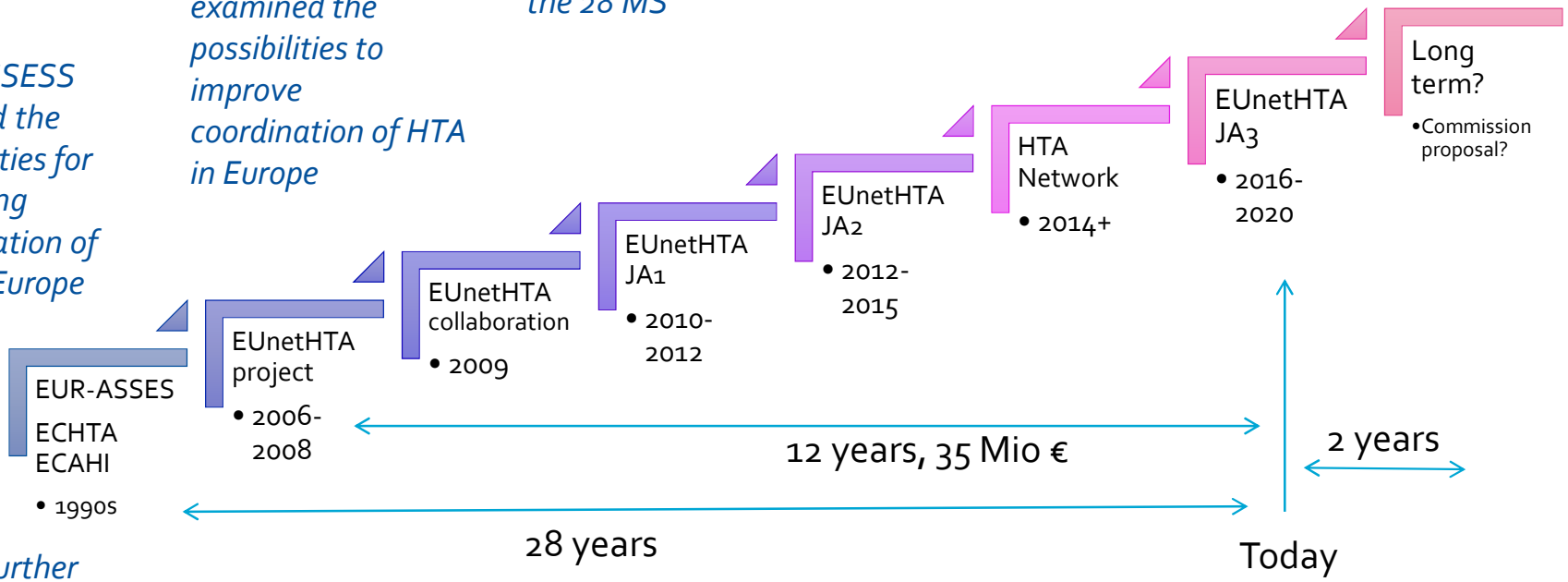
HTA in Europe: the limits of voluntary cooperation (> 28 years of coordination and learning from others)

EUR-ASSESS explored the possibilities for improving coordination of HTA in Europe

ECHTA further examined the possibilities to improve coordination of HTA in Europe

EUnetHTA continued the development of HTA activities among the 28 MS

"These four projects have definitely improved coordination of HTA efforts"
History of HTA: Introduction. David Banta, Uni. Maastricht, Egon Jonsson, Uni. Alberta. Int. J. Techno. Assess. ***2009***



ECAHI further aimed to improve coordination

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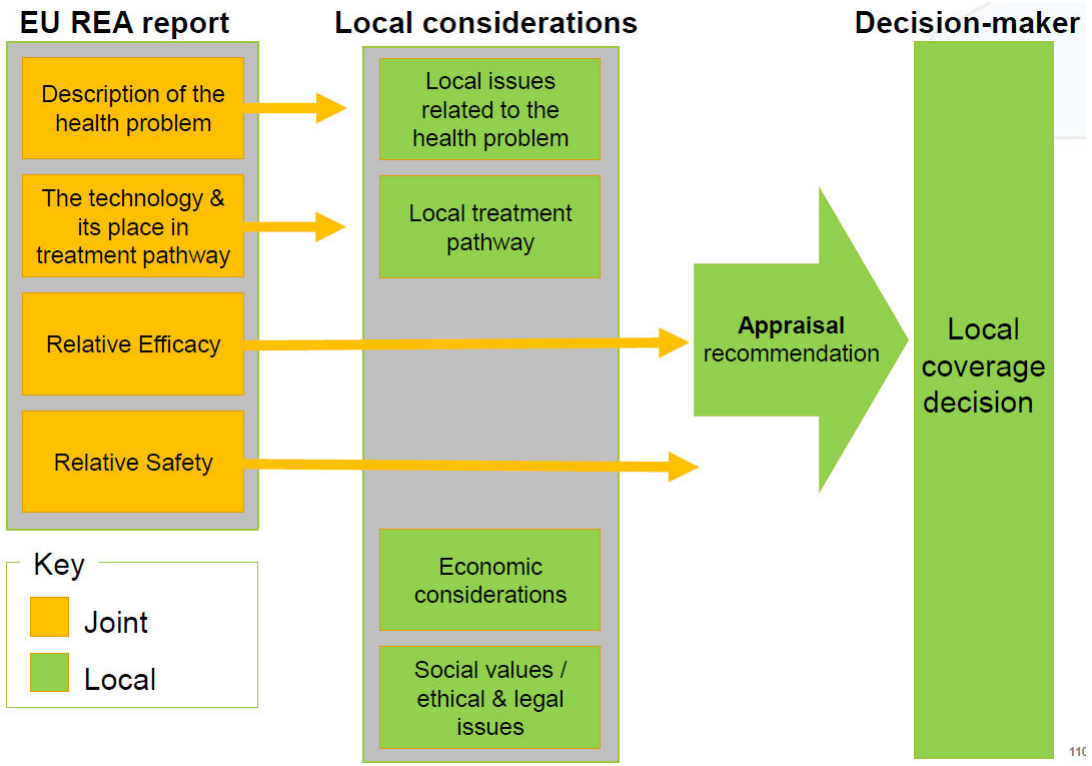
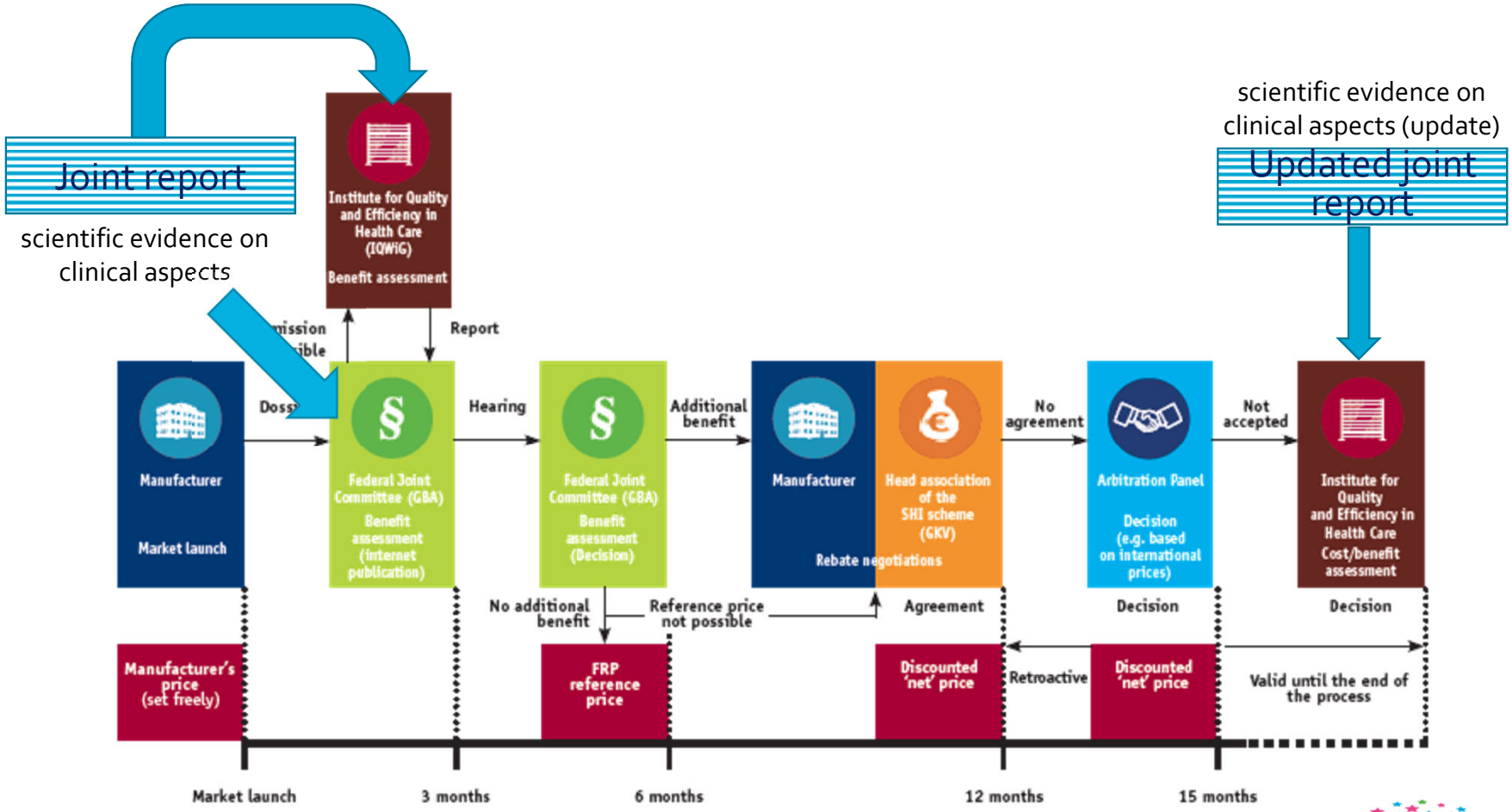
How can it work?

Think of the Clinical Trial Regulation : part I (European), part II (national)



Source: EFPIA

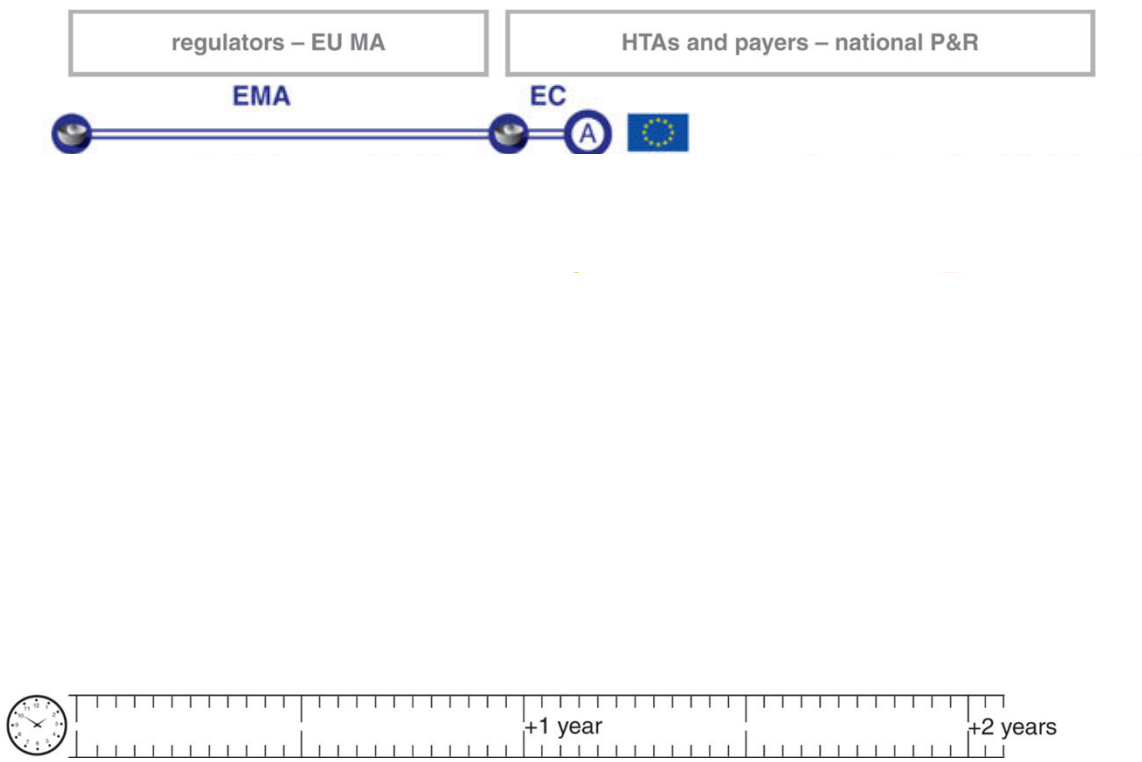
Illustration: impact in Germany



New Drugs: Analysis of timelines of approval and HTA/P&R decisions for oncological products in EU

J. Martinalbo et al. "Early market access of cancer drugs in the EU" Ann Oncol. 2015;27(1):96-105. doi:10.1093/annonc/mdv506

Dashed lines: national early access programmes



- Sample size N=15 (oncological drugs with regular approval in EU between 2011-2013)
- based on median times from EU marketing authorisation (MA) in months

1. Certain HTA Agencies believe they could do better by doing it alone

- Pooling the best European expertise is the best way to develop and apply highest scientific standards everywhere
  - Examples: European Space Agency, Airbus…
  - Counter examples: Philips, Thomson, Grunding and their different standards (VHS vs Pal/SECAM) and how successful they were compared to others…
- It worked for the regulation of medicines some 23 years ago when the EMA network was created: the quality of EMA assessment is higher than any of the pre-existing national agencies
- EUnetHTA has a dedicated activity lead by IQWIG, the German HTA agency, to improve the quality of all HTA joint reports
- Each HTA agency willing to conduct joint HTA will have an opportunity to comment on the joint report before it is adopted
  - exactly like CHMP opinions at EMA where all MS are represented with ample time to comment on preliminary opinions / rapporteurs' reports

3. Some say if a report is well done, MS will use it voluntarily, then there is no need for an obligation

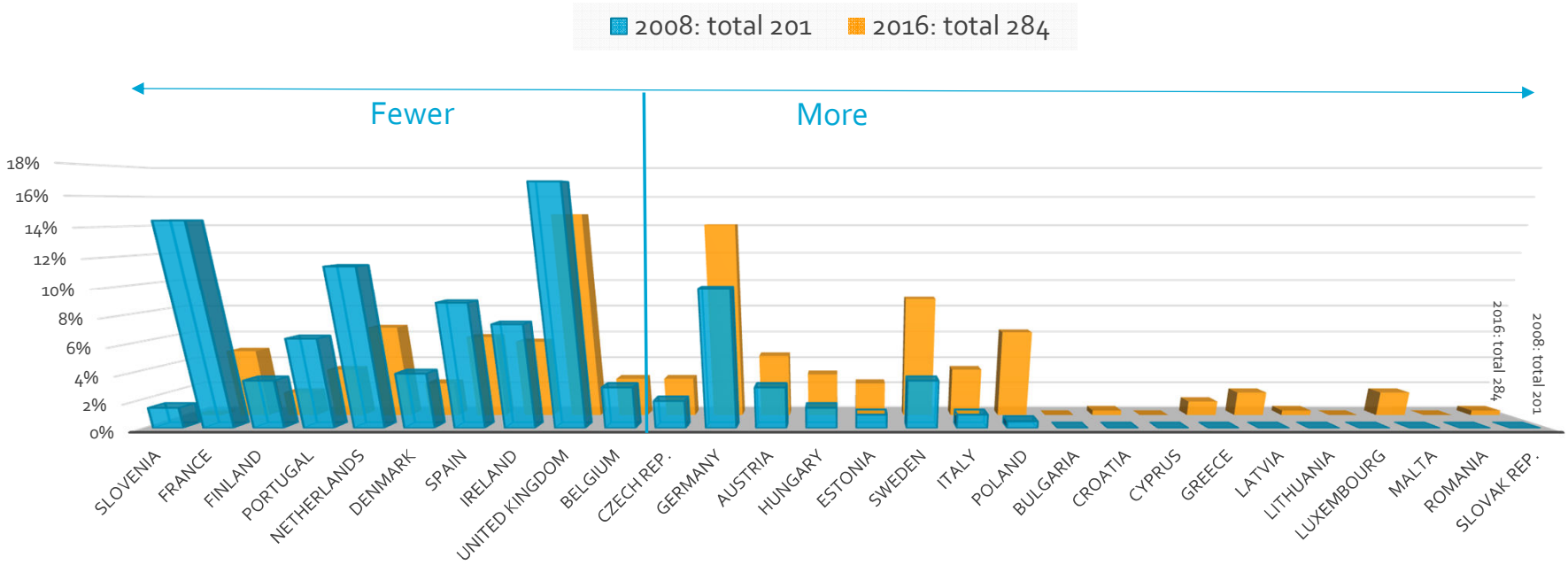
- The requirement for mandatory use of the joint everywhere in the EU work is a guarantee of quality
- From the moment a joint report has a legal validity and MSs have to use it, they all have interest in working at their best
- On the contrary, if nobody uses the joint work, there is no need to do good work

5. Some say there are so many technologies, not all agencies can review all reports in a timely manner

- That is why pooling forces of all HTA agencies together will increase efficiency
- We cannot have 300 assessors in each country, doing the exact same thing. Rather, joining forces to conduct joint HTA reduces duplication and generates efficiency gains
- For pharmaceuticals, before the creation of the EMA, the first cooperation on pharmaceuticals (CPMP 1978-1995) started with 5 procedures per year (multi-state evaluation)
- It is foreseen that the new cooperation on HTA will have the time to gradually increase its workload in a step-by-step manner
- How can we expect industry to improve efficiency (and reduce cost of health technologies) if HTA don't set a good example themselves?

Learning curve: example of the EMA

Rapporteurship & co-rapporteurship CHMP. 2016 compared to 2008 (as % of CHMP reports-coreports)



- 7 Ms that did 76% of the work in 2008 did 56% of the work in 2016
- 80% of the work was done by 8 MS in 2008, and by 11 in 2016
- 10 MS that did 0% in 2008 do 12% in 2016
- Among 10 MS that did 0% in 2008, 4 do 0% in 2016

EURORDIS's proposes amendments

1. Pharmaceuticals: no re-evaluation of the benefit/ risks , as already done by EMA
2. 2 patients' representatives in Coordination Group, as full members with voting rights
3. To analyse / use other data that the ones submitted by industry
4. Minimum of 30 days to review draft report before adoption
5. If developer considers some information to be confidential: in last resort, HTA assessors decide
6. A summary report for the public, in an understandable form for patients, consumers
7. Regulations (EU) 2017/745 and (EU) 2017/746 on medical devices are recent; a longer transition period for them needed for an optimum implementation of regulation for Med Dev and HTA

To choose between transparency provided by the Regulation versus dissonance of nationally driven HTA

Patients are entitled to know on which grounds reimbursement/coverage decisions are made, in all Member States

Find EURORDIS's Statement here

With its annexe, short document explaining what the Regulation proposes here

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Thank you for your attention.

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Director of Treatment Information and Access

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Other remarks

1. The responsibility of patients and their organisations when consulted for an HTA report should be clarified
    - When an agreement is made on the consultation modalities and on the methods, then the patients' organisations involved in joint HTA should adhere to the outcome, even if unsatisfied
2. Funding: 13 Mio € for the HTA cooperation annually
    - How it was calculated? Is it enough? How to conduct its own HTA research?
    - to be compared with the EMA budget in 2016 (305.1 Mio €, of which 114.5 redistributed to Member States for their part of the regulatory cooperation)

Principles of patients' engagement

Inclusion
- We want to be part of all procedures that can affect our lives

Legitimacy
- With equal credibility as other experts

Visibility
- When involved, needs to be known to all patients/public

Publicity
- Procedures and conclusions to be understandable, accessible, verifiable

Relevance
- The information on which the assessment is based must be able to justify the conclusion

Appeal / review
- Mechanism to ensure the possibility of an appeal / review

Responsibility
- When consulted in a manner we agree upon, and we agree with the methods, then we should accept the procedure

Enforceability
- The procedure should ensure that prior conditions are met

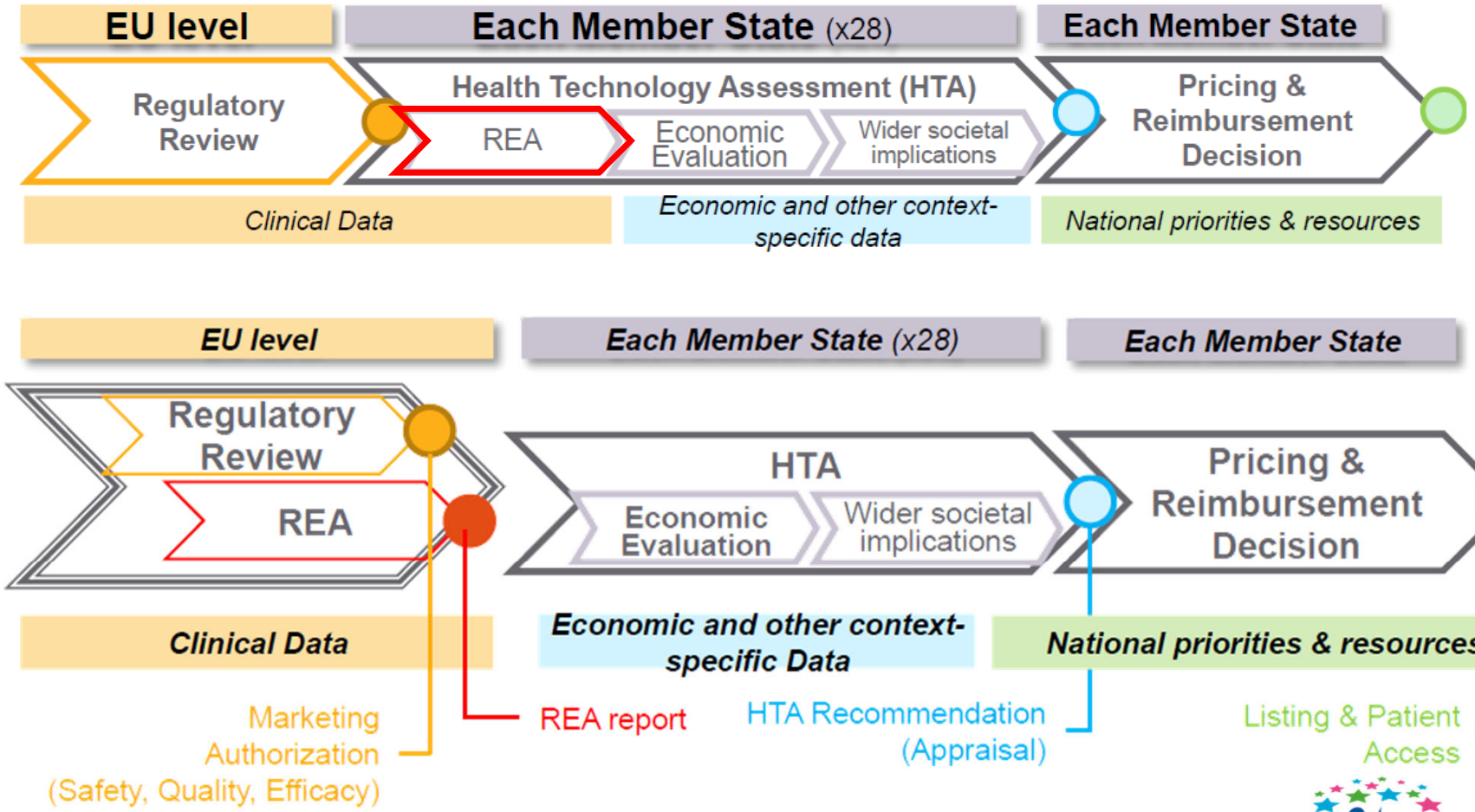
Different outcomes from RD drugs assessments across HTA agencies

Brand name	Glivec®	Tasigna®	Avastin®	Revlimid®	Lucentis®
	Imatinib	nilotinib	bevacizumab	lenalidomide	ranibizumab
	RD oncology	OMP oncology	Off-label in RD	OMP oncology	RD in ophthalmology
GBR	🟢	✖	✖	🔴	🟠
FRA	🟢	🟢	🟢	NA	🟠
ITA	🟠	🟠	🟠	🟠	🟠
ESP	🟠	🟠	🟢	🟠	🟢
CZE	🟢	🟢	🟠	🟠	🟠
POL	🟠	🟠	🟠	🟠	🔴

Approved for reimbursement
- 🟢 As per indication
- 🟠 With restrictions
- 🔴 With severe restrictions

✖ Not reimbursed

Evolution of a process



What defines subsidiarity?

The Subsidiarity Principle under Article 5(3) TEU applies, as the three preconditions for intervention by Union institutions are respected:

The area concerned does not fall within the Union's exclusive competence ✓

The objectives of the proposed action cannot be sufficiently achieved by the Member States ✓

The action can, by reason of its scale or effects, be implemented more successfully by the Union ✓

3. Some say if a report is well done, MS will use it voluntarily, then there is no need for an obligation

- The requirement for mandatory use of the joint everywhere in the EU work is a guarantee of quality
- From the moment a joint report has a legal validity and MSs have to use it, they all have interest in working at their best
- On the contrary, if nobody uses the joint work, there is no need to do good work

4. Some say the reimbursement decision is a national competence and should not be influenced by others

- The reimbursement decision will continue to be a national prerogative, no question
- Simply, all MS will benefit from a high quality relative effectiveness assessment, to which they can add contextual elements such as costs and economic aspects and specific comparators, for their decision-making
- And each MS can use the joint HTA when they need (at MA/CE, or when budget impact too high etc., according to their national practices)
  - Example:
    - Evidence that global warming is the result of human activity has been assessed at the international level
    - Then each MS decides its own policies and measures to be taken
    - Their sovereignty is respected

6. Some say synergies between regulators and HTA agencies are enough to solve the problems, HTA experts and regulators could exchange views

- A dialogue is needed prior to the marketing authorisation, to give a chance to HTA to express their views to regulators prior to the regulatory opinion
- This is part of the strategy to establish synergies between EMA and the European Cooperation on HTA
- This dialogue can best be achieved through the creation of a scientific secretariat with adequate resources
- The EMA is open to welcome HTA experts in its evaluations, but too few HTA assessors have the time and resources to participate every time needed
- A structure with adequate resources will make this dialogue become systematic

7. Some say the new cooperation opens the door to industry funding, thus diminishing the independence of HTA assessors

- This fear is unjustified: the new structure, hosted by the European Commission, cannot collect fees from industry. Funds will come from the European budget only
- And even if partly funded by industry, no dependence link would be necessarily established
- The joint scientific consultation (Early Dialogue), an equivalent service to industry as Scientific Advice is for the regulation of pharmaceuticals, could be paid by the developer that benefits from the service directly, as currently tested by the EUnetHTA cooperation

8. Industry says there is no value in proposing a joint HTA if few MSs use the joint HTA report

- If the European HTA report is on add-on to all HTA reports that needs to be done at the national level, duplication continues to prevail with no encouragement to industry to proceed via the EU cooperation on joint HTA rather than by each MS individually
- Some joint HTA reports are already used by **up to ten** Member States, in part or in totality
- With time (and throughout the current EUnetHTA joint action), HTA agencies learn how to work together, increase their mutual trust, improve the quality of the joint work, and the actual use of joint reports will increase
- This will only be possible if all parties participate with the same good will
- The legislative proposal will accelerate this, making the participation of industry to joint HTA mandatory

9. Industry says there is a need for a specific template for the HTA of orphan medicinal products

- EURORDIS always advocated that orphan products should not benefit from a special case for HTA
- The information needed for an HTA are the same for orphans and for non-orphans
- However, due to smaller populations enrolled in clinical trials and fewer research infrastructures in rare diseases, data will be missing more often. The strength of evidence might be affected, but the evidence requirement must be the same
- This is to ensure that people living with a rare disease can benefit from same quality treatments than others (cf. Criteria for the Prioritisation for Joint HTA)
- No low cost HTA for rare diseases