The case for HTA cooperation

The average life expectancy in Europe has increased dramatically over the last 60 years, with women gaining over 10 years and men just under. However, important differences exist across Europe, with a nearly 10-year gap between the longest and shortest life expectancy: eighty-two in Spain and Italy and seventy-three in Lithuania, Latvia and Romania. This gap is certainly multi-factorial, but given that evidence suggests that newer medicines have contributed to the overall improvements in life expectancy, it only stands to reason that part of the life expectancy gap may be due to different levels of access to and usage of new medicines. Indeed, according to an analysis undertaken by the European Federation of Pharmaceutical Industries and Associations (EFPIA), medicines spending is highly correlated with life expectancy at birth and adult mortality.

Why change is necessary

Healthcare is the responsibility of each member state in the European Union, including decision-making about what medicines to reimburse and their pricing. To help inform these decisions, nearly all are devoting resources to health technology assessment (HTA). These bodies, however, come with a cost. The annual budget for the UK’s National Institute for Health and Care Excellence (NICE) is approximately £60 million. While NICE has responsibilities that range beyond assessing new medicines, at least £10 million is devoted to that task. Many European nations are unwilling or unable to commit this level of resource into HTA and therefore the idea of sharing the HTA workload has been gathering traction.

The concept of European-level HTA to help reduce variability has an analogue at the member state level where there is often local variance in access to medicines and one of the ways governments seek to reduce such variability has been through national HTA bodies. One of the founding reasons for the creation of NICE in the UK was to reduce the ‘postcode lottery’ that existed prior to its existence. The same is arguably true with the Italian Medicines Agency (AIFA) in exerting its primary pricing and reimbursement authority over regional governments in terms of decisions relating to medicines. Currently at the European level there is the equivalent of a postcode lottery for access to new medicines between countries. National HTAs are not solving this problem due to such diversity in methods and approaches that even when the same evidence is assessed, there is often a diversity of HTA recommendations.

Harmonisation of EU regulatory agencies resulted in the creation of the EMA. While regulatory assessment is based purely on scientific information, HTA encompasses science, economics and sociopolitical policy and with these considerations embedded in member state competencies, a harmonised EU HTA agency is not an option. Nor would European patients benefit from such an agency as important local differences do need to be recognised in healthcare decisions. Therefore an alternative solution is required to reduce variability and duplication of European HTA.

Furthermore, HTA bodies take time to make a decision and variation in time can also lead to delays to patients in need. Under the EU Transparency Directive these decisions should be made in 180 days, yet in most member states patients wait for over one year and in some cases more than two years. While part of this review requires a very detailed analysis of how the new technology fits into the local health care system, at least the review of the technology itself is based on the same data that has already been evaluated by the European Medicines Agency (EMA). Sharing this component of the assessment may speed time to decision making.

On the industry side, equally important investments are being made to generate evidence and produce dossiers to meet the growing expectations and variability across HTA bodies. As a mid-size company, we have a significant number of employees devoted exclusively to this task and if you ask any pharmaceutical industry recruiter, they will say that health economists and ‘market access’ specialists are the most in demand professionals within the industry.

Given these different factors, the EU Commission, the HTA community and medicine developers are all working towards reducing this variability in HTA approach by the establishment of EU methodology guidelines and work-sharing, which are viewed as a way forward.

In 2011, the European Parliament and European Council established a permanent Network of HTA bodies (HTAN) under Article 15 of the Cross-border Healthcare Directive. The technical arm of the HTAN is provided by the European Network for HTA (EUnetHTA). One key objective has been to achieve more effective use of healthcare resources and in working towards this goal EUnetHTA developed the ‘HTA Core Model’. This is a framework designed to enable sharing of HTA information across countries while recognising that those using such information will have considerable variance in the extent and scope of their analyses with differing requirements, methodology and processes. Any user of such information can select a subset of assessment elements that are relevant to the specifics of their local approach to HTA.

The HTA core model has been adapted for use in the rapid relative effectiveness assessment (rapid REA) process currently being piloted. While the HTA core model is an attempt to harmonise a broad range of inputs for member state HTA bodies, the rapid REA process is an attempt to harmonise the actual assessment of the effectiveness and safety data available at time of launch. The rapid REA does not provide an added therapeutic value assessment, recognising that such an assessment encompasses both elements that can be generalised to all countries and local elements such as standards of care, social and ethical values that cannot be generalised. As such, the rapid REA provides a factual assessment of the individual elements of effectiveness and safety of a new medicine or device relative to the available alternative options in Europe. The assessment is intended to be undertaken in parallel with the EMA review process and to deliver a report shortly following publication of the European Public Assessment Report (EPAR). Ideally, the report would supplement the EPAR with the comparative assessment.
information required by local HTA’s as part of their appraisal processes. The theory is that the local HTA bodies would be able to achieve efficiencies in workload and review time by redirecting their resources to address locally-specific clinical issues as well as to include local economic, social and ethical factors as needed.

To date, there have been three pilots of the EUenetHTA rapid REA process with mixed results. These pilots have demonstrated the feasibility of the rapid REA process from the perspective of multiple HTA bodies working together to produce an assessment, although the uptake and use by member states has been limited to date. While the pilots have demonstrated the concept, further refinement is required in order for the process to become sufficiently practical that it can achieve the goal of more effective use of healthcare resources.

Is theory conflicting with practice?

A concern observed from the pilots is that EUenetHTA are introducing duplication by including information outside the scope of a rapid REA. This duplication appears to have originated from the way in which EUenetHTA are applying their HTA core model. While the modular framework is a logical way to share information between agencies, it was originally designed for post-market assessment where extensive information would be available. Rather than focussing on what information is typically available and required for assessment at launch, EUenetHTA have focussed on expanding their model’s questions and then shoehorning them into the rapid REA.

The duplication has occurred both in terms of re-worked regulatory information and inclusion of local level data. For example, the Canagliflozin assessment contained a considerable amount of reworking of the EPAR and the Summary of Product Characteristics (SmPC) - an unnecessary duplication given that this information was publically available and also a risk to public health due to the changing of the context of the efficacy and safety information provided by the EMA. In addition, information only relevant at a local HTA level was requested in the form of six annexes which ultimately were not used in the report despite substantial expense incurred to the company to provide such data. To compound this issue, the core model questions relating to such local data will not achieve the level of detail actually needed for local assessment meaning that such data will have to be provided twice by companies.

We suggest that to achieve an efficient process, EUenetHTA need to develop a report focussed solely on relative effectiveness that is designed to complement, not replace the EPAR, and that does not contain unnecessary local level data. For a full technology appraisal as much information as possible is required for decision making and this is the design of the core model. However, rapid REA is not a full technology appraisal and so needs to be designed accordingly. Given that the rapid REA is intended in the long run to be a standard component of the review of new medicines, the level of burden currently demanded would present a significant barrier to the manufacturer, especially to small or medium sized companies. In addition, we also question the capacity of EUenetHTA to upscale their pilot process to reviewing the number of new medicines and devices that undergo EMA licensing review. Therefore, EUenetHTA needs to move away from the focus on the collection of all possible information to what is relevant to member states, what is feasible by manufacturers of all sizes to provide at launch and what they would have the capacity to review. To get to a process that is feasible and achieves efficiencies, EUenetHTA may have to abandon their core model.

Can the rapid REA achieve efficiencies?

We believe that the answer is yes, but not in its current form. Ideally the rapid REA can add value in standardising the assessment of the clinical aspects of relative effectiveness and as such efficiencies would be expected. These efficiencies should be manifest in terms of (1) the potential to close the access gap across countries by harmonising the evaluation of clinical inputs into decision-making; (2) decrease the taxpayer investments in member state HTA bodies by reducing the resources required to assess new medicines; (3) reduce the time patients are waiting for new medicines through availability of already assessed data at an earlier time point and (4) reduce the duplicative resource requirements for industry in having to replicate the same information in different formats across Europe.

However, to achieve these efficiencies, the process shouldn’t duplicate work being conducted by the EMA or member state HTA bodies and needs to be used by the member states. Otherwise it becomes another hurdle for all stakeholders and will have the opposite effect to what is intended.

References: