



Speaker

First Plenary Session

Pros and Cons of a Centralized European Pricing & Reimbursement Agency



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Pros and Cons of a Centralised European Pricing and Reimbursement Agency

Professor Adrian Towse
 Office of Health Economics
 ISPOR Plenary Madrid 2011



Agenda

- What are the options?
- What are the issues for the stakeholders?
- Combining science and politics
 - Is relative effectiveness the same?
 - Is cost-effectiveness the same?
 - Is willingness to pay for value the same?
- Summary: Where should we get to?


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What are the options?

The Name	The Scientific Dossier(s)	Studies	The Decision
Euro NICE Euro HAS Euro IQWiG Euro TLV	Efficacy Relative efficacy Relative effectiveness Incremental costs and effects	One pan-EU 27+ studies	One pan-EU 27+ decisions Valuations of effects Elements of Value included WTP threshold
The location London POLITICS	Relationship with the EMA DETERMINED BY THE SCIENCE	 SCIENCE	 POLITICS AND CHOICE

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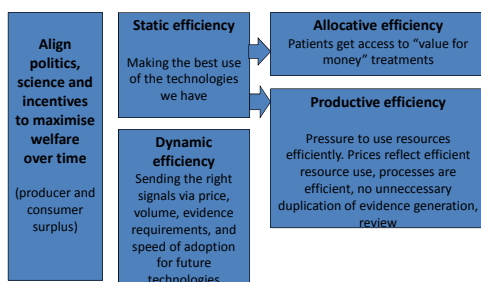
What are the issues?

- Third party payers want to see value-for-money and to keep control over health care expenditure
- They want patients to get access to medicines conditional on the first two
- The EMA wants to approve quickly safe and effective medicines and not approve those that are not
- Patients want access to safe and effective medicines
- R&D-based manufacturers want prices that reflect value and earn a return on R&D
- They and payers want to avoid too much cost and duplication of effort in demonstrating and assessing value
- Will a centralised P&R agency help achieve these?



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An economic framework



What are the issues: for the politics of the European Union?

- The EU wants to promote greater pan-EU collaboration?
- It want reduce duplication of review effort at Member State level
- It wants to increase cross-border competition in the provision of health care services within the EU
- It wants to secure patient rights to access cross-border health care
- Is there a political desire for a EU-wide "European" package of minimum guaranteed health care available to every EU citizen?
- A centralised P&R agency may help achieve these



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Key Definitions

- **Efficacy:** The extent to which an intervention does more good than harm under ideal circumstances. (This comparison is usually based on data from clinical trials, and can be made at launch).
- **Relative efficacy:** The extent to which an intervention does more good than harm compared to one or more alternative interventions under ideal circumstances. (This comparison is usually based on clinical trials data, and made at/near launch).
- **Effectiveness:** The extent to which an intervention does more good than harm under the usual circumstances of health care practice. (This comparison needs to be based on observational or pragmatic trial data collected in usual clinical practice).
- **Relative Effectiveness:** The extent to which an intervention does more good than harm compared to one or more alternative interventions under the usual circumstances of health care practice. (This comparison needs to be based on data collected in clinical practice over time).
- **Cost effectiveness:** Cost-effectiveness analysis (CEA) is a form of economic analysis that compares the relative costs and outcomes (effects) of two or more courses of action



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16 June 2010 (10:00-11:00)
16 June 2010 (10:00-11:00)

Relative effectiveness and the European pharmaceutical market

Keay Jones

Published online 23 June 2010
© Springer 2010

The development of a single European market for medicines over the last decade has made substantial contributions to the health care systems of Europe. However, the benefits of a more competitive market have not been fully realized. The development of a single European market for medicines over the last decade has made substantial contributions to the health care systems of Europe. However, the benefits of a more competitive market have not been fully realized.

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Volume 88 Number 2 June 2010

THE MILBANK QUARTERLY

A Multidisciplinary Journal of Population Health and Health Policy

Publisher
GARMEN HOOKER ODUM

Editorial Director
MILBANK MEMORIAL FUND
PAUL D. CLEARY

Editor
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Director of Publications
MILBANK MEMORIAL FUND
THOMAS HENNINGSEN

Published by the Milbank Memorial Fund since 1923

Conclusions: Reproductive health could improve the efficiency of health care programs, but they have important implications for equity and access.

EBM, HTA, and CER: Clearing the Confusion 256

BRYAN K. LUCAS, MICHAEL DUNNINGS,
DUNCAN JENNISON, PETER J. NEUMANN,
J. SANDRA KOPARDEKAR, LUCY BARNETT,
AND SHAN D. SULLIVAN

Content: The meta-analysis of randomised controlled trials (RCTs) and other clinical trials has shown that it is not clear that randomised controlled trials are the best way to evaluate the effectiveness of health care interventions.

Practice: This article compares an evidence-based and patient-centered approach to the evaluation of health care interventions.

Conclusions: More clinical research and evaluation are necessary for an evidence-based and patient-centered approach to the evaluation of health care interventions.

Notes on Contributors 277



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Might relative efficacy differ within Europe?

- If we are looking at an RCT with an active control then we might expect the relative efficacy results to be the same in any part of Europe if:
 - the patient entry criteria are the same; and
 - the protocol for treating the patients is the same.
- In other words the “same” patients get the “same” health care
- Not clear that we do know this:
 - It is assumed away and not tested in most multi-centre and multi-payer, multi country studies



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OHE Review: Findings and Implications

- Literature testing for heterogeneity in relative efficacy and relative effectiveness across European countries is very scarce.
- The degree of heterogeneity remains an unresolved empirical issue.
- Clinical practice variation is one of the most cited factors when analysing heterogeneity of cost effectiveness results but only from the cost side (no further exploration on relative efficacy or relative effectiveness).



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Might relative effectiveness differ within Europe? – Reason 1

- Differences in the target (treated) population:
 - Base line risk
 - Stage of the disease
 - Other characteristics e.g. age, co-morbidity
- We are interested in differences in *absolute* or incremental effectiveness between products which can arise from:
 - Differences in relative effectiveness
 - Differences in “base line” risk



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Comparison of how relative and absolute reductions in risk may vary by subgroup

		Survive	Die	Mortality Rate	RRR	ARR	NNT
group 1 (N=100)	drug A	80	20	20%	10%	2.0%	50
	drug B	82	18	18%			
group 2 (N=100)	drug A	70	30	30%	10%	3.0%	33
	drug B	73	27	27%			

Notes: RRR: relative risk reduction; ARR: absolute risk reduction; NNT: Number needed to treat
Source: based on Weiland S. Is Relative Risk Reduction a Useful Measure for Patients or Families Who Must Choose a Method of Treatment? Journal of Clinical Oncology, 21(23), 2003: 4263-4264.

Might relative effectiveness differ within Europe? - Reasons 2 and 3

- The comparator technology. Drug B is not used. This may be because of:
 - a P&R "value" or "budget" issue.
 - clinical practice. The payer or provider is willing to allow Drug B to be used, but clinicians do not use it:
 - national / local clinical practice guidelines do not recommend it
 - or given a choice between B, C, and D, Drug B is little used
- Effectiveness of drug A may depend on how it is combined with other health inputs
 - Treatment strategies may include drug A but be different in other respects
 - The skill of clinicians may impact on outcomes
 - Differences in the use of prevention/ screening strategies will impact on the patient mix treated with drug A



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Pan-European initiatives on Relative Effectiveness

- The Swedish EU Presidency conference initiative 2009
 - Objective: to engage cooperation among EU countries to assess drug effectiveness after approval.
 - Emphasis on treatment areas using biologic agents: inflammatory diseases, cancer and orphan diseases.
- The European League Against Rheumatism (EULAR):
 - Eight registers (UK, Sweden, Germany, Spain, Norway, Denmark, the Netherlands, and Switzerland) use a standardised reporting system for serious adverse events of first tumour necrosis factor (TNF) α inhibitors.
- EUNETHTA Joint Action: WP5 on Relative Effectiveness of Pharmaceuticals



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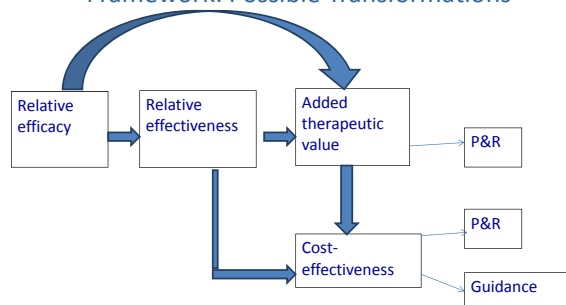
Use of Relative Efficacy in Europe by HTA Bodies

- There is commonality around the starting point of relative efficacy, i.e. it is based on RCTs
- It is unclear, however:
 - Whether the methods used to identify, include, and analyse RCTs are similar?
 - To what extent the choice of comparators used in any assessment of relative efficacy differ?
 - The basis on which indirect comparisons are included
- The derivation of and use made of a relative efficacy assessment seems to be quite different



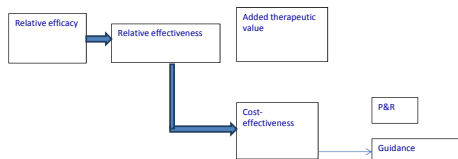
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Framework: Possible Transformations

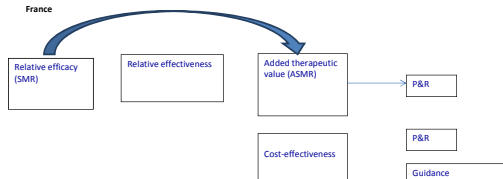


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England and Wales



France



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Trueman et al. 2009

- Four HTAs evaluations of DES vs BMS: England, Austria, Belgium and Canada
 - Substantial differences in data requirements.
 - However, HTAs gave similar recommendations.
- Conclusions: limited convergence in HTA approaches in the evaluation of surgical interventions **but** potential harmonisation in the case of drugs as they are less likely to be susceptible to differences in local practice patterns.
- Tensions between relative efficacy and relative effectiveness can be due to: i) differences in **translation** of efficacy into effectiveness; ii) **real differences** in effectiveness due to local context; iii) differences in the **interpretation** of effectiveness data.



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GLOBAL PHARMACEUTICAL PRICING

By Patricia M. Danzon, Adrian Towse, and Andrew W. Mulcahy

Setting Cost-Effectiveness Thresholds As A Means To Achieve Appropriate Drug Prices In Rich And Poor Countries

DOI: 10.1017/S0269972710000902
HEALTH AFFAIRS 30,
NO. 6, 1085-1098 (2011)
© 2011 Project HOPE—
The People's Health
Foundation, Inc.

Dynamic and static effects

- Pricing drugs at local payer willingness to pay is the most efficient (in a second best world) of achieving most patient access and rewarding companies in a way that stimulates socially optimal amounts and types of innovation
- Price convergence within the EU will reduce access to medicines as well as future innovation



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Summary: the scientific and economic landscape

- We will continue to assume relative efficacy does not vary
- The assessment and use made of relative efficacy by HTA/P&R bodies *may* converge over [a long] time
- HTA/P&R bodies and the EMA will take an increasing interest in outturn (rather than estimated) relative effectiveness
- This will be linked to greater “conditional use” in drug licensing and P&R
- Relative effectiveness will differ from relative efficacy in ways that will differ by Member State
 - Patient mix will always vary, but comparators and other health system effects *may* converge over time
 - However, it will be clear that only certain factors need to be taken into account

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Summary: the scientific and economic landscape

- Resource use *may* converge over [a long] time
- Non-drug prices *may* converge over [a long] time
- Differences in the valuation of health effects *may* converge over [a long] time
- Willingness to pay will continue to differ as it reflects citizen preferences as well as income levels
- Therefore it is efficient for drug prices to vary by Member State



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Summary: policy implications of centralised P&R

- We only need one assessment of relative efficacy if we adjust for comparators and can agree how to do it
- We don't need 27 different estimates of relative effectiveness, but we will need more than one
- We will need to know differences in patient mix to get to incremental effect
- We will need to model differences in resource use and non-drug prices in different Member States
- We will take account of differences in valuation of effects where relevant
- Each Member State will have a different willingness to pay
- Each Member State will therefore have, given use, a different drug price or for any given drug price, have a different use profile
- So we can have one agency making (say) one qualified relative effectiveness assessment and (up to) 27 local assessments of cost-effectiveness



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Summary: policy implications of centralised P&R

- We need 27 decisions about use and price given local willingness to pay for value and local cost-effectiveness
- In theory this could be done by a central body if the local variables could be fed in to a formula
- If one European wide decision about price / coverage was taken using "average" cost-effectiveness, then substantial resource transfers would be needed to "poorer" health systems and higher WTP countries would have sub-optimal use
 - A new Common Health Policy like the CAP
- All of this fails the efficiency test in my view



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Summary: more sensible next steps

- EUnetHTA and other initiatives can make progress:
 - reducing methodological differences in the assessment and use made of relative efficacy by HTA/P&R bodies;
 - developing a workable pan-EU framework for a relative efficacy and a relative effectiveness assessment
 - moving towards pilots of "mutual recognition" of relative efficacy assessments
- EMA needs to be involved in this process:
 - EPAR to inform relative effectiveness assessment
 - Post launch benefit – risk studies
 - Use EMA's skill base and expertise
 - Early "scientific advice" with other DRAs, HTA/P&R bodies is a way forward
- We need more evidence and understanding on the nature of causes of differences in relative effectiveness across the EU
- We need to move away from drug price convergence which is bad economics and bad for patients



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