Same Evidence, Different Decision? A Comparative Review of Oncology HTA Recommendations Across NICE and CDA-AMC

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KEY FINDING

Of 147 oncology drug–indication pairs appraised by both NICE and CDA-AMC between January 2016 and January 2026, 18% received discordant reimbursement recommendations. Discordance was evenly distributed (13 each). Both agencies issued positive recommendations for 90.5% of matched indications.

Background

- NICE and CDA-AMC (formerly CADTH) both use cost–utility analysis to inform reimbursement of new cancer medicines and have formalised collaboration through the 2023 NICE–CADTH–ICER Joint Position Statement.[1]
- Decision thresholds differ. NICE applies £20,000–£30,000 per QALY with a severity modifier (£25,000–£35,000 since April 2026),[2,3] CDA-AMC specifies the price reduction required to reach approximately CAD 50,000 per QALY, which is then negotiated by the pCPA.[4]
- Managed access differs. England funds promising but uncertain cancer medicines through the CDF, Canada uses time-limited recommendations (introduced in 2023).[5,6]
- A previous analysis reported discordant NICE and CADTH recommendations in 20% of shared oncology appraisals (2017–2019).[7]

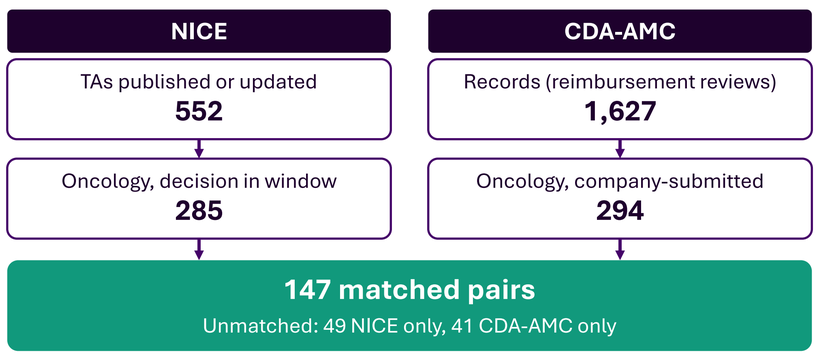
Objective

To compare NICE and CDA-AMC reimbursement decisions for the same oncology drug–indications over the past decade (2016 to 2026), measure how often and in which direction they diverge, and use case studies to illustrate the reasons why.

Methods

- **Data sources**: NICE TAs published or updated between 1 January 2016 and 31 January 2026, and CDA-AMC reimbursement reviews over the same period.[8]
- **CDA-AMC records**: one final recommendation per project was included. Non-recommendation records (newsletters, funding algorithms, withdrawn and "not filed") were excluded.
- **Oncology**: NICE TAs identified by title keyword screen (e.g. cancer, carcinoma, leukaemia, lymphoma, myeloma, melanoma, sarcoma); for CDA-AMC only oncology reviews (pCODR) were included, thereafter excluding non-sponsored reviews.
- **Matching**: drug or regimen, line of therapy, and biomarker (if applicable); one-to-one pairing (Figure 1).
- **Positive recommendation**: NICE recommended or recommended for use within CDF; CDA-AMC reimburse (with or without conditions) or time-limited.
- **Analysis**: percentage agreement and direction of discordance.

Figure 1. Study flow



The remaining 89 NICE TAs and 106 CDA-AMC reviews were excluded: the counterpart differed in regimen, line of therapy, biomarker or population.

References

1. NICE, CADTH, ICER. Joint position statement on confidentiality of clinical evidence informing HTA. April 2023.
2. NICE. NICE health technology evaluations: the manual (PMG36). 2022.
3. NICE. Changes to NICE's cost-effectiveness thresholds confirmed. December 2025.
4. Canada's Drug Agency. Procedures for reimbursement reviews. Accessed 1 October 2026.
5. NHS England. Appraisal and funding of cancer drugs from July 2016 (Cancer Drugs Fund). 2016.
6. CADTH. Procedures for reimbursement reviews: Time-limited recommendations. 2023.
7. Gibson S, et al. Parallel scientific advice from NICE and CADTH: would one submission fit all? ISPOR Europe 2019 (PCN336).
8. NICE published guidance (technology appraisals) and CDA-AMC Find Reports, downloaded 1 October 2026.
9. NICE TA781, TA789, TA812, TA992 (replaced by TA1197); CDA-AMC PC0255, PC0283, PC0300, PC0305.

Results

- From January 2016 to January 2026, NICE published or updated **552 TAs** (**294** oncology drugs), and CDA-AMC issued **712** unique reimbursement recommendations (**315** oncology drugs).
- In oncology, there were **49** NICE appraisals with no corresponding CDA-AMC review and **41** CDA-AMC recommendations with no corresponding NICE appraisal.
- Of the **147** appraisals reviewed by NICE and CDA-AMC, both agencies issued a positive recommendation for **133** (**90.5%**). Recommendations differed for **26** (**17.7%**), with 13 approved only by NICE and 13 approved only by CDA-AMC (Figures 2 and 3).
- The percentage of appraisals with a discordant outcome was stable over time (**18.0%** in 2016–2020; **17.5%** in 2021–January 2026) and highest for lung cancer drugs (**8** of **33**; **24.2%**).
- The median interval between decisions was **6.9** months.
- Table 1 summarises four illustrative discordant cases.

Figure 2. Funding decisions for the 147 matched pairs

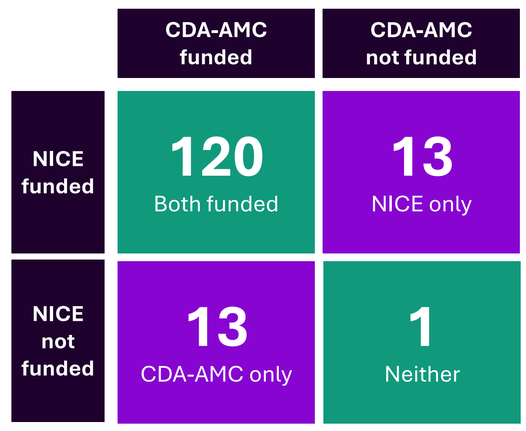


Figure 3. Decision categories for the 147 matched pairs

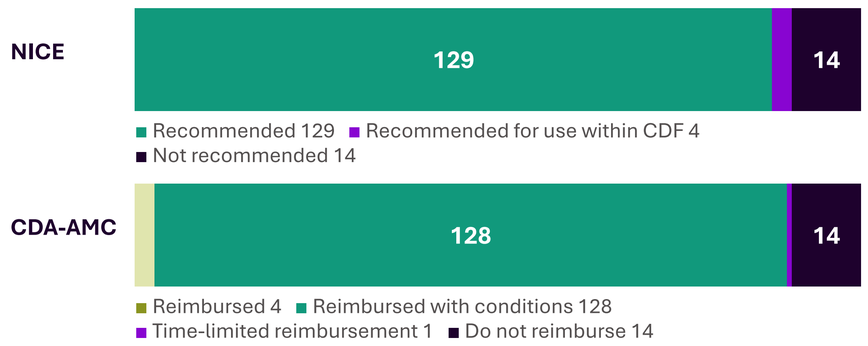


Table 1. Same drug and indication, different decisions: four matched cases[9]

Drug (indication)	Pivotal evidence	NICE decision	CDA-AMC decision	Main driver
Trastuzumab deruxtecan (HER2-low mBC)	DESTINY-Breast04 (phase 3 RCT)	✗ **Not recommended** TA992 (2024): ICER above range despite severity weight	✓ **Reimburse with conditions** PC0305 (2023): 75% price reduction	Cost-effectiveness and price handling
Pralsetinib (RET fusion+ NSCLC)	ARROW (single-arm phase 1/2)	✗ **Not recommended** TA812 (2022): benefit uncertain; no CDF agreement possible	✓ **Reimburse with conditions** PC0283 (2022): unmet need; 70–99% price reduction	Handling of uncertainty
Tepotinib (METex14 NSCLC)	VISION (single-arm phase 2)	✓ **Recommended** TA789 (2022): ICERs within range	✗ **Do not reimburse** PC0255 (2022): uncertain added benefit with single-arm data	Comparative effectiveness
Sotorasib (KRAS G12C NSCLC)	CodeBreaK 100 (single-arm) at NICE; CodeBreaK 200 (RCT) at CDA-AMC	✓ **CDF** TA781 (2022): interim access while data are collected	✗ **Do not reimburse** PC0300 (2024): uncertain clinical benefit versus docetaxel	Managed access and timing

Strengths and limitations

Strengths

- The 10-year review period (January 2016 to January 2026) provides a comprehensive and recent assessment of oncology reimbursement decisions in both jurisdictions.
- Drug–indication pairs were matched on drug or regimen, tumour type, line of therapy and biomarker, and outcomes were derived from published guidance and recommendations.
- Case studies based on the agencies' published rationales provide insight into the drivers of reimbursement decision-making.

Limitations

- Oncology appraisals were identified and matched using keyword-based methods; identification and matching may therefore be incomplete.
- Confidential commercial arrangements and negotiated prices were not available.
- The NICE dataset excludes appraisals replaced or updated after 31 January 2026.

Conclusion

- Despite a shared cost–utility framework and increasing collaboration, NICE and CDA-AMC issued discordant reimbursement recommendations for approximately one in six oncology drug–indication pairs appraised by both agencies during the last decade. Discordance was evenly distributed in both directions and consistent over time.
- The case studies indicate that divergence arises from differing interpretation of clinical evidence, differences in decision thresholds, the handling of price and the availability of managed access. Comparable evidence therefore does not guarantee comparable access.

What this means

- **For patients**: access to the same oncology medicine may depend on jurisdiction, and not solely on its demonstrated clinical value.
- **For manufacturers**: a single evidence package and pricing strategy is unlikely to meet the requirements of both agencies; early engagement with each agency's expectations is advisable.
- **For HTA bodies and health economists**: methodological alignment alone does not produce aligned decisions, because each system addresses uncertainty differently.

Abbreviations

CAD: Canadian dollars; CADTH: Canadian Agency for Drugs and Technologies in Health; CDA-AMC: Canada's Drug Agency; CDF: Cancer Drugs Fund; HTA: health technology assessment; ICER: incremental cost-effectiveness ratio; mBC: metastatic breast cancer; NICE: National Institute for Health and Care Excellence; NICE-CADTH-ICER: National Institute for Health and Care Excellence (England)-Canadian Agency for Drugs and Technologies in Health (now CDA-AMC)-Institute for Clinical and Economic Review (United States); NSCLC: non-small-cell lung cancer; pCODR: pan-Canadian Oncology Drug Review; pCPA: pan-Canadian Pharmaceutical Alliance; QALY: quality-adjusted life-year; RCT: randomised controlled trial; TA: technology appraisal.

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Disclosures

No conflicts of interest.

Use of AI:

Claude was used to support the drafting and editing of this poster.

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