EU CONSULTATION ON THE FUTURE OF EU COOPERATION ON HTA
EUCOPE SUBMISSION

INTRODUCTION

GENERAL CONTEXT

In recent years a number of Member States have introduced so-called health technology assessments (HTA). Typically HTA measures the added value of a new technology in comparison with existing technologies. For the purpose of this survey, health technologies include, pharmaceuticals, medical devices, medical and surgical procedures and other measures for disease prevention, diagnosis or treatment used in healthcare. More information on health technologies is available at http://ec.europa.eu/health/technology_assessment/policy/index_en.htm.

HTA is a very useful tool, as it helps Member States to decide which health technology to favour at national/regional level. It also helps Member States to keep their health budgets under control, as products with no or limited added value cannot expect to be reimbursed or to obtain high prices. Last but not least HTA encourages industry to invest in innovation with substantial added benefits for patients.

Traditionally two types of assessments have been distinguished, namely (1) assessments focusing on clinical/medical benefits of the new technology (does a given technology work better than an existing one) and (2) assessments focusing on the economic benefits of the new technology (value for money). These assessments can be carried out jointly or consecutively, by dedicated HTA bodies or other organisations (e.g. regulators for pharmaceuticals).

At this stage, the vast majority of HTA are carried at national/regional level, i.e. EU Member States assess the new technology according to its national legislation. This leads to duplications of efforts for Member States and industry which translate in unnecessary costs throughout the HTA process. It can also lead to diverging results/outcomes (i.e. health technologies available earlier in some countries compared with others), which in turn can result in limited business predictability for industry and delayed access for patients.

Several projects funded by the EU have allowed Member States to share best practices on how HTA is carried out at national and/or regional and local level. Also a limited number of joint HTA reports have been prepared, but the use of these results is still decided at national level. In practice this has meant that the joint reports have not (yet) been used on a large scale.

There is consensus that HTA requires significant scientific, technical and economic expertise, and is costly. Currently not all Member States have such expertise at their disposal. Budget constraints also mean that even advanced Member States considered to be more advanced in this field cannot assess all new technologies. This has triggered the question whether there is a need to strengthen EU cooperation for HTA, in particular for the period beyond 2020 when the current financing of EU cooperation ends (so-called EUnetHTA Joint Action 3[3]).

For further details please refer to the Inception Impact Assessment on strengthening EU cooperation on Health Technology Assessment (HTA)[4].

OBJECTIVE OF THE CURRENT SURVEY

The aim of this public consultation is to gather detailed views and opinions regarding the future of the EU cooperation on HTA. The results of this public consultation will feed into the envisaged impact assessment which the Commission services are currently preparing on strengthening the EU cooperation on HTA.

This questionnaire is addressed to administrations, associations and other organisations. Citizens are asked to fill in a separate non-specialised questionnaire.

1. INFORMATION ABOUT THE RESPONDENT

Please provide the following data on your organisation/association/administration:

***1.1. Please indicate the name of your organisation/association/administration**

European Confederation of Pharmaceutical Entrepreneurs - EUCOPE AISBL

***1.2. Please enter the country where your organisation/association/administration is based**

Belgium

1.3. Please indicate whether your organisation/association/administration is listed in the Transparency Register?

Registration number of the Transparency Register: 87600691525-93

* In the interest of transparency, organisations and associations have been invited to provide the public with relevant information about themselves by registering in Transparency Register and subscribing to its Code of Conduct. If the organisation or association is not registered, the submission will be published separately from the registered organisations/associations.

***1.4. Please enter your e-mail address (this data will not be made public).**

sude@eucope.org

***1.5. The name of a contact person (please note that the name will not be made public and is meant for follow-up clarification only)**

Oliver Sude

***1.6. Do you consent to the Commission publishing your replies?**

- a) Yes (*On behalf of my organisation/association/administration I consent to the publication of our replies and any other information provided, and declare that none of it is subject to copyright restrictions that prevent publication*)

- b) Yes, only anonymously (*The replies of my organisation/association/administration can be published, but not any information identifying it as respondent*)
- c) No (*The replies provided by my of my organisation/association/administration will not be published but may be used internally within the Commission. Note that even if this option is chosen, your contribution may still be subject to 'access to documents' requests.*)*

* As set out in Regulation (EC) No 1049/2001, any EU citizen, natural, or legal person has a right of access to documents of the EU institutions, including those which they receive, subject to the principles, conditions and limits defined in this Regulation.

2. IDENTIFICATION OF RESPONDENT

***2.1. Main field of work of the responding organisation/association/administration (*one answer possible*):**

- a) Public administration (other than payers)
- b) Patients and consumers
- c) Healthcare provider
- d) Payer (irrespective of status i.e. public or private)
- e) Industry or service provider
- f) Academia or scientific society
- g) Other

***2.1.e. Please specify the type of industry or service provider (*one answer possible*):**

- a) Commercial operator/company SME [*]
- b) Commercial operator/company non-SME
- c) Association/Trade organisation
- d) Other

** Small and medium-sized enterprises (SMEs) are defined in the Commission Recommendation 2003/361. The category of micro, small and medium-sized enterprises is made up of enterprises which employ fewer than 250 persons and which have an annual turnover not exceeding EUR 50 million, and/or an annual balance sheet total not exceeding EUR 43 million.*

***2.2. Please specify the geographic coverage of your organisation/association/administration (*one answer possible*):**

- International/European
- National

- ○ Regional/local

***2.3. Are you an organisation/association/administration representing the interests of the stakeholders mentioned in question 2.1 (*one answer possible*)?**

- ◉ Yes
- ○ No

***2.4. Please specify which health technologies are of interest for your organisation/association/administration (*one or more answers possible*):**

- ☑ a) Pharmaceuticals
- ☑ b) Medical devices [*]
- ☐ c) Other

** "Medical device" means any instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for human beings for the purpose of: diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap; investigation, replacement or modification of the anatomy or of a physiological process; control of conception, and which does not achieve its principal intended action in or on the human body by pharmacological, immunological or metabolic means, but which may be assisted in its function by such means (Council Directive 93/42/EEC of 14 June 1993 concerning medical devices). Please note that the current legislation has been revised and the new requirements will be published soon.*

3. STATE OF PLAY

3.1. Please indicate your opinion on the following statements:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know
*a) There are differences between **HTA procedures** among EU Member States (e.g. responsibilities of authorities, including advisory vs decision-making role and product scope; prioritisation/selection of health technologies to be assessed; duration of procedures; rights/obligations of sponsors during the procedure)	◉	○	○	○	○	○

*b) There are differences between **HTA methodologies for the clinical assessment (REA[= relative effectiveness assessment])** among EU Member States (e.g. different data requirements for the submission dossier; choice of comparator; endpoints accepted; way of expressing added therapeutic value).	◉	○	○	○	○	○
*c) There are differences between **HTA methodologies for the economic assessment** among EU Member States (e.g. different approaches for economic models, budget impact and health-related outcomes; importance of local economic context).	◉	○	○	○	○	○

***3.1.a. For a) please provide concrete examples of the differences you are aware of and their effects for your organisation:**

The procedures of Member States' HTA bodies largely result from the structure and organisation of the national statutory health insurance schemes and the respective legal frameworks. Thus, there is significant variability in the scope and remit of HTA bodies. The procedures not only vary from Member State to Member State but in some Member States (such as Italy and Spain) national procedures are followed by regional and even by local ones, with differences among them not only in terms of methodological aspects, but also regarding their outcomes, impacting patients' access to new treatments. We would like to provide an example of the significant differences between countries which currently exist, both in terms of process, methodology for clinical assessments and methodology for economic assessments. In Sweden most pharmaceuticals undergo clinical and economic evaluations by the Dental and Pharmaceutical Benefits Agency TLV, who decides on reimbursement. In Norway, a clinical and economic evaluation is conducted by the Medicines Agency SLV, followed by a national tender, and then funding is being decided by the four health-care regions. In Denmark, there is a committee, which evaluates the clinical benefits of expensive medicines, and issues clinical guidelines. This is then followed by a national tender. Also the requirements and types of assessments differ between the countries. Such differences will often impact the length, cost and success rate of drugs undergoing such procedures, and even more so, will impact access to treatments in various different ways. They also bear a major impact on SMEs with limited resources, thus contributing to a discriminatory environment.

It is not possible to list the entire range of differences here. We trust that this will be subject to the study conducted by the consortium of Sogeti, the Austrian Public Health Institute (GÖ FP) and the London School of Economics and Political Science (LSE Health). At this stage, we would like to give certain examples. As far as procedural aspects are concerned, the duration and timelines considerably vary, e.g. the procedure with the Scottish Medicines Consortium (SMC) takes about 3 months, other procedures much longer.

Further differences include:

- involvement of patients;
- opportunities for dialogue with authorities;
- transparency of the proceedings (e.g. SMC allows for observers during their discussions).

In addition, there are significant differences how orphan medicinal products (OMPs) are assessed by HTA bodies. While most Member States apply a "one-size-fits-all approach", not considering the specificities of OMPs, there is a lack of consistency in the proceedings where Member States have put separate processes for OMPs in place (e.g. England, Scotland). Due to the rarity of the diseases these treatments are intended for, available evidence and data are limited. Furthermore, when an unmet medical need exists, the study design might be unable to be comparative (no alternative). Additionally, a significantly positive impact on strong outcomes may not be demonstrated due to the limited number of patients and possible study design. In such cases, where the methodology used to evaluate the demonstration of relative efficacy is such a critical factor, access for patients may be restricted, delayed or even impeded. Ultimately, the absence of a common approach towards the assessment of OMPs leads to considerable differences in patients' access to those medicines in the Member States.

***3.1.b. For b) please provide concrete examples of the differences you are aware of and their effects for your organisation:**

As far as the methodology is concerned, the approaches taken by the Member States differ significantly, for instance:

- Different definitions of comparator, standard of care, consideration of off-label use treatments (if mentioned in guidelines), differentiation per sub-population;
- Acceptability of sub-population analysis;
- Acceptability of indirect comparisons and real world evidence.

In addition, HTA methodologies for the clinical assessments are particularly challenging for OMPs as their diversity results in inconsistent outcomes of value assessment across Member States. For example, OMPs often run into issues including, but not limited to, the below due to the application of criteria designed for more common conditions:

- Defining comparator outcomes;
- long-term outcomes;
- quality of life data.

It has also been observed that some HTA agencies may have diverging views from the European Medicines Agency, thus requiring additional post-hoc analyses, which are both expensive and time-consuming for SMEs. To illustrate these differences and their consequences, we refer to the German AMNOG-procedure. As a general rule, the early benefit assessment in Germany requires direct comparisons (head-to-head comparisons) or effect measures such as odds ratio, risk ratio even though these were not included in the clinical development programme. This leads to a situation where companies often have to perform post-hoc analyses that are expensive and time-consuming.

***3.1.c. For c) please provide concrete examples of the differences you are aware of and their effects for your organisation:**

Again, the differences in the economic assessments largely result from the diverging structures of Member States' statutory health insurance systems. For instance:

- Nordics consider indirect costs, but no other countries;
- Budget impact may include/not include diagnosis costs;
- Budget impact may focus on theoretical costs (based on SPC) vs real life costs (considering compliance, real use of medicines, etc);
- Different thresholds for cost/QALY.

In some Member States, an additional layer of differences exists at regional or even at local level, leading to additional evidence requirements, additional resources and eventually to differences in relation to the access to treatments for patients within the same country.

As mentioned above, the diverse HTA methodologies for economic assessments are particularly problematic for OMPs since many of the current HTA processes involve cost-effectiveness/cost-utility analysis which are inappropriate for their evaluation. Not only are OMPs forced into an inappropriate evaluation framework that was designed for medicinal products to treat more common diseases, attempts to adapt these frameworks to their unique considerations are often arbitrary, ad-hoc, and lack transparency.

***3.2. In your opinion, differences among EU Member States regarding HTA procedures and/or methodologies may contribute to (*one or more answers possible*):**

- [x] a) Duplication of work for your organisation
- [ ] b) Less work for your organisation
- [x] c) High costs/expenses for your organisation
- [ ] d) No influence on costs/expenses for your organisation
- [x] e) Diverging outcomes of HTA reports
- [ ] f) No influence on the outcomes of HTA reports
- [x] g) Decrease in business predictability
- [ ] h) No influence on business predictability
- [ ] i) Incentive for innovation
- [x] j) Disincentive for innovation
- [ ] k) No influence on innovation
- [ ] l) Other
- [ ] m) None of the above

- [ ] n) I don't know/No opinion

*3.3. In recent years EU-funded projects and two Joint Actions have been carried out which aimed at strengthening cooperation on HTA across the EU. Are you aware of these initiatives? (*one answer possible*):

- ( ) a) Yes, I have participated in one or more of these
- (•) b) Yes, I am aware of them, but did not participate
- ( ) c) No, I am not aware

***3.3.1. In general terms do you think the EU cooperation on HTA (e.g. projects, joint actions) has been**

- ( ) a) Useful
- (•) b) To some extent useful
- ( ) c) Not useful
- ( ) d) I don't know/No opinion

***3.3.1.1.Please indicate which of the following factors concerning projects and Joint Actions were relevant for your reply (*more than one answer possible*)**

- [x] a) Allowed for sharing best practices
- [x] b) Allowed for better knowledge of procedures and methodologies in other EU Member States
- [ ] c) Allowed for savings in your organisation
- [ ] d) Contributed to building trust between organisations and professionals involved
- [x] e) Contributed to HTA capacity building
- [x] f) Provided access to joint work[*]
- [ ] g) Provided access to work done by other HTA bodies
- [ ] h) Provided access to expertise not available in my organisation
- [ ] i) Reduced workload for my organisation
- [x] j) Contributed to increasing awareness and knowledge on HTA issues in my organisation
- [ ] k) Promoted involvement of patients' representatives in HTA activities
- [ ] l) Other

** "Joint Work" refers to activities in which countries and/or organisations work together in order to prepare shared products or agreed outcomes. These may include, for example, literature reviews, structured information for rapid or full HTAs, early dialogues or scientific advice on R&D planning and study design. Joint work aims at supporting Member States in providing objective, reliable, timely, transparent, comparable and transferable information and enable an effective exchange of this information (according to HTA Network's "Strategy for EU Cooperation on Health Technology Assessment" adopted in October 2014)" (according to HTA Network's "Strategy for EU Cooperation on Health Technology Assessment" adopted in October 2014)*

***3.3.1.1.1. Please provide additional explanations and, if available, evidence supporting your answers to question 3.3.1.1. (please provide a link to supporting documents in English)**

While EUCOPE applied for the participation as an observer in the Health Technology Assessment Network and in the EUnetHTA Stakeholder Forum, due to a limited number of seats, EUCOPE was not admitted. The answers to question 3.3.1.1. originate from EUCOPE members' experience:

- Sharing of best practices and access to joint work deliver quotable documents reflecting a state-of-the-art scientific view as well as a European view on statistical methods and clinical practice.

- Joint Assessments deliver a transparent and comprehensible data presentation.

3.3.1.1.2. Please indicate to the best of your knowledge to which degree joint work from EU-funded projects or Joint Actions was used by HTA bodies at national/regional level as part of their decision-making process:

	To a great extent	To a limited extent	Not used	I don't know
*a) Joint tools (templates, databases, etc)	○	◉	○	○
*b) Guidelines (e.g. for clinical and/or economic evaluations)	○	◉	○	○
c) Early dialogues	○	◉	○	○
*d) Joint reports on clinical assessments (REA)	○	◉	○	○
*e) Joint full HTA (clinical and economic assessment)	○	○	◉	○
f) Other (please specify below)	○	○	○	◉

* Early Dialogue (ED or early scientific advice) aims to provide prospective, transparent and timely advice by regulators or HTA body/bodies (multi-HTA) or both (parallel) to product' sponsors so that they may integrate their specific needs in the product development and generate evidence appropriate for HTA purposes (definition proposed by the EU-funded study SEED)

***3.3.1.1.3. Please indicate which shortcomings – if any - you identified in the EU-funded projects and/or Joint Actions**

The Joint Actions have not sufficiently reflected the specificities of OMPs, as there currently are no HTA model adjustments that address the challenges of the small patient populations and data limitations inherent in OMPs.

In addition, patient involvement is crucial, in particular in the field of OMPs where patients are the most knowledgeable individuals on the given disease.

4. EU COOPERATION ON HTA BEYOND 2020

***4.1. In your opinion is there a need to continue EU cooperation on HTA after 2020 (when the EUnetHTA Joint Action 3 will end)?**

- (●) a) Yes
- ( ) b) No
- ( ) c) I don't know / No opinion

*****4.1.a. If yes, please specify:

As explained above, the differences between HTA procedures as described above lead to considerable challenges for the industry, in particular for small to mid-sized companies. Thus, further cooperation and alignment regarding HTA methodologies is desirable while at the same time it is essential that this cooperation does not lead to a delay in patients' access to new forms of treatment.

4.1.1. In your opinion, for which health technologies an EU cooperation on HTA would be more useful and respond to your needs?

	Very useful	To some extent useful	Not useful	I don't know
*****a) Pharmaceuticals	(●)	( )	( )	( )
*****b) Medical devices	( )	( )	( )	(●)
c) Other (please specify below)	(●)	( )	( )	( )

***4.1.1.c. Please specify 'Other':**

- diagnostic procedures

- monitoring procedures
- oncological follow-up
- gene therapies

4.1.1.2. For which activities and if so to which degree do you consider that continuing EU cooperation on HTA beyond 2020 would respond to your needs?

	Responds very much to your needs	Responds to some extent to your needs	Does not respond to your needs	I don't know / No opinion
*a) Joint tools (templates, databases, etc)	◉	○	○	○
*b) Guidelines (e.g. for clinical or economic evaluations)	◉	○	○	○
*c) Early dialogues	◉	○	○	○
*d) Joint clinical assessment (REA)	◉	○	○	○
*e) Joint full HTA (clinical and economic assessment)	○	○	◉	○
f) Other (please specify below)	○	○	○	◉

***4.1.1.2.1. Please comment on the potential advantages and disadvantages of an EU initiative including the activities you consider useful for your organisation (e.g. workload, long-term sustainability of national healthcare systems, patients' accessibility to new technologies, business predictability, innovation)**

Advantages of an EU initiative would be:

- a reduction of the methodological differences, which could lead to a decrease in workload and increases business predictability and innovation;
- common guidelines that reflect the clinical practice in Europe will and create common standards for HTA production across the EU Member States;
- alignment on data requirements.

However, bearing in mind that the design and administration of healthcare systems is an exclusive Member State competence and that the national healthcare systems differ significantly, it is doubtful whether a joint full HTA including an economic assessment is a reasonable approach. Another possible disadvantage could be a delay in patients' access to new treatments due to the efforts to find a common denominator. Such delay has to be avoided.

***4.1.1.3. In case EU cooperation on HTA will continue beyond 2020, in your opinion, what type of financing system should be envisaged? (*one possible answer*):**

- ○ a) EU budget
- ○ b) Member States
- ○ c) Industry fees
- ○ d) A mix of A to C
- ◉ e) Other

***4.1.1.3.e. Please specify 'Other':**

The cooperation should be financed by the EU and Member States. Industry fees are only an option if there are costs offsets at Member State level. It is essential that the cooperation does not put an additional financial burden on companies, in particular SMEs.

***4.1.1.3.1. Please explain your answer and comment on issues such as feasibility, advantages and disadvantages**

2000 character(s) maximum (1990 characters left)

See above.

***4.1.1.4. In case EU cooperation on HTA will continue beyond 2020, in your opinion, the secretarial/organisation support should be ensured by (*one or more answers are possible*)**

- ☑ a) European Commission
- ☐ b) Existing EU agency(ies)
- ☐ c) New EU agency
- ☐ d) Member States HTA bodies on rotational basis
- ☐ e) Other

***4.1.1.4.1. Please explain your answer(s) and comment on issues such as feasibility, advantages and disadvantages**

2000 character(s) maximum (1831 characters left)

The European Commission would be the best suited institution to run the secretarial functions of such EU cooperation, to ensure coherence and neutrality in the process.

4.1.1.5. In your opinion, regarding an initiative on EU cooperation on HTA beyond 2020, which type of cooperation would respond to your needs? Please rank the following options from the most to the least preferable option).

	a) Most preferred option	b)	c)	d)	e) Least preferred option
*a) Voluntary participation with voluntary uptake of joint work (i.e. as carried out by EUnetHTA Joint Actions)	○	○	○	◉	○
*b) Voluntary participation with mandatory uptake of joint work for the participants	◉	○	○	○	○
*c) Mandatory participation with mandatory uptake of joint work	○	○	○	○	◉
d) Other (please specify below)	○	○	○	○	○

***4.1.1.5.1. Please explain your answer(s) and comment on issues such as feasibility, advantages and disadvantages**

2000 character(s) maximum (1676 characters left)

We assume that "voluntary" and "mandatory" refer to the participation of Member States. Against the background of the Member States' exclusive competences on pricing and reimbursement a mandatory participation is not an option. However, if stakeholders agree on the participation the results of this exercise should be taken up at national level. It is essential that any duplication of work will be avoided.

5. Any other comments. Uploading relevant documents is also possible.