EUCOPE

Market Access / Pricing & Reimbursement Meeting

Brussels, 10 September 2019

Agenda (1/2)

I. **Welcome / Introduction / Meeting agenda and objectives**

II. **Greece: New pricing system & the establishment of the HTA agency**
Isidoros Kougioumtzoglou, VIANEX

III. **The UK: UK environmental update: policy, pricing and reimbursement**
Stephen Norton, MAP BioPharma

IV. **Reimbursement models in the Middle East**
Hanadi Nahas ElDana, AccessCore

- **General overview of the region**
- **Pivotal hurdles common in the region**
- **How to overcome these hurdles**

V. **The Multi-Stakeholder initiative on how to optimize evidence generation to demonstrate the value of highly innovative technologies**
Marie-Hélène Fandel, AMGEN & **Laura Batchelor**, FIPRA

Agenda (2/2)

VI. **Germany: The implementation of the Act for More Safety in the Supply of Pharmaceuticals – GSAV**

- **Mandatory data collection and pricing**
  Hans-Jürgen Seitz, IGES
- **Legal aspects of the implementation process**
  Alexander Natz, EUCOPE

VII. **EU-Proposal on Joint HTA**
Karolin Eberle & Annette Fasan & Nina Seiler, AMS

- **Differences in methodology (Proposal – EUnetHTA - Germany)**
- **Choice of comparator**
- **Health outcomes and outcome measures**
- **Type of required studies and evidence**
- **Positioning of EUCOPE**

VIII. **AOB / End of meeting**

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I.
Welcome / Introduction / Meeting agenda and objectives

Chairs

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Upcoming Events

https://www.eucope.org/calendar-of-events/

- 11 September 2019: Workshop Post-EU Elections
- 30 September 2019: Legal Working Group Meeting, Geneva
- 9 October 2019: OMP Meeting, Brussels
- 16 October 2019: EUCOPE Members' Meeting, Brussels
- 5 November 2019: Regulatory / PV / Medical Devices Meeting, Brussels
- **21 November 2019: Market Access / Pricing & Reimbursement Meeting, Brussels**
- 10 December 2019: OMP Meeting, (TC)

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EURIPID Stakeholder Network Meeting

- EURIPID is a voluntary cooperation of a number of European countries which maintains a (publicly not accessible) database with information on national prices
- EURIPID has organised a Stakeholder Network Meeting on Monday, **23 September 2019, 10:30 am - 5:00 pm in Budapest**
- The draft agenda foresees the formation of three working groups, namely
  - Increasing Transparency of Pricing (including "*investigating the options to share real prices*")
  - Monitoring the Uptake of the Recommendations of the EURIPID Guidance Document on External Reference Pricing
  - Measuring patients' access to medicines with the help of EURIPID

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International Horizon Scanning Initiative

Industry information meeting on 12 July

- EURIPID IHSI aims to **develop a horizon scanning database** to inform decision-makers on emerging and **new pharmaceuticals for reimbursement decisions**.
- Objectives of the meeting were to **provide information and an update on IHSI**, **facilitate an exchange of experiences of Horizon Scanning (HS) systems**, discuss **timelines** and **initiate a partnership with the industry**.
- Final **list of participating countries** is expected by November 2019.
- Discussions focused on the **database**, **synergies** with existing national HS systems and EMA early dialogues, and the definition of "**high impact**" and **criteria for prioritisation of products** selected for the high impact reports.
- **Tendering process** (to select the operator that will set up and manage the database) to be launched soon, and **first board meeting** to take place before year end.

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II.

Greece: New pricing system & the establishment of the HTA agency

Isidoros Kougioumtzoglou, VIANEX

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Greece: New pricing system & the establishment of the HTA agency

10 Sept. 2019, Brussels

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Agenda

Greece

- Pharmaceutical Market
  - Demographics
  - Pharma Expenditure
- Market Access
  - New Pricing System
  - Reimbursement & HTA

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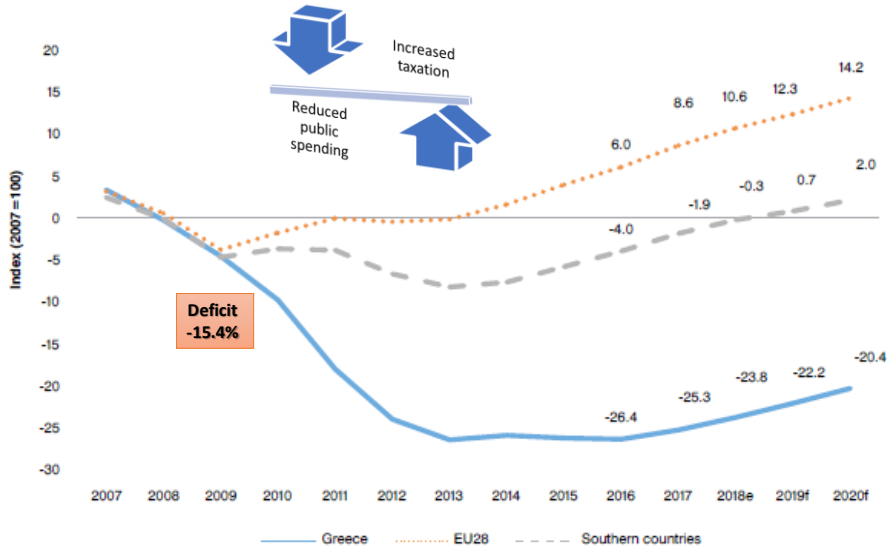
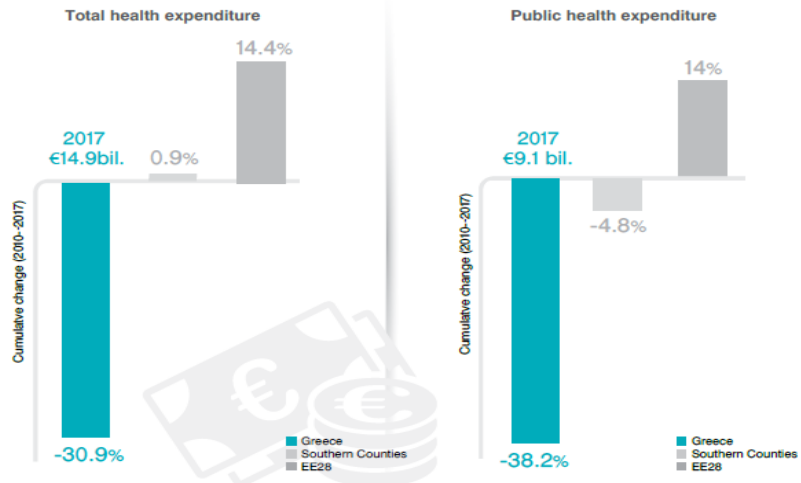
Index of cumulative GDP change (%) Greece-EU28-Southern countries



SOURCE: Eurostat, 2019, AMECO, European Commission, Winter 2019 Economic Forecast (February 2019), GDP Chain linked volumes 2010, data processing IOBE*Southern countries (Italy, Spain, Portugal), e-estimation, f-forecast

Health & pharmaceutical expenditure

"Total health expenditure decreased by -30.9% in the period 2010-2017, with «the largest decline in public health expenditure by -38.2%, respectively"



SOURCE: System Health Account (SHA) 2016, OECD Health Statistics, 2018, IOBE data processing. Southern Countries (Italy, Spain, Portugal) Percentage changes between 2009 and 2017 have been calculated in the Fixed Price Data ($ 2010 PPS, OECD).

Demographics factors

"Life expectancy is high, steady reduction of the population (births-deaths) and increased ageing population"

	Greece	Southern countries	EU
Life expectancy (years) 2016	81.5	83.2	81.0
Births-Deaths (thousand persons) 2017	-35,948	-245,286	-190,871
Share of population > 65 years (%) 2020	22.6%	21.8%	20.4%

SOURCE: OECD, Health Statistics 2018, Southern countries (Italy, Spain, Portugal), data processing IOBE, Natural change is defined as the change due only to the difference in births - deaths without taking into account immigration. The number of births does not include stillbirths, which in 2017 amounted to 363. Eurostat, Population Projections, 2018, data processing IOBE, not included the possible legalization of migration from 2015 onwards

Population >65: **36.5%** in 2050

Unemployment rate & Poverty risk

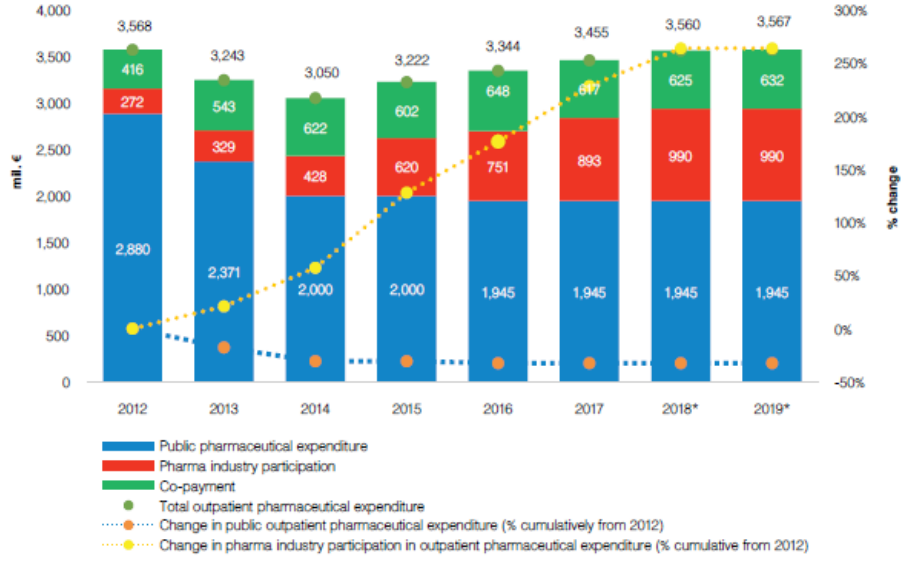
"The high unemployment rate, more profound on young people - almost half out of the labour market - composing the most productive age group, resulting in brain drain"

		Greece	Southern countries	EU
Unemployment (%) 2017	Population	21.5%	12.9%	7.6%
	15-24 years	47.3%	39.6%	18.7%
Poverty Risk (%)2017		34.8%	27.3%	22.5%

SOURCE: Eurostat, 2019, European Commission, Winter, 2019 Economic Forecast, data processing IOBE. Southern countries (Italy, Spain, Portugal). Percentage of people at risk of poverty: percentage of people with disposable income equivalents below 60% of the national median income. Median income is the income above which is the 50% of the population

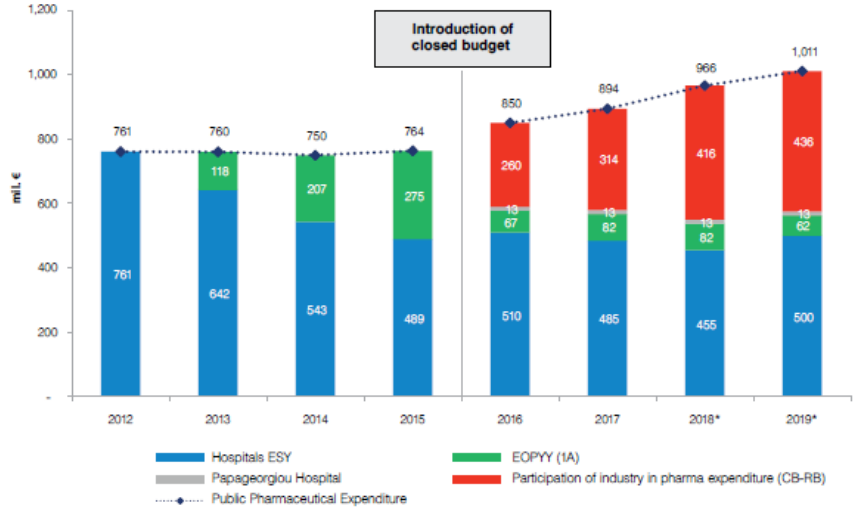
Unsustainable Environment

Total outpatient pharmaceutical expenditure



Source: EOPYY 2012-2018, State Budget 2014-2018, data processing IOBE-SFEE Patient participation: What the patient pays to the reimbursed market (i.e. 0%, 10%, 25%) and the burden resulting from the difference between Retail Price - Reimbursement Price.

Public hospital pharmaceutical expenditure and industry's contribution

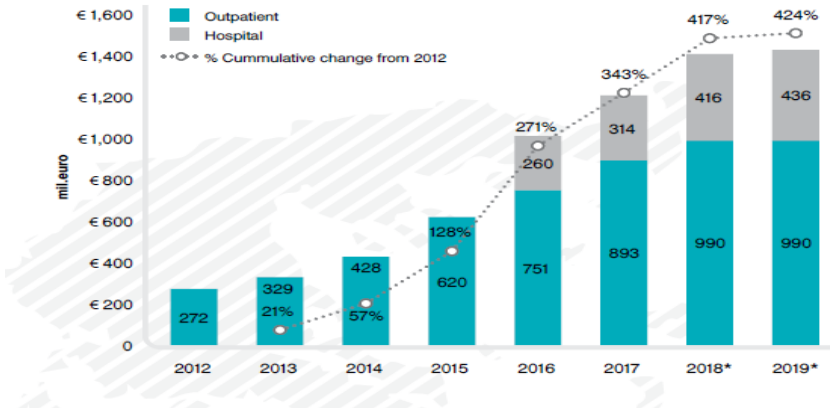


Source: EOPYY 2012-2018, State Budget 2014-2018, data processing IOBE-SFEE. Note: Estimations for 2018 for industry's contribution according to 2017. Public hospital pharmaceutical expenditure: data from ESY.net and EOPYY for 2013-2015.

The contribution of pharmaceutical industry

EUCOPE
European Confederation of Pharmaceutical Entrepreneurs AISBL

Industry contribution on total pharmaceutical expenditure (clawback and rebates)



"The significant reduction in the public sector's contribution to pharmaceutical expenditure, resulted in a shift towards private sector and the pharmaceutical industry especially. The pharmaceutical industry, through clawback and rebates, covers the needs of patients for pharmaceutical coverage by providing free of charge 1 out of 3 outpatient and 1 out of 2 hospital medicines"

VIANEX S.A.

Rebate & Clawbacks

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Rebate:

The mandatory discount that private providers (physicians, pharmacists, pharmaceutical companies, diagnostic centers) are obliged to make to EOPYY and Hospitals depending on their revenues.

14% - 30%

Formula: $$P_0 = \min\left\{P_0^{max}, \min\left[P_v^{max}, \sum_{i=0}^{i=2}\left(\frac{a_i + b_i \times I_{50}}{100}\right)X^i - P_{HCD}I_{HCD}\right] + P_{New}I_{New}\right\}$$

+25% new active substances

Clawback:

Clawback is a mechanism introduced by the Greek government for the control of public pharmaceutical expenditure. This mechanism ensures that the budgets of social insurance funds and hospitals do not exceed a certain ceiling of pharmaceutical expenses, and the excess amount is automatically requested from the pharmaceutical companies.

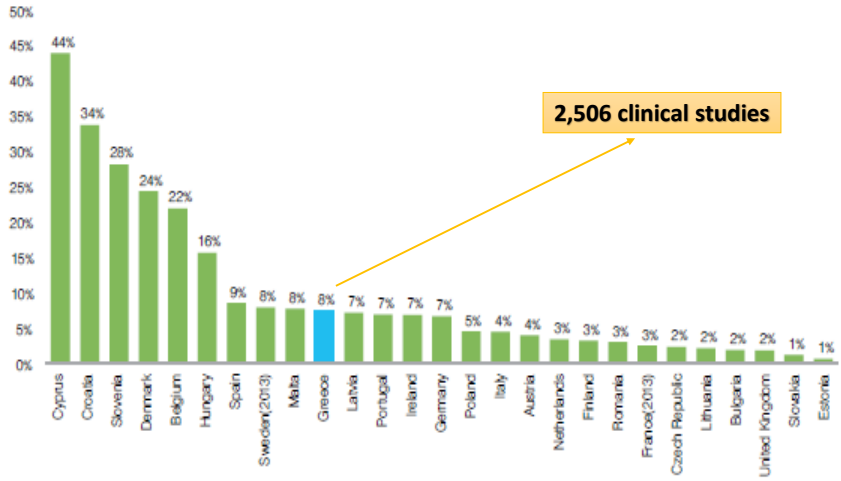
Excess = Total Reimbursed Market – Spending Target

90% → $MSh(\%) = \frac{RmbSales_{NVS}^{2017}}{\sum_{for\,allC} RmbSales_{C}^{2017}}$ → Share Penalty

10% → $GSh(\%) = \frac{Sales_{NVS}^{2017} - (Sales_{NVS}^{2016} - CB_{2016}^{NVS})}{\sum_{for\,growingC} Sales_{C}^{2017} - (Sales_{C}^{2016} - CB_{2016}^{C})}$ → Growth Penalty

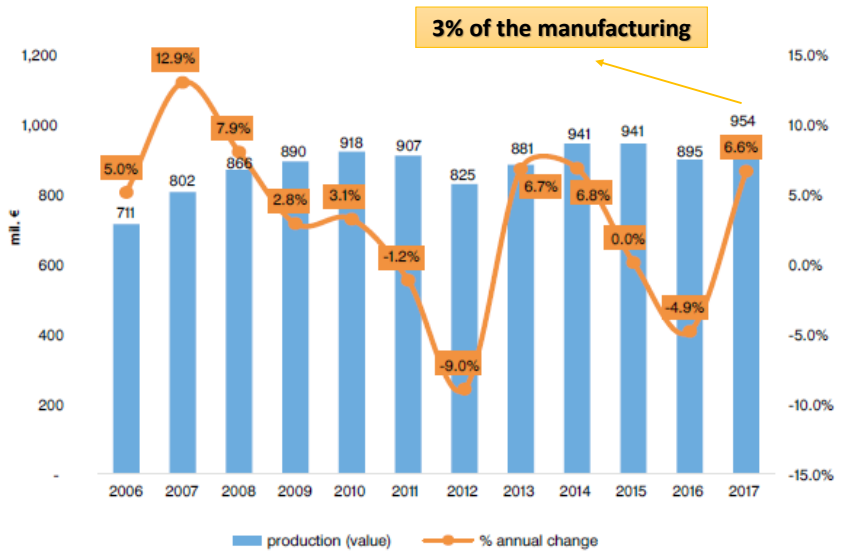
VIANEX S.A.

Pharmaceutical R&D expenditure (% of total R&D expenditure)



SOURCE: Eurostat, 2018, data processing IOBE

Production of pharmaceutical products (mil. €)



Source: Eurostat 2018, PRODCOM Database. *Any changes based upon review of data from Eurostat

New Pricing System in Greece

L.4600 – 09/03/2019
Government Gazette 1508/ B/ 07-05-2019

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Why a new pricing system was needed?

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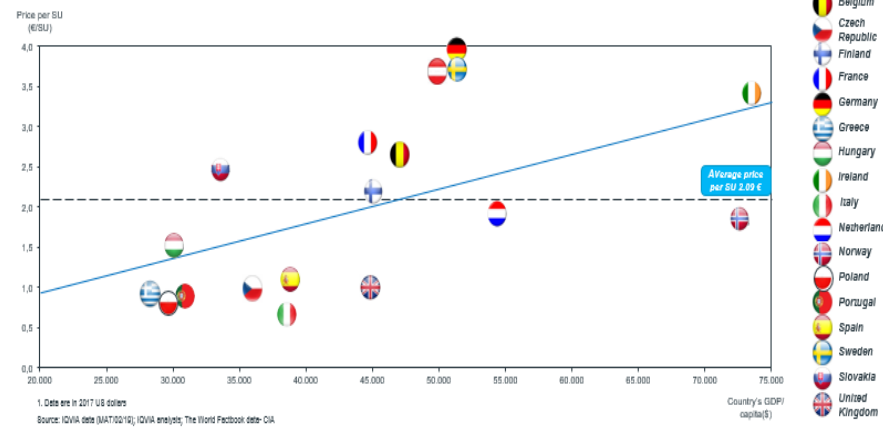
*"On-patent drugs in Greece have one of the **lowest average prices**, compared to other EU countries having similar GDP per capita[1]"*

Price per SU (in €/SU) and country GDP – (MAT/02/19)

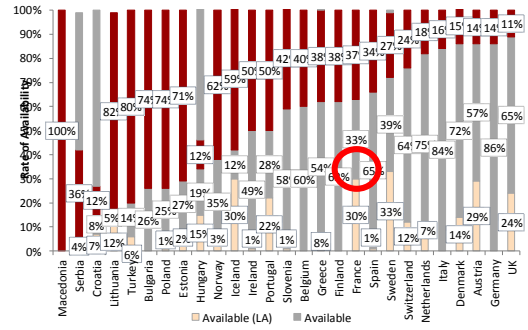


1. Data are in 2017 US dollars
Source: IQVIA data (MAT/02/19); IQVIA analysis; The World Factbook data- CIA

VIANEX S.A.

Rate of Availability (%)

" The rate of availability, measured by the number of medicines available to patients in European countries as of 2018: for most countries this is the point at which the product gains access to the reimbursement list. "



IQVIA: Data N/A- data is not provided by associations (companies have not sent data or are not members of the association)
Available (LA) - products which have been reimbursed or are pending reimbursement, with specific conditions

Pillars of the new pricing system

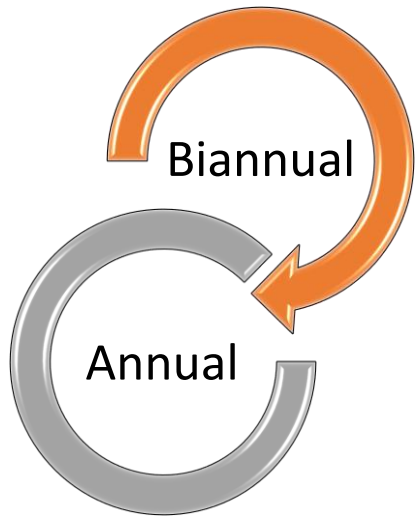
What hasn't changed

- International reference pricing **(IRP)** remains the method used by Greece to set its drug prices
- IRP is the **sole** criterion for the prices

What has changed

- Frequency of pricing reviews
- Basket of countries
- Methodology for the calculation of the prices

Frequency of pricing reviews



The former minister of health argued:
" A simpler and more transparent legislative system *"*

Old basket - EU countries

"The ex-f prices were determined by the average of the 3 lowest EU countries"

New basket - EZ countries

"New medicines should be priced in at least 3 EZ countries"*

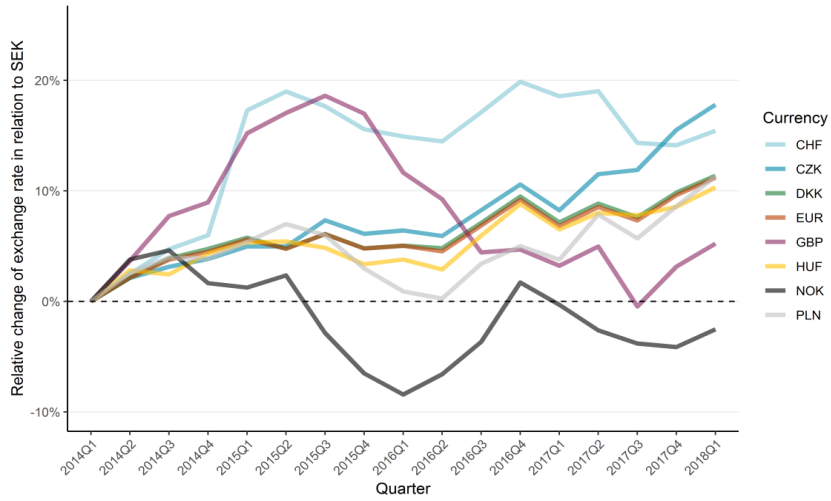
"The ex-f prices is set by the average of the 2 different lowest EZ countries "

"Leads to higher prices in the majority of the cases"

**Orphan drugs excluded*

Additional advantage of the new basket

" Prices are not affected by the floating exchange rate "



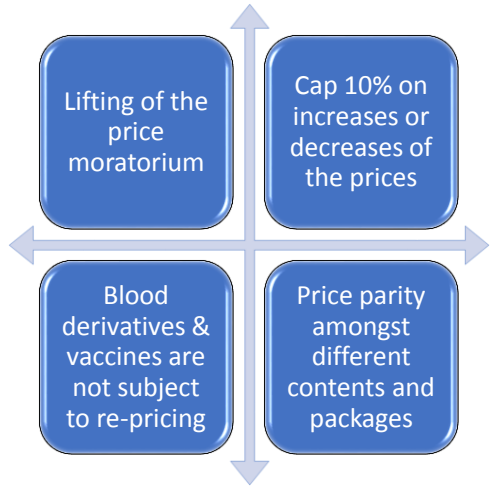
Relative exchange rate fluctuation of the currencies of the report's countries in relation to the Swedish krona. Q1 2014 - Q1 2018

Source: Eurostat and TLV analysis.

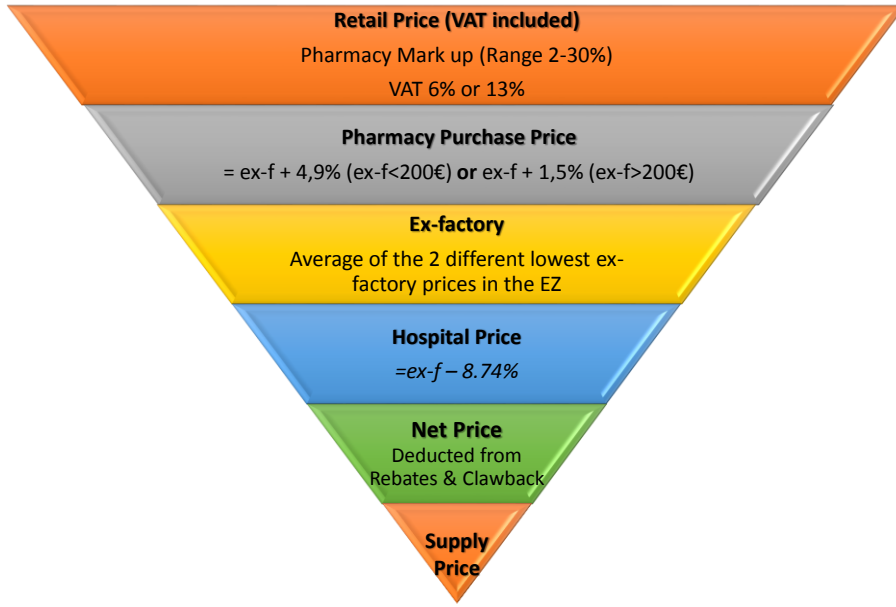
Analytic overview of the pricing system

On patent medicines		Average of the 2 different lowest ex-factory prices in the EuroZone (19) *Same formulation – concentration - package*
Biologics, Biosimilars, Orphans, Blood derivatives, Vaccines		
Off patent medicines		Average of the 2 different lowest ex-factory prices in the EuroZone (19) *Same formulation – concentration - package*
Generics	Ref. Product Availiable	• 65% of the current price of the ref. product (which is determined based on the IRP system)
	Ref. Product Non - availiable	Price linkage to marketed generics
Domestically manufactured AND Unique Generics		Cost plus approach
Hybrids & well-established (Domestically Manufactured)		

Pricing methodology



Price's Levels



Published prices

Which price levels are publicly available?

- Ex-factory
- Pharmacy Purchase Price
- Retail Price

Official Web Site

http://www.moh.gov.gr/articles/times-farmakwn/deltia-timwn

Rebates, Clawbacks and discounts during the negotiation process, **are never published.**

The establishment of the HTA agency

1 year experience

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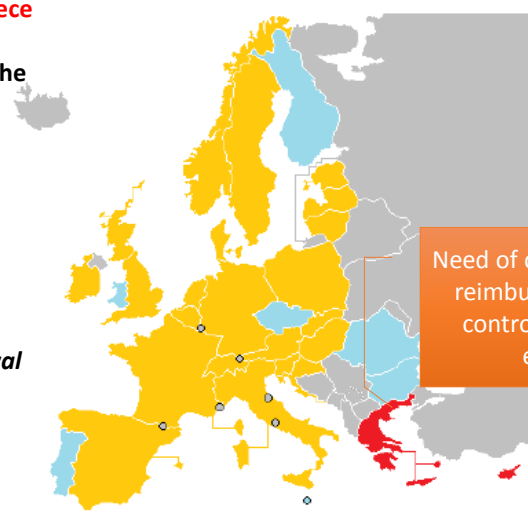
Overview of HTA activity

Reimbursement before HTA in Greece

Submission of documentation to the Positive List Committee

1. *Application*
2. *Fee*
3. *Clinical trials*
4. *SPC*
5. *Pharmaco-economic studies*
6. *External criteria*

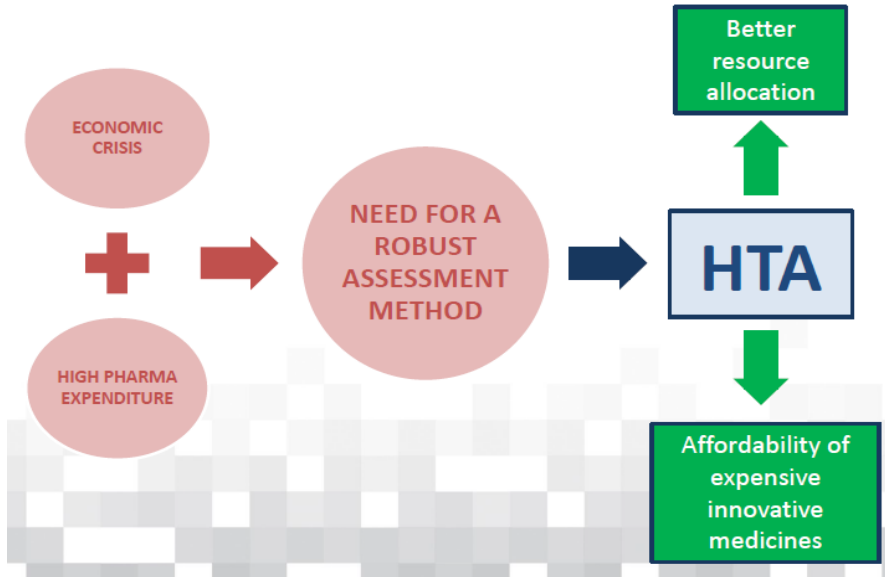
60 days to reimbursement approval



Need of changing medicines' reimbursement policy to control pharmaceutical expenditure

Key: N=31 countries with England, Scotland and Wales counted separately; red = no current HTA procedure; blue = pharmaceuticals only; yellow = both pharmaceuticals and non-pharmaceuticals

HTA is a critical change



New Reimbursement System - HTA


ΕΦΗΜΕΡΙΔΑ ΤΗΣ ΚΥΒΕΡΝΗΣΕΩΣ
ΤΗΣ ΕΛΛΗΝΙΚΗΣ ΔΗΜΟΚΡΑΤΙΑΣ
ΝΟΜΟΣ ΥΠ' ΑΡΙΘΜ. 4512

January 2018: Institutionalization of HTA Committee


ΕΦΗΜΕΡΙΔΑ ΤΗΣ ΚΥΒΕΡΝΗΣΕΩΣ
ΤΗΣ ΕΛΛΗΝΙΚΗΣ ΔΗΜΟΚΡΑΤΙΑΣ
ΑΠΟΦΑΣΕΙΣ
Αριθμ. οικ. 52029

July 2018: Scientific Sub-Committee (HTA)

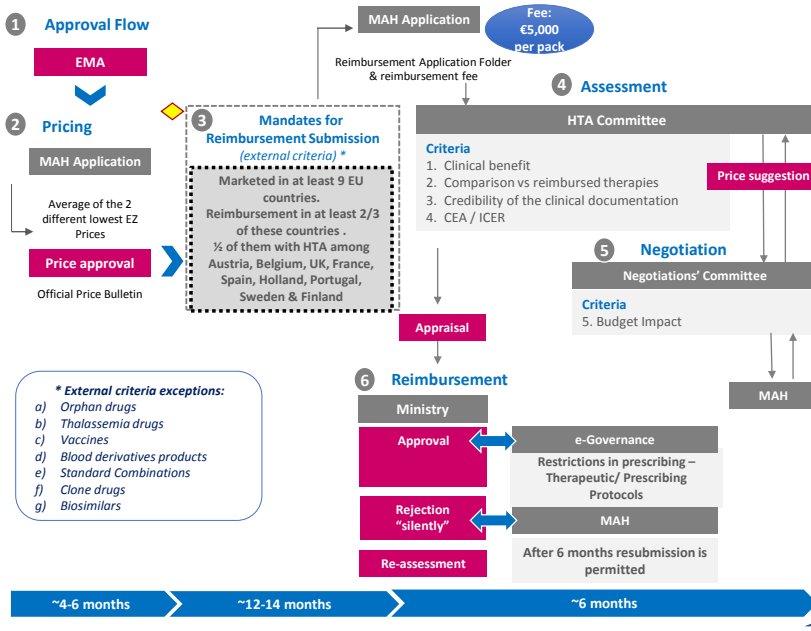
- *Main stakeholder for reimbursement decision.*
- *Assesses the clinical benefit (added value) of the treatment (based on clinical trials, HTA decisions of EU countries & Cost-effectiveness analysis)*


ΕΦΗΜΕΡΙΔΑ ΤΗΣ ΚΥΒΕΡΝΗΣΕΩΣ
ΤΗΣ ΕΛΛΗΝΙΚΗΣ ΔΗΜΟΚΡΑΤΙΑΣ
ΑΠΟΦΑΣΕΙΣ

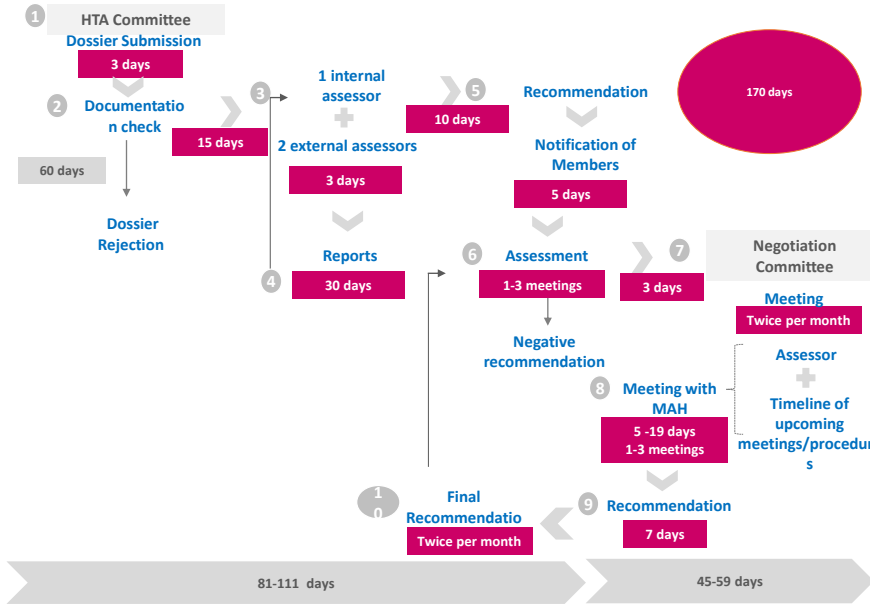
August 2018: Negotiation Sub-Committee

- *Main stakeholder for setting/negotiating the final reimbursement price.*
- *Assesses the Budget-Impact of the new treatment to be reimbursed.*

Flowchart of the HTA process



Flowchart of Dossier Assessment



Actual time to final HTA assessment

All new prescription drugs are subject to HTA assessment (on-patent, orphan drugs, vaccines, blood products, generics, biosimilars, clone drugs) and even new indications, formulations or packages

- **Timelines (180 days) of final assessment have not been followed**

1. **Due to:**
   - The volume of technologies to be assessed
   - Low availability of reviewers (mainly due to conflict of interests)
   - Low quality or even absence of clinical trials (HTA Committee opinion)

❓ **2. "Silent" rejection**

Source: Kanavos, P. et al. (2019) Archives of Hellenic Medicine

Submitted Dossiers to the HTA Committee

Month	Number of Submitted Dossiers
August 2018	6
September 2018	15
October 2018	19
November 2018	6
December 2018	19
January 2019	1
February 2019	9
March 2019	10
April 2019	17
May 2019	3
June 2019	6
July 2019	3
Total	**114**

✓ Only 6 drugs have gone through negotiation and have been reimbursed

Source: Hellenic Association of Pharmaceutical Companies (SFEE)

HTA Dossier

1. Description of the product (indication, administration)

2. Disease Description (epidemiology, burden of disease)

3. Clinical Benefit (therapeutic added value, summary of clinical trials, innovation description)

4. Comparison with currently reimbursed options (competitor landscape, guidelines, treatment pathway)

5. Economic Evaluation (CEA, BIA, Summary of HTA appraisals)

Assessment Criteria

1. <u>Clinical Criteria</u>

a) Added therapeutic value

- Burden of disease (morbidity, mortality)
- Safety and efficacy of the product
- Comparison with currently available (reimbursed) treatment options

b) Credibility of the clinical documentation (GRADE)

c) Innovation (medicinal value, value for the healthcare system, innovative product)

2. <u>Economic Criteria</u>

a) Cost-effectiveness analysis

b) Budget-impact analysis

HTA Committee's recommendation concerns the specific indication, pharmaceutical formulation & dosage of the product under evaluation

Health Economic Assessment

- ***Cost-effectiveness analysis*:**
  - ❑ Submission of local CEA and all available CEAs
  - ➢ *Absence of specific guidelines regarding the structure and methodology of CEM*
  - ➢ *Non-determined ICER threshold*

- ***Budget-impact analysis*:**
  - ❑ Submission of local BIA with 5-year time-horizon
  - ❑ Pre-specified tables to be included in the Value Dossier
    - ✓Budget-Impact (in case of reimbursement of drug under evaluation)
    - ✓Management Cost
    - ✓Market Shares
    - ✓Drug Acquisition & Administration Savings
    - ✓Non-pharmaceutical Savings (i.e. management of disease)
  - ➢ *Limited local epidemiological data (absence of patient registries)*
  - ➢ *Limited costing data (i.e. regarding AEs, cost of illness)*

The role of the Negotiation Committee

BIM consists a tool for the Negotiation Committee!

a) Negotiation of reimbursed prices through discounts or risk-sharing agreements for the Public payer (EOPYY) & Public hospitals

b) Recommendation to the Scientific Committee regarding the BI of the treatment for the public payer by its inclusion to the Positive List

c) Binding and **Confidential** agreements with MAH

Starting point for Negotiation is the impact of Rebates & Clawbacks

Summary

Delays in drug inclusion to the Positive List are the biggest threats to:

- pharmaceutical companies (medicinal market access, investment in market access departments and experts) *and are at the expense of*
- *public health and patients (access of innovative drugs for life threatening diseases)*
- *public health expenditures (financial burden due to delays in access of generics & biosimilars)*

Source: Kanavos, P. et al. (2019) Archives of Hellenic Medicine

THANK YOU!

III.

The UK: UK environmental update: policy, pricing and reimbursement

Stephen Norton, MAP BioPharma

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UK environmental update: policy, pricing and reimbursement

MAP BioPharma presentation to EUCOPE MA P&R group September 2019

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Topics for today

- 2019-24 VPAS
  - Continuing developments in implementation
- NICE 2020 Methodologies Review
  - Progress so far
  - Focus on real-world evidence
- NHS England Commercial Framework
  - What we know
- News from Scotland

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2019-24 VPAS update

Voluntary Scheme for Branded Medicines Pricing and Access

- Scheme received well, overall
- Builds on productive aspects of previous PPRS
- Rebate level expected between 8-11% for 2020
  - Reported at September EMIG meeting
- Key items to be resolved:
  - Extra support for five highest health gain categories
  - NICE to review all new products
  - Establishing a new Commercial Framework

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NICE 2020 Methodologies Review

Familiar themes are in scope for the Review

1. Modifiers considered in decision making	*Requirement of the 2019 VPAS*
2. Exploring uncertainty	
3. Types of evidence (sources and synthesis)	*Scientific and methodological innovations*
4. Health-related quality of life	
5. Technology-specific issues	
6. Discounting	
7. Cost-minimisation methods	
8. Equality considerations in guidance development	*Other general improvements*
9. Costs used in Health Technology Assessment (HTA)	
10.Position of technologies in the care pathway	
11.General approach to decision making	

From: https://www.nice.org.uk/news/article/nice-announces-details-of-health-technology-evaluation-methods-review

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Real-world evidence (RWE) has been highlighted in two specific topics of the NICE methods review

- Topic 2: Exploring uncertainty
- Topic 3: Types of evidence (sources and synthesis)

2015	2016	2017	2018-19
Commissioning through Evaluation – promising products needing more evidence	EMA Adaptive Pathways pilot Public discussions of pros and cons of RWE: *"can be a useful addition"*	Using RWE in decision-making GetReal Initiative • Decision-making framework, case-studies, trial design	Aug 2017 – Aug 2018, 15.8% with MEAs (n=101) Aug 2018 – Aug 2019, 22.0% with MEAs (n=59) **All** recommended, CDF, or optimised

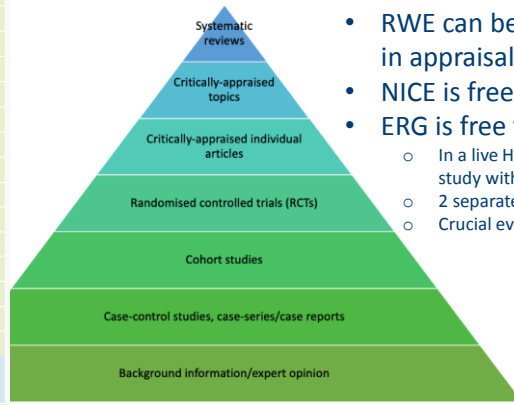
Topic 2 poses questions RWE could answer, given the right system

Topic 2 asks: how should NICE quantify and compare uncertainty?

- Uncertainty arises from:
  - **Extrapolation** when making long-term claims from short-term data
  - Choice of/assumptions in analytical methods
  - Justifying the use of **real-world evidence**
- Managed entry arrangements (MEAs), Cancer Drugs Fund (CDF): collection of RWE to mitigate uncertainty **under current rules**
- If uncertainty is quantified, would this become mandatory at some threshold?

Topic 3 may answer some key industry requirements around acceptable evidence

This topic will explicitly determine if randomised, non-randomised, and real-world evidence types are considered appropriately.



- Not all evidence is objectively equal
- RWE can be the deciding evidence in appraisal
- NICE is free to make a judgment
- ERG is free to make a judgment
  - In a live HST, ERG has replaced pivotal Ph III study with other data in the model
  - 2 separate single-arm trials
  - Crucial evidence is RWE from US-based study

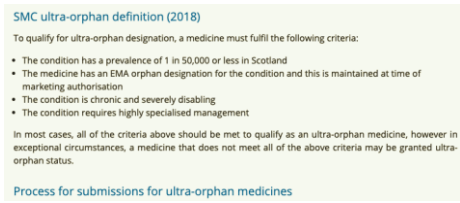
NHS England Commercial Framework

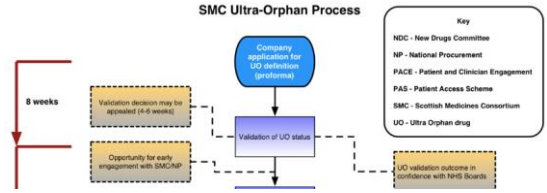
- Commercial Medicines Directorate established under Blake Dark
- Focussed on ensuring products demonstrate **value**

Framework will:	Framework will not:
• Facilitate enhanced horizon scanning • Ensure confidence that commercially sensitive information remains so • Allow proactive engagement between NHS and industry to ensure alignment on mutually beneficial objectives • Support the NICE appraisal process and the publication of timely guidance • Clarify the process for innovative solutions to healthcare challenges on a case-by-case basis • Facilitate development of strategic partnerships	• Compromise or contravene the principles of the Voluntary Scheme • Provide an alternative route to market via bypassing NICE

Scotland update – SMC

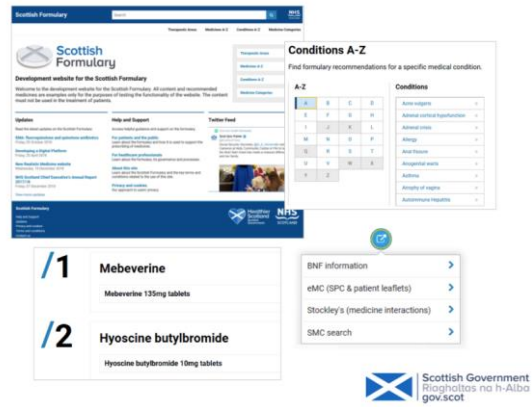
- SMC ultra-orphan process
  - Allows temporary access with later review
  - Mandatory data collection phase (RWE)





Scotland update – Single National Formulary

- Delayed from original timeline
- Single region in 2019, national in 2020
- Condition-based formulary
- Details still unclear



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Thank you for your attention

MAPOnline
The only validated web-based market access resource

MAP BioPharma
ACCELERATING PATIENT ACCESS

IV.
Reimbursement models in the Middle East

Hanadi Nahas ElDana, AccessCore

Pricing and Reimbursement in MENA Region

Presented by Hanadi Nahas

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Brief Biography

- Pharmacist, 24 years experience in Pharma
- 16 years in Roche: 10 years Market access for region: Iraq, Leb, Jordan, UAE,etc…
- Feb 2019, GM Accesscore, consultancy company for health policy and access

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P & R in MENA region

- Lebanon
- Iraq
- Jordan
- UAE

P & R in MENA region
Lebanon

- Overview of country
- Different reimbursement bodies
- Registration timelines
- Decision making
- Key Access issues impacting Economic and Environmental
- Key challenges for the new drugs
- Solutions

Lebanon: Where do we stand ?

Country status

- Country: Lebanon
- Population:4,501,636 (1)
- GDP: 2.3%
- Large public debt & slow economic growth

Healthcare (HC) situational analysis

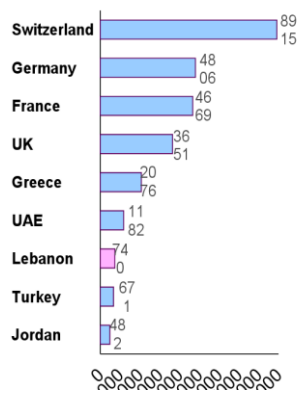
- HC system well developed in private and public sector
- The access to HC is high across the Lebanese territory
- Several reimbursement bodies in place, covering all the Lebanese population
- HC expenditure/GDP:(2) 6.91%
- HC expenditure: $4.14 billion in 2017 to $4.32 billion in 2018.
- Per capita health care expenditure is expected to rise from $681 in 2017 to $868 in 2022.
- MOPH to curb expenditure on Oncology due to high annual average cost (6,475$ per patient (3))

1:MOPH Statistical Bulletin 2016
2:Reimbursement of Oncology Drugs in Lebanon Fadia Elias Pub 2016
3: Financial Burden of Cancer Drug Treatment in Lebanon, Fadia Elias and al, APJCP.2016.17.7.3173
BMI

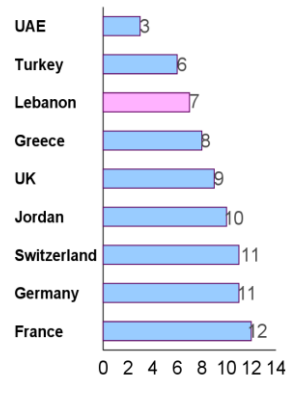
Basic Comparative Metrics

Lebanon HC expenditure is high and comparable to some EU countries

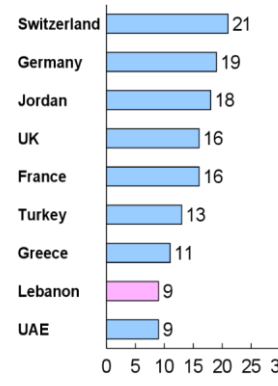
Total country health expenditure per capita (Current US $)



Total country health expenditure (% GDP)



Expenditure in % of total government expenditure



Notes: Lebanon is well developed in HC compared to other Arab countries, the aspiration is to meet the European standards. The UK Nice is being taken as reference for reimbursement. France has quite similar HCS. Greece has similar genetics. Source: World bank 2012

Patient Access today – General Situation*

Total Population: 4'501'636 **M

83% of the population are covered by the biggest 3 segments

Segment Name	Segment Size	Segment definition
MOPH	40%	Public, covers all the uninsured patients
NSSF	33%	Private, employment-based
MOD	10%	Public, Military scheme
COOP	9%	Public, covers all public administration
ISF+GSF+SSF	5%	Public, Military Schemes
OoP	3%	Private
Total	100%	

*Primary MR- MOH/NSSF/COOP Website –Market insights- Internal sales reports
*µMOPH Statistical Bulletin 2016

Registration Process

Submission to technical approval: 4-5 months

- Registration file CTD
- Legalized CoPP
- 2 samples + 3 CoAAs
- Statement identifying the responsible party
- Price Certificate
- Full shelf-life stability data
- Statement showing the Drug Substance manufacturer
- FDA/EMEA approval

✓ Legalized Annex 3
✓ Legalized GMP

Price Review: 1-1.5 months

Technical Committee 8 members → Meets 6x/ month First installment of fees (900 USD)

Technical approval

Pricing committee

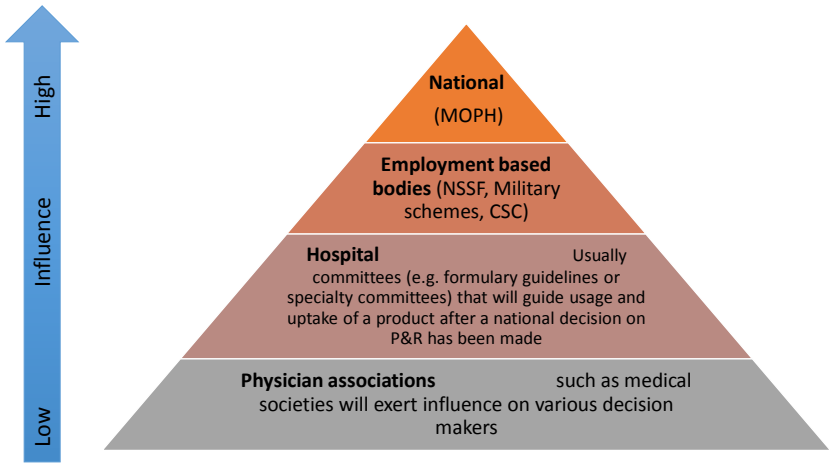
Administrative step: 1 month

Pricing approval

MA approval (Indefinite validity) → Second installment of fees (2250 USD)

Registration process takes around 9 months

Hierarchy for decision making for drugs and the need of considering these different stakeholders when developing a Market Access Strategy



National Social Security Fund

Covers around 30% of the Lebanese population

National Social Security Fund - NSSF

1. The manufacturer submits the Technical file known as the Value Dossier
2. Medical Control Department Studies the Clinical Effectiveness and the Economic Evaluation of the drug
3. The dossier will then be presented to a committee, which consists of pharmacists and physicians who perform the assessment and issue the decision regarding the reimbursement

Timeline: 3-4 months

Trend	Description
Regional Political Crisis	• Burden of refugees on the economy • Negative impact on tourism • The Government priority in not on HC but to manage the detrimental effect ➢ **Significant negative impact on HCS**
MOPH to curb expenditure on Oncology	• Trend towards decreasing the oncology budget • Laws are subject to change with the termination and assignment of new ministers ➢ **Current Pricing regulations create instability in pricing forecasts** ➢ **More pressure and delay in the registration and reimbursement of new products (NICE guidelines)** ➢ **BS accelerated entry**
Rising importance of HTA and Guidelines	• Many reimbursement bodies are interested to have HTA in place • Reimbursement bodies influenced by global HTA (NICE) • Willingness to discuss new innovative pricing models • Increasing delay for reimbursement for ID ➢ **Increase emphasis on outcomes and PE models/CA**
Increasing cooperation between HA & pharmaceutical companies and private sectors	• MOPH invites private sector to contribute to cost savings • MOPH established a National Committee for MEA • Public payers openness to innovative PPP including PSP ➢ **Potential to create PPP/MOU between Pharma and HA**
Increased adoption for local manufactured drugs & encouragement for BS entry on the short term	• BS local regulations published in 2016 • Lack of BS procurement guidelines and policies (incl PV) • Accepting and encouraging local manufacturing for NCBs submission ➢ **Reduce budget availability for innovative drugs**
Private budget constraint	• Access is based on ability to pay rather than ability to care • Working under a fixed budget which lead to a limited number of patients ➢ **Opportunity to work with external partners and negotiate deals with Pharma companies**

Key Challenges in Obtaining Access to Novel Drugs

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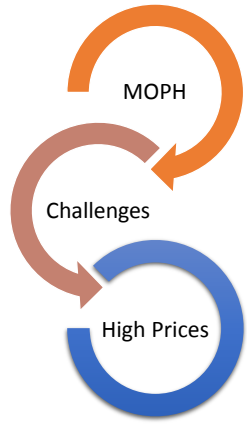
High prices are seen as an obstacle. More and more **patient access schemes/MEAs** are considered a solution. However, there is **no framework** nor **infrastructure** to facilitate the **implementation of MEA** yet.



Decisions for oncology drugs are primarily considered in the first instance at **MOPH** and account for **50% of MOPH yearly pharmaceutical spending**. **Cost** of cancer drugs have **doubled** in the **5-year period** (2011-2016) with **immunotherapy introduction** accounting for **19%** of budget in **2016**. This created pressure on the budget and strict containment measures.

Source: Cost of Oncology Drugs in Lebanon: An Update (2014-2016): Fadia Elias, Ibrahim R. Bou-Orm, Salim M. Adib, Selim Gebran, Anthony Gebran, and Walid Ammar

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Interventions at Health Policy Level to Manage Spending on Healthcare

- Universal health coverage: a sweeping review of financing options
- Biosimilars introduction guidelines and local manufacturing promotion
- Upgrading the registration process of pharmaceutical drugs and revisiting the pricing structure
- Establishment of a HTA unit
- Scaling up epidemiological surveillance and response: "Lebanon Clinical Trials Registries:/ implementation of bar code project, etc..

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P & R in MENA region
Iraq

- Overview of country
- Different reimbursement bodies
- Registration timelines
- Decision making
- Key Access issues impacting Economic and Environmental
- Key challenges for the new drugs
- Solutions

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Executive summary

- *Iraq population* ***40.8 Mio***
- *HE in 2017 10.377 USD bio,* ***10.905 USD*** *bio in 2018*
- *HE/GDP is* ***4.2%*** *in 2018*
- *Continuous serious budget constraints impacting the evaluation of new drugs approval*
- *National board of drug selection willing to assess High unmet medical needs innovations by requesting customized flexible pricing solutions*
- *Access to HC in Iraq is 100% for all Iraqi population, yet, as budget is limited, many drugs are put on hold before approval, limiting opportunity for patients to have access to new innovation*
- ***Delays in LC opening, jeopardizing the speed of access of medications to patients, resolved by approved decision to ship goods without LC***
- Iranian NCB is in tender
- New fast track registration (not yet implemented)
- Establishing “hands on experience” as either CT or registries , RWE facilitating Fast track
- HE as a tool to manage budget

Public Health Sector

- Public health system, handled almost entirely by the MOH.
- Many Directorate Generals at MOH/HQ, each with many Depts. and Sections dealing with different technical topics
- **16 Departments of Health** (DoH) in **15 provinces** in the center and south of Iraq (2 in Baghdad), each in the center of each province.
- The **3 DoHs** in the Northern provinces are directly connected to the MOH in Erbil.

Private Health Care System

- **Any drug that doesn't exist in the tender can be present in Private Sector**
- The organizational model of private hospitals is primarily individual or group practices owned primarily by physicians and entrepreneurs.
- The principal funding of the above private facilities are purely private.
- Almost all owners of private hospitals are medical specialists and the same is true to private clinics too.

Patient groups/NGO

- There is very limited experience in the provision of health care by NGOs.
- Patient group mapping identified 18 Pags in Iraq by Jan 2017
- Iraqi BC association, Al Hayat for MS and Hemophilia group
- Increasing role of patient groups in Iraqi HCP is foreseen in the coming 5 years

Market access decision-makers overview & Influencers

Timeline 18-24 months

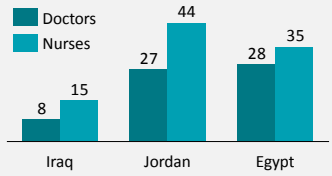
National Board for Drug Selection (NBDS) & Pharmacoeconomics(PE) committee

Responsible to approve molecules, doses, indications, and dosage forms in the Iraqi National Formulary (INF) whether in essential list for tender products or in general list for private market

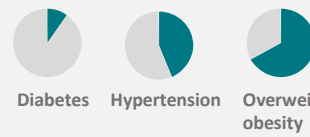
- Consulting Committee — Reviews the file and replies to the NBDS Secretary with their scientific opinion
- Technical committee that studies the pharmaceutical product
- Price committee — negotiates the pricing proposal with the manufacturer and validates the price
- Quality control — Performs Requirements analysis and technical conformity
- Bioequivalence committee

Healthcare remains slow to adapt to the country's epidemiological evolutions, spurring the emergence of a private sector

Health professionals per 10,000 people



Incidence of non-communicable diseases



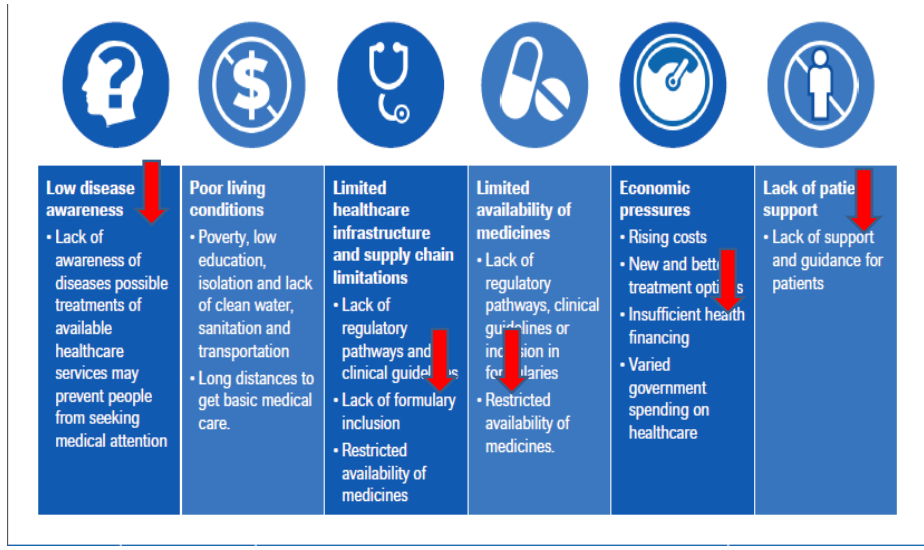
2010's

$6-8 billion

Annual healthcare budget, with massive investments in primary healthcare centers

10-12K	Private clinics	**1/3**	Out of pocket expenditures go to private clinics
10K	Private pharmacies	**30+**	Local insurance companies

National Infrastructure requirements



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Macro Trends

Including impact for healthcare

Trend	Description
Political or National security and Post-ISIS era	• High cost of reconstruction of liberated regions • Post-war social and economic consequences (expect time for economic recovery is 2 to 3 years) ➢ **Impact: Continuation of healthcare budget constraints for the sake of the reconstruction costs**
Current economy	• Slow down in oil productionpart of OPEC agreement • Continuing budget cuts (for all ministries) • Country budget: 85 billion USD • Healthcare budget (Kimadia) 450 million USD ➢ **Impact:Toll on economic growth and more busget constraints**
Public policy	• PAGs: more active yet faced by physicians • Improved capabilities (Strategic planning, funding, volunteering, advocacy) • Iraqi FDA scope? Future decision making? • Health policy makers are more involved in decision making ➢ **Impact: Closer collaboration with non conventional SH to support patient access to medications, including Roche drugs**
Healthcare priorities	• Tendency towards having a multiple winner tender • Continuing NCB threats & Future threats • Accountability of decision-makers towards the NCBs entry is questionable • Oncology drugs remain a prioritty

Opportunity Neutral Challenge / threat

P & R in MENA region
Jordan

- Overview of country
- Different reimbursement bodies
- Registration timelines
- Decision making
- Key Access issues impacting Economic and Environmental
- Key challenges for the new drugs
- Solutions

Executive Sur

Fisheye Lens

5,767	Jordan GDP per Capita 2017, USD
93%	Gross debt to GDP ratio
7.8%	Healthcare spending as a percentage of GDP
15%	Mandatory discount for JPD Tender submission vs list prices
15%	Price difference preference for local companies in JPD tender
2-5	Years on average needed for a new product to be reimbursed in MOH
9	Celltrion Biosimilars will be marketed by Hikmah (local manufacturer) in Middle east as per signed agreement

•Jordan is an emerging market economy with low-middle income (2017 GDP per Capita: 5,767 USD)
•High pressure on governmental expenditure as the gross debt to GDP ratio to an estimated 93 %
•However, healthcare spending as a percentage of GDP remains high at approximately 7.83%
•National pro-generic/pro-biosimilar and pro local companies policy (15% price difference preference for local companies in Joint Procurement Department JPD tender
•JPD Tender is responsible for drugs procurement for MOH and both universities. It includes a mandatory minimum 15% price discount vs registered price

Jordan Healthcare Market Insights

Jordan is a public segment based market

	Public	Private Insurance	OOP & Others
Population Covered	5.029 Mio	0.478 Mio	0.351 Mio
Percentage of Population Covered	74.0%	6.9%	5.2%

Oncology	MOH	DRMS	Private Insurance	Universities	Royal Court	OoP & Others
Population Covered	3,553 Mio	1,679 Mio	0.065 Mio	0.084 Mio	0.885 Mio	0.194 Mio
Percentage of Population Covered	52.3%	24.7%	1.0%	1.2%	13.0%	2.9%

*14% don't have access to treatment
*5% don't have access to oncology treatment

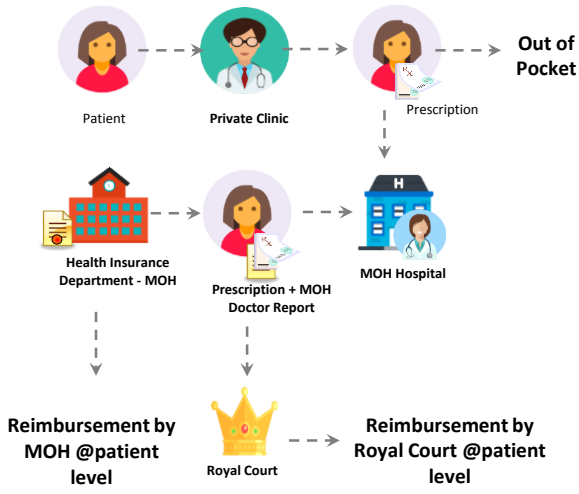
Jordan Healthcare Market Insights

Segmented public market

Oncology Scope	MOH	DRMS	KHCC	Universities
% Patients Treated	23.8%	30.4%	27.6%	11.5%
Tender	JPD Tender (Annual)	DRMS Tender (once every 2 years)	Direct Purchases	JPD Tender (Annual)

Pre Registration and/or Pre Tender Access

Reimbursement through Health Insurance Department – MOH & Royal Court



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RoadMap to Reimbursement in KHCC

Submission form filled and signed by department head	(-6) - 24 months
Internal health technology assessment	2 - 3 months
Price negotiations	1 – 2 months
P&T committee meeting	1 – 2 months
Inclusion in treatment protocols and purchase order	1 - 2 months

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Trends (1/2)

- Universal healthcare coverage
- Increasing Cancer treating capacity
- JFDA faster registration
- Increasing demand for hands on experience
- Relative stable political environment, but numerous risks

Opportunity | Neutral | Challenge/Threat

Trends (2/2)

- High economic pressure
- Mechanisms to decreasing drugs prices
- JFDA pricing and importation regulations
- Non RDL products restrictions

Opportunity | Neutral | Challenge/Threat

The Jordanian Healthcare system consists of five key players: MOH, Royal Medical Services (RMS), King Abdullah Hospital (KAH), Jordan University Hospital (JUH), and the private sector

Ministry of Health

Formulary inclusion takes place at the level of the Jordanian Rational Drug List (JRDL)

Price Decision
Jordan Food and Drug Administration (JFDA) drug pricing committee reviews the lowest price among the following: the price in the country of origin, the median benchmark price in the 16 referenced countries, and the price in Saudi Arabia

Joint Procurement Department (JPD) is responsible to purchase medicines and medical supplies to all governmental institutions (Centralized tender business)

JP committee gives priority to drugs produced in Jordan by giving 10% privilege to the local products over the imported items

Having RDL: Rational Drug List endorsement is essential to take part in JPD tenders
- Companies shall apply for RDL through the gov. institutions

Any one of the governmental institutions can fill the RDL form and submit it to the national drug committee whom are responsible to approve or disapprove the product
- Even if the product is approved in the RDL, it is not mandatory to be purchased by all institutions

Feb 2017 JFDA announced in the official Journal a briefed note about the verification=60 days review process July 2017, detailed final guideline was published

Eligibility Criteria:
USFDA & EMA approvals (Verification)

Timeline:
60 days

Additional specificity:
Public Assessment Report
Retroactive for products submitted already
Life cycle maintenance included

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The Challenging Market Environment for Innovative Drugs

An optimally designed Strategy that is aligned with market access objectives will ensure that these hurdles are overcome to achieve a successful uptake

The growing importance of real world evidence gathering e.g. through registries

To accelerate access of innovation to the needy

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P & R in MENA region
UAE

- Overview of country
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- Solutions

Dubai Healthcare system overview

HC distribution	Public
Population	4.6 Mio
Percentage of Population Covererage	96%

46% of population insured expats with accessc to expensive drugs
50% expats with basic insurance limited access to expensive drugs except in some special programs like cancer or renal failure supported by special fund
Locals fully covered

Dubai Healthcare system overview

Population Covered	4.6 Mio
Private sector	60% from HC

DHA	50 insurance companies
Managing Governmental hospitals & Regulators	Health insurance

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Abu Dabi Healthcare system overview

Population	Public
	4.6 Mio
Percentage of Population Covered	80%

	DHA	HAAD	DAMAN
Population Covered	Managing Governmental hospitals	Responsible for Regulatory process	2.24 Mio
Percentage of Population Covered			80%

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Abu Dhabi Healthcare system overview

HC distribution	Public
Population Covered	2.8 Mio
Percentage of Population Coverage **Private sector is 40% of HC capacity**	80%
	30% of population insured expats with access to expensive drugs
	55% expats with basic insurance limited access to expensive drugs except in some special programs like cancer or renal failure supported by special fund
	Locals fully covered

V.

The Multi-Stakeholder initiative on how to optimize evidence generation to demonstrate the value of highly innovative technologies

Marie-Hélène Fandel, AMGEN & Laura Batchelor, FIPRA

Real-world evidence to enable appropriate patient access to highly innovative technologies

POLICY GUIDANCE

10 September 2019 • EUCOPE meeting • Brussels

REAL WORLD EVIDENCE RWE4Access

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Problem Statement

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The RWE4Access initiative considered the following questions in relation to highly innovative technologies:

1. How can the potential of RWD/RWE strengthen HTA/payer decision-making and lead to better tailor-made decisions on reimbursement?
2. What is the place of RWE in the lifecycle of these technologies?
3. Can valuable RWE be obtained from RWD? If so, which HTA questions can be answered with RWE, from what data, and under which conditions?

CONTEXT

RWE4Access Vision

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Stakeholders agree **what** RWD can be collected for highly innovative technologies - **when**, **by whom** and **how** - in order to generate RWE that meets the needs of patients and healthcare systems.

VISION

INAMI papers

CONTEXT

2016	2017	2018
The use of real world data throughout an innovative medicine's lifecycle [Link]	Outcomes based pricing and reimbursement of innovative medicines with budgetary limitations [Link]	TRUST4RD – Tool for Reducing Uncertainties in the evidence generation for Specialised Treatments for Rare Diseases

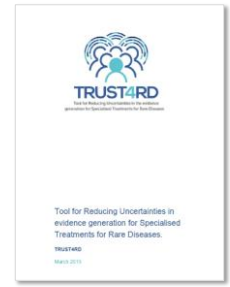

The use of real world data throughout an innovative medicine's lifecycle

1. Introduction and objectives


Outcomes based pricing and reimbursement of innovative medicines with budgetary limitations

Discussion document for the multistakeholders meeting on pharmaceuticals (Meeting DG GROW 12th September 2017)

1. Introduction



Stakeholder Roles

RECOMMENDATIONS

Effective use of RWD to inform decisions about use of highly innovative technologies requires a collaborative effort across stakeholders, with each playing their part:

- HTA bodies/payers
- Regulators
- Industry
- Policy-makers and national/European authorities
- Registry-holders
- Clinicians & Patients
- Patient groups

Policy Recommendations (transversal)

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This guidance has focused on the specific case of RWE for HTA/Payer decisions on highly innovative technologies, but it recognizes that some underpinning cross-country initiatives relating to the use of RWD are needed:

- ☑ **Share good practices on e-Health strategies** which have been successfully implemented - in particular around integrated data systems, encouraging uptake of standardised data collection, quality standards and overcoming legal barriers.
- ☑ **Encourage more efficient RWD collection across Europe** by standardisation of electronic health records, core outcome sets and registries.
- ☑ **Encourage collaboration across Member States** to agree methodologies and specifications for RWD collection and analysis to avoid duplication.
- ☑ **Insist on transparency in reporting of RWE studies** (in terms of plans and results) as is required for clinical trials.
- ☑ **Enact the WHO Global Strategy on Digital Health 2020-2024**, which encourages national and regional Digital Health initiatives to be guided by a robust strategy that integrates financial, organizational, human and technological resources.
- ☑ **Develop a legal framework, platform and governance processes for sharing of confidential health data across Europe** that can be accessed via appropriate governance mechanisms for bona fide research and decision-making purposes by any stakeholder (including health care systems), taking into consideration the implications of commercialisation of patient and health system data.

Recommendations

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TO INDUSTRY

- ☑ Create a RWE generation plan very early in development that addresses what outcomes will be used to determine patient benefit, how natural history and effectiveness of the comparator will be explored and plans for evaluation of long-term effectiveness.
- ☑ Discuss the RWE generation plan at various stages throughout the technology life cycle with regulators, payers, HTA bodies, clinicians and patients.
- ☑ Ensure protocols, data management and statistical analysis plans for RWE studies that are answering major questions for HTA are publicly available.
- ☑ Apply the FAIR principles to RWD – make it Findable, Accessible, Interoperable, Reusable.
- ☑ Support disease-based registries, instead of product-based registries (particularly relevant for long-term effectiveness).

RECOMMENDATIONS

Call for Action

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We call for a multi-stakeholder learning network to be created that:

- encourages implementation of these RWE4Access recommendations in each stakeholder group, linking into existing policy initiatives
- monitors progress of implementation of the RWE4Access recommendations
- shares case studies of challenges about use of RWE in HTA/payer decisions about highly innovative technologies
- develops learnings to continuously improve approaches
- develops guidance on use of RWE to promote access to highly innovative technologies.

Next steps

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MINISTRY OF SOCIAL AFFAIRS AND HEALTH

JOINT MEETING OF
HEALTH AND PHARMACEUTICAL SECTOR CHIEF OFFICERS
(CMO, CDO, CNO AND DIRECTORS OF PHARMACEUTICAL POLICY)

THE ECONOMY OF PHARMACEUTICALS – HOW TO FIND EVIDENCE TO EVALUATE THE VALUE OF PHARMACEUTICALS?

26-27 September 2019, Finlandia Hall, Helsinki, Finland

Ideas for Dissemination

Timeline	Event	Participants/lead
26-27 September	Joint meeting of Health and Pharmaceutical sector chief officers, Helsinki	Karen Facey
October	European Commission - Jo De Cock request for meeting with Andrzej Rys	INAMI
29-30 October	1st Joint DIA-EUCOPE Workshop on ATMPs, Innovative Gene and Cell Therapies, Basel	Karen Facey
October-December	Dissemination of Policy Guidance in stakeholder networks	EPC, ECPC, EUCOPE, EuropaBio (tbc)…
H1 2020	Engagement with German Ministry of Health and relevant German stakeholders	
2020	Dissemination via BeneluxAI and EUnetHTA, International Horizon Scanning Initiative (IHSI) …	
2020	Engagement FDA	

VI.

Germany: The implementation of the Act for More Safety in the Supply of Pharmaceuticals – GSAV

Mandatory data collection and pricing

Hans-Jürgen Seitz, IGES

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Legal aspects of the implementation process

Alexander Natz

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VII.

EU-Proposal on Joint HTA

Karolin Eberle & Annette Fasan & Nina Seiler, AMS

EUCOPE
European Confederation of Pharmaceutical Entrepreneurs AISBL

AMS
Advanced Medical Services

EU Joint HTA

– Priorities for the Introduction of an European HTA System

Priority 1: The Comparator

- Exact definition of the derivation process for the comparator (approved, proved in practical use, German guidelines)
- Documentation is published for each assessment (criteria and systematic search)
- Orphan drugs: The registration trials are relevant (no additional comparator)
- Comparator does not reflect in all cases clinical practice
- Orphan drugs: When annual sales exceeds 50 million a comparator is defined by G-BA, which can differ from the registration trials

- Consideration of clincial practice and upcoming therapies
- All WP6 partners can give input for the choice of comparator(s) in order to achieve „European relevance“
- Relevant are i.a. clinical practice guidelines, routine use in clinical practice, evidence
- No guidance which guidelines are (more) relevant
- Exclusion of comparators even if approved in some countries
- Comparator may be a compound available at the time of report publication -> may be relevant for national uptake of the joint assessment in some countries
- Orphan drugs: Comparator for orphan drug assessments

Recommendation:

Definition of a consistent process for the derivation of comparator(s) by the coordination group, taking into account national requirements *and* scientific state of the art.
Guidance which guidelines are (more) relevant in different indications.
Comparators identified during the scientific advice process should be relevant for the joint assessment.

Priority 2: Relevant Studies

- Orphan drugs: Evidence from registration trials, additional benefit is granted (quantification only by G-BA)
- Exclusion of studies ("80% rule" - 80% of the study population have to comply with the label)

- Inclusion of studies with different evidence level
- Tendency towards a broader body of evidence
- So far no definition of "relevant studies", nothing like "80% rule"

Recommendation:

Provision of categories of evidence levels and their priorities.
Definition of situations or indications where e.g. single-arm studies are best available evidence.

Priority 3: Patient Relevance

- Definition: How patients feel, experience function and activity, survival
- Concrete measurements are expected: E.g. imaging techniques, laboratory parameters (HbA1C) or the reduction of infusion rate are not accepted; PFS as surrogate only

- Patient input to inform the scope of the assessment, e.g. on patient relevant outcomes or possible neglected outcomes
- More consistency with the endpoints in the registration trials
- Recommendation only: Comprehensively defined and justified in protocol and report
- Numerous different terms are used when endpoint issues are described at various places in the documents

Recommendation:

Definition of patient-relevant endpoints: What is important for the patient in clinical care, in particular the achievement of clinically relevant therapy targets.
Exact definition and consistent use of terms for endpoints.
Joint definition by EMA & EUnetHTA/EU HTA cooperation on relevant endpoints.
Endpoints accepted in the approval process should also be accepted in the joint assessment.

Priority 4: Subgroup Analysis

- ⊕ Clear request: Subgroup analysis for all patient-relevant endpoints required, at least for age/gender/site, country/status of disease
- ⊖ Necessity of post-hoc analyses, study not powered for subgroup analysis

- ⊖ No distinct EUnetHTA guideline on subgroups, no standardized procedure

Recommendation:

Standardized subgroups for registration and HTA, standardization for criteria to form subgroups.
Fixed definitions/wording of indications.
A feasible approach for subgroup evaluation may consider the stability of the subgroup effects across different endpoints, the biomedical plausibility, the pharmacological aspects and the appropriateness of the methods.

Priority 5: National Uptake and (no) Duplication of Work

- Conclusion of joint clinical assessment limited to analysis of the relative effects of the technology based on patient-relevant outcomes and the degree of certainty
- Conclusion on added therapeutic value or cost-effectiveness remain on national level
- Further context-specific considerations on national level (e.g. number of patients affected in member states, how patients are currently treated in the healthcare system, costs), ethical, organizational and legal considerations

Recommendation:

Definition of the process in between the European assessment and the subsequent national appraisal: Requirements (e.g. further analyses) need to be clear early in the HTA process.

Priority 6: Early Dialogues and the Parallel Consultation Process

- Chapter II proposed regulation: „The Coordination Group will carry out an annual number of joint scientific consultations based on its annual work program, taking into account the resources available to it.“

Recommendation:

The proposed scientific advice process must be adequately resourced in order to ensure that advice and joint clinical evaluation are properly linked. Definition of requirements so that studies can be adequately planned by the MAH.

Priority 7: Mandatory Data & Confidentiality

- Clear definition which documents must be handed in with the dossier
- VerfO regulates which documents are required, which documents are published and which documents are regarded as confidential („Liste der Betriebs- und Geschäftsgeheimnisse")
- Orphan drugs: Guidance (VerfO) which parts do not need to be filled in in the dossier

Recommendation:

Definition of specific submission requirements for companies (data & documents), definition of "confidential data for commercial reasons", provision of an adequate and secure data transfer system, guidance for handling of copyright issues on European level (e.g. provision of hyperlinks to references only instead of handing in copies).

Do You Have Further Questions?

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VIII.

AOB / End of meeting

Thank you for your time