

QUESTIONNAIRE FOR ADMINISTRATIONS, ASSOCIATIONS AND OTHER ORGANISATIONS

Fields marked with * are mandatory.

INTRODUCTION

QUESTIONNAIRE FOR ADMINISTRATIONS[1], ASSOCIATIONS AND OTHER ORGANISATIONS [2]

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] For the purpose of this survey, administrations refer to both public administrations, as well as private administrations with public service obligation

[2] For the purpose of this survey, associations and other organisations refer to trade associations, professional associations, academia and scientific societies and organisations representing the interests of specific stakeholders

[3] European Network for Health Technology Assessment (EUnetHTA) is a Joint Action, co –funded by the Health Programme of the European Commissions (DG SANCO) and participating organisations. It gathers mainly national and regional HTA bodies. Its scope of activities is on scientific and technical issues. www.EUnetHTA.eu

[4] http://ec.europa.eu/smart-regulation/roadmaps/docs/2016_sante_144_health_technology_assessments_en.pdf

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

EFPIA

*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?

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* 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).

edith.frenoy@efpia.eu

*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)

Edith Frénoy

*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
<p>*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)</p>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*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).

<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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*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).

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

HTA of pharmaceuticals is a national competence and is often used as an input to pricing and reimbursement (P&R) and access decisions. The HTA procedures are therefore closely linked to national P&R and access procedures of pharmaceuticals. Concretely this means that pharmaceutical companies, which are seeking reimbursement in individual countries, need to submit specific dossiers to each competent authority at the national level, in line with national requirements.

Some Member States review all medicines at launch (e.g. France), others review only a selection of products (e.g. England). Some specific medicines' segments (e.g. vaccines, orphan medicinal products) follow specific processes in some Member States.

As outlined in the Commission introduction to this consultation, there are national systems that use mainly or exclusively the clinical parts of HTA to support their decisions (e.g. France and Germany) whilst others use a full HTA to support access decisions. In this latter category, another distinction needs to be made between systems that have sequential assessments (clinical followed by economic e.g. the Netherlands) or systems where the full HTA is done in one step (e.g. Sweden and England).

There are differences of data permissible within HTA submissions e.g. France requires data to be published if they are not available in the clinical study reports, whilst England accepts data on file (i.e. non published). These differences in data also relate to differences in methodologies relevant to 3.1.b and 3.1.c.

Timing of submissions and evaluations also vary significantly and the length of time taken by the various agencies to perform assessments varies

significantly. For example, some systems allow for submission as early as CHMP positive opinion (e.g. Netherlands for the accelerated EMA procedures, Sweden) or even earlier (England), whilst other systems require a full marketing authorization to start the process (e.g. France, Germany, Poland, Spain). Germany has a specific system which allows launch and availability for patients whilst conducting an assessment in parallel. Timelines differ, but most of the Member States are in general aligned with the Transparency Directive (89/105/EEC) when HTA is used to support P&R and access decisions.

Most pharmaceutical companies have national affiliates that will prepare national reimbursement files, and engage with competent authorities at the national level. National affiliates will base their tailored evidence package on a central file when it comes to the clinical profile of the product. The need to develop such central relative efficacy information required by HTA bodies has substantially impacted industry's planning of clinical development programs which led to organizational and procedural adjustments in the global functions of pharmaceutical companies. More context-specific evidence e.g. like health economic impact, fit with local health care priorities etc. will be the responsibility of the national affiliate. These will reflect differences between member states in terms of local context, healthcare priorities, degree of investment in healthcare, or underlying structure of healthcare system as well as variations in societal preferences and values.

It is not possible to list all these differences here. The Commission initiated research on HTA processes will reveal these process and method differences (also applies to questions 3.1.B and 3.1.c). A study currently conducted by LSE health (https://lse.eu.qualtrics.com/jfe3/form/SV_9REQ8V1JRfBiUx7) can also contribute relevant findings.

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

There are similarities and differences between HTA methodologies for the clinical assessment amongst EU Member States.

As defined by the High Level Pharmaceutical Forum in 2008, relative efficacy may be defined as the extent - under ideal circumstances - to which an intervention does more good than harm, compared with one or more alternative interventions. By contrast, relative effectiveness is essentially the extent - under the usual circumstances of health care practice - to which an intervention does more good than harm compared with one or more intervention alternatives.

At launch, any decision is based on efficacy information provided by registration clinical trials. At this stage, by definition, effectiveness information is not available, except in few cases (e.g. where products have been launched earlier in other regions of the world, where products have been made available through various access schemes prior to standard launch, or where pragmatic controlled trials have been used in development).

To support decisions at launch, all healthcare systems currently require information on the relative efficacy of a new pharmaceutical compared to existing alternatives. Companies will use the same data from registration trials to provide this information. On the basis of this relative efficacy data, only some Member States will seek to predict relative effectiveness to support their decisions; others will stay at the level of relative efficacy (e.g. Germany).

However companies will present the data in different ways, because HTA agencies adopt different approaches to interpreting this same clinical data. This might apply to trial design, relevant endpoints, appropriateness of defined patient subgroups and treatment comparators. Differences between UK and Germany provide good examples of the differences in clinical assessment methodology. For surrogate endpoints, IQWiG have a strict validity criteria, whilst NICE will tend to follow EMA and account for validity concerns with uncertainty analysis in models. Other key areas are: acceptability of indirect treatment comparisons, acceptance and interpretation of analyses of survival that adjust for trial cross-over. Sometimes, additional national clinical trials will be required.

- For companies, this means duplicative administrative work.
- For agencies, this means sometimes inability to conclude on the basis of the evidence provided, because the evidence was generated for other purposes and does not fit national requirements.
- For patients, this means unnecessary trials, potential delays, and access restrictions because of methodological misalignment (rather than the intrinsic properties of products).

EFPIA commissioned a study from Charles River Associates on the current country barriers to adoption of European assessments of relative efficacy at time of launch. In seven of the nine countries analysed, the differences in current methodological approaches for relative efficacy assessment could be easily resolved (main findings shared in separate document).

There is however an additional step which HTA agencies conduct on the basis of a relative efficacy (and in some cases relative effectiveness) assessment, which is often referred to as “appraisal”, i.e. the translation of the factual evidence assessment into an added therapeutic value rating (e.g. France, Germany). Added therapeutic value ratings are the result of a context-specific interpretation of a factual assessment in light of the national burden of disease or national priority considerations and follow therefore very different patterns between countries. They are usually issued in a deliberative process including key national representatives of healthcare stakeholders. Added therapeutic value ratings cannot be easily shared across jurisdictions.

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

Economic evaluations are expected to be conducted in line with national regulation with regard to the economic perspective that has to be taken given the national organization of the health care system, different health care settings in which a new technology is applied, different health care priorities and cost structures etc., so different results will be achieved in different countries. This is mainly because European countries enjoy varying economic circumstances, and costs of alternative treatments, medical services associated with a condition, including the cost of medical care by healthcare professionals, are likely to diverge. Economic methods should be adaptable to allow countries to introduce weightings and data which reflect social values which are specific to Member States.

To sum up, differences between HTA methodologies for the economic assessment among EU Member States are fully justified, given considerable differences in the organization of national health care systems and delivery of health care services.

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

- a) Duplication of work for your organisation
- b) Less work for your organisation
- c) High costs/expenses for your organisation
- d) No influence on costs/expenses for your organisation
- e) Diverging outcomes of HTA reports
- f) No influence on the outcomes of HTA reports
- g) Decrease in business predictability
- h) No influence on business predictability
- i) Incentive for innovation
- j) Disincentive for innovation
- k) No influence on innovation
- l) Other
- m) None of the above
- n) I don't know/No opinion

*3.2.1. Please specify if 'Other':

- Lost opportunity to integrate more harmonised European data requirements into global development plans
- Challenges in designing pivotal RCTs that reflect the evidentiary needs of the majority of HTA authorities across the EU
- Potential need for additional clinical trials to satisfy national HTA requirements
- Differences in access to medicines for patients in different EU countries

We would like to clearly underline that one needs to distinguish between the different components of HTA when answering this question. EFPIA refers to the nine domains of the EUnetHTA core model and considers that the first four domains (with a focus on efficacy rather than effectiveness) are in scope of the European cooperation, whilst the rest is not. EFPIA considers that more alignment on relative efficacy assessment at time of launch (with a joint scientific advice process involving regulators and national authorities responsible for relative efficacy assessment) would streamline processes and lead to better decision-making in the interest of patients in the European Union. The first four domains should be able to cover patient-specific aspects. EFPIA equally clearly underline that it is not possible to align on full HTA as this covers context-specific elements which are best dealt with at the national level.

Pharmaceutical companies are operating at a global level as they seek to bring treatments to patients all over the world. The primary guidance in

terms of development plans comes from regulatory agencies, and development plans need to meet the requirements of regulatory agencies worldwide, such as the US FDA, Japanese PMDA, in addition to the EMA in Europe.

The challenge with national requests for relative efficacy information today is that pharmaceutical companies are trying to fill their submission files with data that was generated to satisfy the evidentiary expectations for regulatory purposes. This data is designed to support the safety and efficacy of the medicine at launch. However the multiple and fragmented evidentiary expectations of HTA agencies are driven not by the clinical context, but by their desire to make informed reimbursement, pricing or coverage decisions. This explains why sometimes conclusions state that 'no conclusion is possible' because of 'lack of appropriate data'. At the same time, agencies differ with regard to their clinical evidentiary standards as well e.g. because they found different approaches to handle remaining uncertainty. Early dialogue with regulators and agencies responsible for national relative efficacy assessment is going some way to bridging this gap.

The fragmentation of requests today makes it difficult for companies to respond to all requirements: trade-offs necessarily need to be made. Harmonized clinical data requirements across HTA agencies responsible for relative efficacy assessment, aligned with EMA regulatory requirements, would ensure that evidentiary expectations of European stakeholders and decision makers have a better chance to be adequately reflected in global development programs. Concretely, this means less risk of inconclusive assessments at the national level on procedural grounds, and more certainty for all actors involved, not the least patients. Industry strongly calls for an optional standing joint scientific advice process involving the EMA and a minimum representative core group of national HTA agencies responsible for relative efficacy assessment to deliver on this.

*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*)

- a) Allowed for sharing best practices
- 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
- e) Contributed to HTA capacity building
- 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
- 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)

EFPIA has been actively involved in EUnetHTA JA1 and JA2 - we have been one of the first stakeholders in the Stakeholder Forum. We welcome the progress achieved so far. JA1 set up an operating network of HTA agencies. JA2 piloted some joint work for pharmaceuticals (joint scientific advice process involving EUnetHTA and regulators and joint assessments of relative efficacy at time of launch) but the joint work has not been used to the extent that it should have. JA3 now needs to set the grounds for the future by establishing a sustainable permanent model.

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
*b) Guidelines (e.g. for clinical and /or economic evaluations)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
c) Early dialogues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
*d) Joint reports on clinical assessments (REA)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
*e) Joint full HTA (clinical and economic assessment)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
f) Other (please specify below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 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

Joint Actions have created a community of HTA technicians. However:

- The membership of the Joint Actions has failed to include all relevant agencies for pharmaceuticals. Only agencies involved in supporting decisions on access to pharmaceuticals should be involved in European assessment of relative efficacy at time of launch. Where there are different agencies/departments involved in one single country depending on the type of pharmaceuticals (e.g. vaccines or OMPs), this should be reflected in the membership of JA3 and any future sustainable mechanism. Otherwise it runs the risk of being disconnected from the reality of decision-making.
- The outcomes of technical discussions have not been used in national decision-making. Although HTA is relying on scientific inputs and methodology, it is not an academic undertaking for its own sake but is there to support decision-makers in making evidence-based decisions. The HTA Network has been a good opportunity to gather representatives of national health ministries to discuss the future of the HTA cooperation, but it has

not helped to ensure national adoption of results of concrete pilots of joint work. This in itself inhibits the willingness from the industry side to put forward more concrete projects

EFPIA members have been actively involved in both joint scientific advice sessions (EUnetHTA reported 9 early dialogues on pharmaceuticals in JA2), and joint relative efficacy assessments (5 pilots in JA2).

- For scientific advice, it is difficult to measure their concrete impact given the early nature of this joint work. They have been highly appreciated by EFPIA members which continue to seek this opportunity.

However, although attempts were made during joint SA processes to align diverging perspectives of HTA agencies this was in some cases not achievable given the need to satisfy diverging national evidentiary standards which had been developed by the HTA agencies in isolation.

- On the joint assessments, the list of uses on the EUnetHTA website shows that, in many instances, the joint reports were used as additional input /literature but did not reduce any duplication in the system. This is confirmed by EFPIA members. We do not consider that this is proper use of joint work. The existence of a joint report should remove some work currently conducted at national level.

Other EUnetHTA work:

- Tools/template : the submission template developed by EUnetHTA is a summary of all the questions an HTA agency may consider at the national level rather than a consolidated view of the data inputs that are needed for European assessment of relative efficacy at time of launch. EFPIA has made concrete suggestions to EUnetHTA on how to streamline/optimize the template and make it more relevant for joint work. We recommend that this is taken forward in JA 3.

- Guidelines: guidelines developed by EUnetHTA are a summary of best practices, but will not guide assessments moving forward. Differences in methodologies remain, which should be addressed. Some medicine segments bring methodological questions which should be addressed by EUnetHTA.. e.g. for OMPs, there are data availability issues related to the small size of the patient population and the lack of knowledge due to the rarity of diseases. Comparative assessments might be challenging when alternative treatments do not exist.

We need an open discussion on barriers to national adoption, and a commitment and political willingness to address them. Any future permanent model should:

- Focus on European assessments of relative efficacy of pharmaceuticals at time of launch fully taking into account the lessons from the pilots conducted so far;
- Include only agencies involved in supporting decisions on reimbursed access to pharmaceuticals and develop processes on the basis of a rapporteur system;
- Ensure that MS formally commit to use and implement outcomes of European assessments of relative efficacy at time of launch in their national processes (Participation in a European assessment of relative efficacy should effectively substitute the national assessment of relative efficacy);
- Identify elements of the national assessments that European

assessment of relative efficacy at time of launch can effectively replace to ensure the European report is not an add-on but an integral part of national processes;

- Develop consensus among MS and foster plans to adapt national assessments to ensure that European assessments of relative efficacy at time of launch can be fully integrated in national HTAs; and,
- Ensure that European assessments of relative efficacy at time of launch build on best practice at the national level to ensure iterative engagement with the manufacturer. Other expert input from patients and health professionals should also be integrated in the process.

In order to build trust for manufacturers to engage, industry need clear indication from MS that they will fully use reports in national processes.

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:

A permanent system is needed as otherwise the investments of JA1 to JA3 would be lost. EFPIA does not believe that continuing with the system of Joint Actions or project-based collaboration would be an efficient way forward. As indicated above, these voluntary collaborations have enabled the development of a network – however political commitment is needed to deliver on the collaboration and make sure that joint work directly informs national decision-making. This requires a permanent structure, including funding and secretarial/organisational support (see responses below).

The experience from JA2 showed that there was little uptake or use of joint outputs by countries. For cooperation to continue after 2020 it should be clear from JA3 that the system is timely, increases the speed at which joint work is performed, reduces duplication and improves consistency.

Until this has been demonstrated, continued cooperation after 2020 could exist under a permanent system but this should be voluntary for both companies and Member States in a transition period until the system has proven itself.

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	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
*b) Medical devices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
c) Other (please specify below)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*4.1.1.c. Please specify 'Other':

The term 'pharmaceuticals' covers a broad spectrum of technologies. Some segments of pharmaceuticals, such as vaccines or orphan medicinal products, require specific methodologies and the involvement of specific national agencies. Furthermore, some pharmaceuticals are linked to co-dependent technologies. These additional complexities need to be taken into account in the cooperation post 2020.

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)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
*b) Guidelines (e.g. for clinical or economic evaluations)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
*c) Early dialogues	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
*d) Joint clinical assessment (REA)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
*e) Joint full HTA (clinical and economic assessment)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
f) Other (please specify below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*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)

We strongly underline that “joint reports on clinical assessments” by definition (see above) can only focus on relative efficacy assessment. We believe that European collaboration can contribute to reducing access differentials through an EU-wide view on a product’s relative efficacy. This requires both harmonization of clinical data requirements and reduction of duplicative assessments.

Therefore, from the EFPIA perspective, an EU initiative should focus on delivering:

- A capacity for joint scientific advice process involving regulators and HTA bodies

- A capacity for European assessments of the relative efficacy of pharmaceuticals at time of launch

These two elements could be considered as complementary steps on the same path.

EFPIA considers that Member States should conduct European assessments of the relative efficacy of pharmaceuticals at time of launch in a collaborative manner. Based on experience of EUnetHTA pilots, EFPIA considers that the most efficient approach is to work on the basis of a rapporteur and reviewer system. Rapporteurs and reviewers should be part of a Committee, which should endorse the European report produced. EFPIA calls on Member States to identify scientific experts in relative efficacy assessment of pharmaceuticals; these experts should also have a direct link to national reimbursement/access decision-making in order to ensure integration in national systems/uptake of joint work and avoid duplication. Care should be taken in identifying relevant rapporteurs so as to ensure expertise is commensurate to the product assessed.

Any European assessments of the relative efficacy of pharmaceuticals at time of launch must be conducted on the basis of EUnetHTA methodological, analytical and quality standards, assuming that these standards are accepted in all EUnetHTA member organizations. Member States contributing to European assessments of the relative efficacy of pharmaceuticals at time of launch must therefore commit to relying on accepted methodology and adapt methods and processes of their home country where needed. Ultimately it is the reviewer's expertise that is relevant, not the country of origin.

As a requirement, where Member States are involved in a European assessments of the relative efficacy of pharmaceuticals at time of launch (either as rapporteur or reviewer), they should formally commit to use and implement its outcomes in their national processes (Participation in European assessments of the relative efficacy of pharmaceuticals at time of launch should substitute for national assessments of the relative efficacy of pharmaceuticals at time of launch). Before setting up a sustainable system, it is necessary to identify national assessments that European assessments of the relative efficacy of pharmaceuticals at time of launch can replace, as well as any barrier preventing Member States to use European reports with solutions to overcome identified barriers. Where Member States fail to replace national elements they should no longer be involved in European assessments of the relative efficacy of pharmaceuticals at time of launch until they commit to this replacement.

European assessments of the relative efficacy of pharmaceuticals at time of launch should be science-based and reflect the following principles:

- Transparency
- Good governance, including no duplication with the marketing authorisation process
- Involvement of stakeholders (including industry, clinicians and patients)
- Appropriate appeal mechanisms including the opportunity for resubmission

- Realistic handling of uncertainty and inclusion of a wide range of evidence and outcomes
- Reflection of the patient perspective
- Consideration of the transferability of the outcomes

Iterative engagement with the manufacturer is needed with, at a minimum:

- a scoping meeting with the rapporteurs prior to submission of the manufacturer dossier, and
- a discussion at the Committee before the European assessments of the relative efficacy of pharmaceuticals at time of launch is finalised. The sponsor of the therapy should be provided the opportunity to supplement the file during the assessment process.

The interim period between the current established ways of working at the national level and a potential future system of European assessments will require adaptation from both Member States and companies. In order to avoid any damage to patient access it is important to allow for a voluntary process until the process has proven itself to manage the transition in the best possible way.

Joint tools and guidelines are necessary prerequisites to joint work in the form of a joint scientific advice process and European assessments of the relative efficacy of pharmaceuticals at time of launch. Tools and guidelines should be adapted to specific technologies. Some segments of pharmaceuticals (e.g. vaccines, orphan medicinal products) require specific methodologies.

*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

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

2000 character(s) maximum

EFPIA supports the setting up of a specific financing mechanism in order to ensure the sustainability of a long-term collaboration on REA. Funding should be representative of the anticipated workload.

Member States would contribute to funding the European cooperation since joint work will reduce some of the activities that are currently taking place at the national level. Direct contribution from Member States would also reinforce their commitment and show political willingness to use European reports.

EFPIA members are also open to continue the current practice of paying a fee to receive scientific advice, provided the system to be set up is fit for purpose and responds to industry needs. Any fee system would need to be thoroughly discussed with the industry before being implemented, allowing for agreement on process of how the system is going to work. Metrics are needed to measure the efficiency of the system.

EU funds should also be made available to contribute to some of the aspects of the cooperation, such as secretarial/coordination capacity.

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

EFPIA would like to put forward principles of secretarial/organisation support, rather than determining the location of this support.

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

2000 character(s) maximum

Any secretarial/organisation support function should be based on high scientific standards and should receive appropriate resources. The Permanent Secretariat of EMA located in London is a good model for a successful and scientifically based secretarial/organization support active in the field of pharmaceuticals. This does not mean that the Permanent Secretariat of the EMA should become the Secretariat of a permanent EU cooperation on HTA, as many options can be considered. It is however an example of good practice for pharmaceuticals.

The secretarial/coordination function will need to work with a Committee of Member States, and therefore requires appropriate project management skills, as well as sufficient resources.

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
*b) Voluntary participation with mandatory uptake of joint work for the participants	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
*c) Mandatory participation with mandatory uptake of joint work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
d) Other (please specify below)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

***4.1.1.5.d. Please specify 'Other':**

We consider that the three options listed need to be clarified. We underline the importance of a voluntary process of participation for both Member States and manufacturers until the process has proven itself, however with mandatory uptake of joint work.

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

2000 character(s) maximum

Given that experience is not yet satisfactory in terms of use of European outputs of cooperation, EFPIA does not consider that a fully mandatory system can be put in place at this stage. In order to minimize disruptions which are intrinsically linked to moving from established national processes to a European approach, the process needs to start on a voluntary basis for both Member States and industry. I.e. there should be a European option in addition to national options.

However, where Member States have chosen voluntarily to participate in the European collaboration, uptake of joint work at the national level should be mandatory otherwise the benefits of the process will not be realized. i.e., if a Member states contributes to assessing a product at the European level it should not re-assess (the relative efficacy) of this product at national level. Similarly, it should be voluntary for companies to choose a 'European' or a 'national' route. If a company chooses to seek European advice or choose the European option of relative efficacy assessment for its product, they should not (have to) seek duplicative national advice or REA from the same HTA agencies.

To note, it will be important to ensure a critical mass of experienced Member State representatives to make the system work.

If experience is positive, we expect that both Member States and manufacturers will increasingly choose the European option. This was the case when the European Medicines Agency was set up, when the centralized procedure was originally limited to some products (see Council Regulation (EEC) No 2309 /93). The first general activity report of the EMA provides good insights into the challenges of setting up the EMA: http://www.ema.europa.eu/docs/en_GB/document_library/Annual_report/2009/12/WC500016821.pdf

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

2000 character(s) maximum

We attach the EFPIA priorities for JA3 previously shared with the Commission, as well as the main findings of a report on identified national barriers for the adoption of reports of European assessment of relative efficacy at time of launch.

We also point to the various studies previously shared with the European Commission and available on the EFPIA website:

- HTA Accelerator In-Depth Analysis: Final report (The report provides an in-depth review of regulatory and market access approvals to answer the research question: Where and how does the review of the clinical data presented to HTA agencies differ from the regulatory review): <http://www.efpia.eu/uploads/Modules/Documents/150116-merck-ema-hta-analysis-final-report.pdf>
- CRA analysis of the EUnetHTA pilot assessments (2015) (EFPIA asked Charles River Associates (CRA) to prepare an analysis of the five EUnetHTA pilot assessments of relative effectiveness): <http://www.efpia.eu/documents/175/82/CRA-analysis-of-the-EUnetHTA-pilot-assessments-2015>
- IMS Situational Analyses on Health Technology Assessment (2015): <http://www.efpia.eu/uploads/Modules/Documents/2015-ims-analysis-situational-analysis.pdf>
- Making collaborative relative effectiveness assessments relevant: Experience of 5 EUnetHTA pilots across pharmaceuticals and medical devices: [http://www.efpia.eu/uploads/Modules/Documents/isor-milan-eunetha-poster-final-96-x-120-cm-\(1\).pdf](http://www.efpia.eu/uploads/Modules/Documents/isor-milan-eunetha-poster-final-96-x-120-cm-(1).pdf)
- Heterogeneity in relative efficacy assessments (REA) across European HTA bodies: opportunity for improving efficiency and speed of access to patients? [http://www.efpia.eu/uploads/Modules/Documents/03-11-2015_poster_eu_ispor_ver8_printready-\(1\).pdf](http://www.efpia.eu/uploads/Modules/Documents/03-11-2015_poster_eu_ispor_ver8_printready-(1).pdf)
- <http://www.efpia.eu/documents/185/82/A-comparative-analysis-of-the-role-and-impact-of-Health-Technology-Assessment-2014>: <http://www.efpia.eu/uploads/Modules/Documents/hta-comparison-report-june-2014.pdf>

EFPIA is aligned with the Vaccines Europe and EuropaBio responses.

Please upload your file (2Mb max)

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