

Prescrire Position on the proposed Regulation on HTA and amending Directive 2011/24/EU

“Health Technology Assessment (HTA) is an evidence-based process that allows competent authorities to determine the relative effectiveness of new or existing technologies. HTA focuses specifically on the added value of a health technology in comparison with other new or existing health technologies” (cf. recital 2). HTA plays an important role in the decision-making process on pricing and reimbursement of health technologies. HTA should rely on high standards, robust methodologies and should be carried out in an independent and transparent manner.

The main rationale of the proposal is that HTA at national level currently *“contributes to impeded and distorted market access”* for health technology developers (cf. p. 1 and 2 of the proposed Regulation) and *“the availability of innovative technologies for EU patients”* (cf. p. 2 of the proposed Regulation).

As a matter of fact, as a key source of assessment of new drugs coming to the market during the last 37 years in France and Europe, we know that the main obstacles to market for patients today are:

- 1) excessive prices of new drugs;
- 2) the lack of evidence that new drugs are indeed innovation and therapeutic advances. Indeed, EMA has acknowledged that *“innovative”* means no more than *“new”*. *“The term is neutral with respect to whether a given “innovative” product is more (or less) effective and/or safe than existing treatment options. Experience shows that many new products are an improvement over existing therapies but others are not”*¹.

No mandatory framework

We are very much in favour of enhancing cooperation between HTA bodies: sharing methods, data, etc. But the proposed Regulation on Health Technology Assessment goes a step further than strengthened cooperation by establishing a framework for mandatory joint clinical assessments of certain health technologies (mainly new medicines/indications and certain medical devices) based on a ban for duplication of clinical assessment at Member State level. **We disagree with article 8** settling down this ban and forcing Member states to *“apply joint clinical assessment reports”* in their respective national health technology assessments.

¹ Letter 16 June 2016 EMA/365120/2016 Senior Medical Officer page 5
http://www.ema.europa.eu/docs/en_GB/document_library/Other/2016/06/WC500208968.pdf

Overcoming existing divergent national procedures and methodologies by imposing a European mandatory system without a consensus on the evidence required, methodologies and procedures is questionable.

Risk of lowering standards

Joint clinical assessments should rely on established and widely agreed methods and processes. However, the Commission's proposal doesn't outline evaluation standards (methodology, data, studies, outcome measures) but instead foresees that these should be adopted separately through **delegated and implementing acts**. In addition, the proposed Regulation removes the possibility for Member states to duplicate assessments already done jointly. Thus, the proposed harmonisation process carries a risk that HTA bodies with higher methodological standards would be forced to downgrade their assessments towards "EU" lower standards, which is not acceptable. Therefore, **we recommend that the "ban of duplication" be deleted**. The Commission's proposal, if adopted in its current version, would certainly improve business predictability at lower cost for companies BUT **without** providing a guarantee for **strengthening the quality of HTA** across the EU.

Need for comparative trials

Clinical assessments aim to evaluate the "*added therapeutic value*" of a health technology vis-à-vis standard treatments based on outcomes that are relevant for the patient (greater efficacy, increased safety, greater convenience). The proposal correctly points out that "*HTA is thus an evidence-based process that independently and objectively assesses a new or existing technology and compares it with other health technologies and / or the current standard of care*" (cf. p. 2 of the proposed Regulation).

But currently, "*added therapeutic value*" is not considered as a key criterion for marketing approval. This is clearly acknowledged in the EMA's letter quoted above and shown in our experience as well as pointed out in several studies published in BMJ and elsewhere: many new drugs have not been assessed in phase III clinical trials and/or comparative trials, or are assessed against questionable endpoints. Comparative assessment is undertaken by HTA bodies, who need to ask for additional data from the manufacturers in order to ascertain how new products compare with those already available. This process takes time. To speed up the work done by HTA bodies and help them to assess the added therapeutic value of health technologies, the proposed Regulation on HTA should therefore **provide for comparative trials against the best standard therapies**. To streamline the process and to make sure that HTA bodies can base their assessments on robust data, **comparative trial data** should be made available in applications for marketing authorisations. Providing for comparative trials would go a long way towards facilitating the activities of HTA bodies, saving time and resources, and benefiting patients and society in the short term, and the pharmaceutical industry in the medium and long term, thanks to a focus on real therapeutic advances.

Independence

Whether the proposed EU funding provides a better guarantee for a long-term cooperation than the current EUnetHTA project-based cooperation is questionable. In *recital 31*, a **fee-paying mechanism** by health technology developers is mentioned that *would create an inherent conflict of interest*, establishing an environment of institutional capture and reciprocity.

Due to its critical role in generating evidence-based information on the value of a product to be considered in the national pricing and reimbursement decisions, HTA bodies and processes should be free from political pressure and other vested interest in medicines policy. The role of the European Commission outlined in the proposal needs therefore to be limited to a purely administrative role. In addition, such a gatekeeping function **cannot be ensured by the European Medicines Agency**, as it is in charge of marketing authorisations, mainly financed through pharmaceutical fees and with no robust conflict of interest policies in place.

Joint scientific consultations (scientific advice) need to be fully transparent

Contrary to what is proposed in the draft Regulation, joint scientific consultations should not take place behind closed doors. The provision for anonymised summary information in annual reports (cf. *article 14*) is not satisfactory. The experience with opaque scientific advice offered by EMA to drug companies need to be considered. The content, procedures and the conduct of scientific consultations should be fully transparent and rely on appropriate scientific standards and guidelines.

Transparency

The Commission proposal needs to be amended to guarantee that the whole process, activities and results arising from the proposed Regulation takes place in full transparency with public access to data and documents (not only final reports or summaries) as provided for by Regulation 1049/2001.

Improvement of the availability of innovative health technologies: very unlikely

In 2017, Prescrire assessed 92 new medicines². As in previous years, few clinical advances were identified: 18 were rated “possibly helpful”, 9 were considered as “offering an advantage” and only 1 was rated as “a real advance”. Many products were rated providing no progress: 45 rated as “nothing new” (me-toos).

² “L’année 2017 du médicament en bref”; Rev Prescrire 2018; **38** (412): 145-146
“Drugs in 2017: a brief review” Prescrire Int 2018, **27** (192): 110-111.

Every month, Prescrire publishes an independent and methodical review of the latest developments in the pharmaceutical market: new substances, new indications, new pharmaceutical formulations. On the basis of its assessments, Prescrire attributes ratings built upon 7 categories according to the added therapeutic value and safety profile:

- Bravo
- A real advance
- Offers an advantage
- Possibly helpful
- Nothing new
- Not acceptable
- Judgment reserved

And some medicines even represented a step backward, with 15 new products that were more dangerous than useful. The 2017 results are comparable with those of the last 10 years. Therefore, we consider that only a minority of newly authorised products provide a tangible therapeutic value.

Conclusion

The real barrier to access to medicines is not caused by national differences in clinical assessments or duplication of assessments, **but by the exorbitant prices that are disconnected from added therapeutic value or R&D cost.**

HTA bodies may take some time for doing their job at national level, but this is mainly due to the lack of data on the therapeutic value of the new drugs. **The timely availability of genuine comparative trials data at the time of drug approval would represent an undeniable support to streamline HTA bodies' remit.**

Mandatory participation and uptake of European clinical assessments would weaken HTA in the most advanced countries and not help the others.

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For more information



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