The PBS Post Market Review Team
PBAC Guidelines Review
Pharmaceutical Evaluation Branch
Department of Health Canberra ACT
PBSpostmarket@health.gov.au

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Bayer Australia Limited
ABN 22 000 138 714

875 Pacific Highway
Pymble NSW 2073
Sydney, Australia

Postal Address
PO Box 182
Gordon NSW 2072
Sydney, Australia

Ph: (61) 2 9391 6000
Fx: (61) 2 9988 3311
www.bayer.com.au

Dear Sir/Madam,

Re: PBAC Guidelines Review (draft v5.0), submission to the public consultation process

Bayer welcomes the public consultation on draft Version 5.0 of the Pharmaceutical Benefits Advisory Committee (PBAC) Guidelines, and supports the recommendations put forward to the Guidelines Review Steering Committee (GRSC) by Medicines Australia. Additionally, this submission briefly elaborates on key areas of concern in the draft guidance, based on Bayer's experience as a sponsor of innovative PBS listed medicines, specifically:

1. Comparator selection;
2. Scope of costs considered in value quantification;
3. Increasing burden of proof;
4. Rare diseases; and
5. Patient voice.

These elements of the draft guidelines are each addressed briefly and in context below. Several of these key issues are closely interrelated and are discussed accordingly.

The new draft guidance includes an explicit reference to cost in the selection of a comparator, as follows (p.16): "Where multiple alternative therapies could be used for the majority of patients, the PBAC cannot recommend a new medicine at a price that is substantially higher than the least expensive alternative medicine unless it is satisfied that the new medicine provides a significant improvement in efficacy or reduction in toxicity over that alternative medicine". Bayer strongly opposes this guidance, on the basis of foregone system efficiencies and poorer patient outcomes, as discussed below.

A reimbursement system that appropriately recognises innovation is the vital requirement for the sustainability of its core purpose of providing health outcomes in an increasingly efficient manner. It is only with continual increases of incremental innovation that an increasing efficiency of health outcomes delivery can be achieved for the population the system serves. The system itself is symbiotic in nature and requires that a consistent and appropriate balance is achieved between incentivising the entry of innovative therapies with that of overall affordability determined by policy decision makers.

The key driver of the value assessment in the PBS system is the intra-system comparison relative to the nominated main comparator/s to which a new listing or line extension of a pharmaceutical is anchored. This comparison evaluates comparative health benefits and cost impacts of the new therapy, and defines the value recognised in the PBAC recommended reimbursed price of the new listing. It follows that in current practice only direct costs and health outcomes are considered in decision making for reimbursement, without any explicit guidance regarding how quantified value derived from non-health benefits or indirect societal benefits and costs is incorporated into the recommended reimbursed price.

In this context of intra-system comparative evaluation which has a narrow scope of value recognition of new entries, the draft guidance signals a bias which undermines the incentive to innovate by explicitly nominating direct intra-system cost as a factor governing comparator selection. This approach can expose an innovative medicine to an isolated comparison of only direct incremental health benefits relative to an off-patent comparator product which has had its value already eroded through successive price disclosure cycles on the F2 formulary.

If implemented, the updated guidance on direct intra-system cost-based comparator selection would systematically erode the value that sponsors can substantiate for their innovative medicines if only direct health benefits and direct intra-system costs are in scope for recognition and quantification. The broader benefits that a new innovative therapy may offer society, patients, and the broader healthcare system remain unrecognised and unrewarded. Such benefits may include:

- Societal value: productivity, reductions in welfare dependence and disability payments.
- Non-health benefits: patient preferences and willingness to pay (e.g. different mode of administration, such as injection versus oral).
- Local investment in therapeutic areas by sponsor companies: disease awareness, and activities or services which both increase treatment uptake and improve Quality Use of Medicines, resulting in better health outcomes (these investments are generally associated with on-patent therapies).

The narrow scope of costs accounted for in measuring the value of new listings creates a discrepancy between the value recognised by the system and the value perceived by patients, as well as a discrepancy between the value recognised by the PBAC and equivalent decision-makers in other health systems in the global commercial environment that sponsor companies operate within.

If main comparator determination is driven predominately by direct intra-PBS cost comparisons, it is likely to result in the systematic under-valuation of new innovative therapies in the Australian market versus other countries and healthcare systems. Bayer recognises that this is also driven by affordability and the absolute budgetary investment of the PBS, which is not within scope or the remit of the PBAC. It is however intrinsically linked with policy of how new innovative pharmaceutical items are evaluated.

All innovative pharmaceutical companies operate in the global commercial environment. If there is a systematic divergence of how the Australian PBS system values innovative medicines versus other systems, it will ultimately result in a delay to timely patient access to some innovative therapies via the PBS and reduced efficiency in the system's ability to deliver health outcomes to the population.

By omitting important elements of the value of medicines, the system fails to capture the full value perceived by the population it serves. Patients place real value on a broad range of costs not currently accounted for in the value assessment by the PBAC. The scope of relevant costs considered of primary relevance in the guidance should be broadened to better represent the perspective of those on whose behalf it operates.

Bayer does recognise that guidance on patient-relevant and societal factors has been included in the Version 5.0 (e.g. patient preference, productivity gains, other indirect costs) however is disappointed that these have been relegated to areas of "supplementary" consideration. Given the risk of systematic under-valuation, Bayer believes these factors should be recognised as part of the economic evaluation section of the guidelines.

It is important to consider the incentives for innovation that result from public policy. The nomination of cost as a factor governing comparator selection in the draft guidelines should be revised to align with the interests of patients and with the Government's innovation policy platform.

The draft guidance reveals a trend towards an increasing burden of proof for sponsor companies seeking PBS reimbursement, such as the new section outlining independent external validation of the model used to quantify the economic value of a medicine proposed for PBS listing. However, anticipated practical issues might limit the ability of sponsors to comply with this guidance and thereby limit value of the process to inform the PBAC's decision. For example, the PBAC may be unconvinced of the independence of an external reviewer due to remuneration such an expert might reasonably expect from the sponsor company for their services.

It may instead be pragmatic to recognise in the final version of the guidelines that the most credible external review process in the eyes of the PBAC will continue to be that undertaken by the evaluation groups contracted by the Department.

The current draft omits specific guidance for submissions seeking reimbursement of treatments for rare diseases. There are intrinsic challenges regarding the clinical development of therapies for these diseases. These challenges also translate to the review of cost effectiveness. The usefulness and practicalities of fitting a treatment for a rare disease into the decision criteria for a relatively more common disease requires attention in the final version of the guidance.

Traditional evidence expectations of cost-effectiveness are not suitable for the evaluation of most treatments for rare diseases. There are numerous challenges in the analysis and interpretation of cost-effectiveness analyses of these treatments. From an economic modelling perspective, the natural history of disease progression is often lacking so it can be difficult to extrapolate the short-term clinical trial results for the lifetime of patients. In addition, given the small number of patients, with the disease, clinical trials are often limited to small sample sizes. This leads to uncertainty when translating the clinical trial results in to an economic model. There is also difficulty in identifying an appropriate comparator for these treatments, because existing treatments for rare diseases are often older and have been used off-label. Such treatments often do not have well-designed clinical trials in the specific disease area for a proper comparison.

Due to the uncertainties and multiple challenges in conducting economic evaluations of treatments for rare diseases, it can be difficult for the PBAC to draw concrete and meaningful conclusions based on the results of these evaluations. The evaluation challenges for treatments for rare diseases, in turn, present important equity of access issues for affected patients. The significant level of concern in the patient community over this issue is evident in the input received in response to the public consultation phase of defining the scope of the PBAC guidelines review. A specified higher level of uncertainty should be allowed for pharmacoeconomic evidence requirements in a fit-for-purpose evaluation framework for treatments of rare diseases included in the final version of the guidelines, given that it often provides little useful information to inform decision-making.

The public consultation process will benefit from a range of credible opinions from the technical HTA community, and Bayer welcomes the opportunity to be involved in the process as a sponsor with experience of the reimbursement system. However, the integrity of the system is anchored in the extent to which it employs these methodologies to reflect societal preferences for the allocation of resources. Throughout this submission, several areas of the technical guidance have been raised that have a real impact on patients. Further, several elements of the value quantification process for new listings have been highlighted which require closer alignment with patient values.

Therefore, it is critical that the GRSC work towards the development and communication of a clear vision of what meaningful patient participation in the HTA process will look like in practice. In addition, the guidelines should offer clarity of how patient perspectives and consumer input informs parameters specific to the recommendation. Bayer commends the recent interaction of the Department with forums focused on exploring contemporary methods for quantifying patient choice, such as the 'Room with a Patient View Forum' held on 26 February 2016. An example of progress that is being made in this area internationally is available in the work of the HTAi Patient and Citizen Involvement recommendations. The GRSC has a wealth of willing patient groups available to assist in this important and urgent evolution of the Australian HTA process, as evident in the submissions received from patient organisations to date.

To summarise, Bayer feels that the following areas would benefit from further consideration in the development of the final version of the guidelines:

1. Removal of cost as a factor governing comparator selection;
2. Inclusion of indirect societal costs and outcomes in the value substantiation of new listings within the main economic section of the guidelines;
3. Revision of the requirements for sponsors to undertake independent external model validation;
4. Addition of guidance on fit-for-purpose assessment criteria for treatments of rare diseases; and
5. Addition of guidance on what meaningful patient participation in the HTA process looks like from the GRSC's perspective.

Yours sincerely,

Matt Slabbert
Manager, Market Access
Bayer Pharmaceuticals