Fastest access to the best medicines

Merck Sharp & Dohme (MSD) Australia's submission on items included in the Pharmaceutical Benefits Advisory Committee Guidelines Review

September 2015

Public

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MSD welcomes the opportunity to contribute to the public consultation process for the items included in the PBAC guidelines review. The review is a valuable opportunity to enhance both the methods used to assess the benefits that medicines provide to Australian society and the process followed in completing PBAC evaluations.

Over the past five years MSD has been one of the top three companies by submission volume. Our organisation has extensive experience with different types of submissions across different therapeutic areas. The PBAC guidelines are critically important to our work, hence our interest in the review and the request for input on the review items in particular.

A significant number of the items covered in the review's terms of reference are procedural. These set out the process that the contractor selected to complete the review, Health Technology Assessment (AHTA), will follow in identifying issues, developing technical papers, consulting stakeholders and finally consolidating all findings and feedback into revised guidelines for the PBAC's consideration. This process appears fair and transparent, and MSD looks forward to further opportunities to input into the review.

MSD will therefore focus this submission on the substantive issues in the items, i.e. the methods and processes used to complete evaluations.

As outlined in the title above, our contention is that the PBAC guidelines review should improve patients' access to the best medicines. For this to happen, we believe that:

- PBAC methods must capture the full societal benefit of new medicines
- Assessment pathways and methodologies to address situations where comprehensive and/or robust data is lacking should be incorporated
- Evaluations should be flexible, fit for purpose and integrate seamlessly

This paper addresses each of these issues in turn.

1. PBAC methods must capture the full societal benefit of new medicines

PBAC evaluations currently assess medicines on the basis of reference pricing or cost-effectiveness assessment, through the application of a narrow perspective of health benefits and costs for the new medicine relative to standard of care. Particularly in situations of high unmet need, standard of care usually consists of older medicines whose cost has been dramatically reduced through successive price disclosure cuts.

The current narrow perspective contributes to the perverse situation whereby cost effectiveness of new medicines is more difficult to prove in circumstances where newer medicines are needed most.

High disease burden or the absence of treatment alternatives may influence the frame through which new medicines are evaluated, through higher ICER thresholds for example. However there is no formal way of incorporating patient need into the consideration of a new products' value or of assessing how the community might value such need. Neither is there any consideration of the potentially substantial societal benefits that accrue indirectly from medicines including the increased productivity and lower welfare requirements of patients and carers.

These considerations point to the following proposals that would improve the guidelines.

i. **Include societal benefits and costs in PBAC evaluations, as part of a more comprehensive assessment of cost effectiveness and budget impact of new medicines**

Provide guidance on the incorporation of the following in economic analyses:

- Indirect costs within healthcare: upstream or downstream costs that are impacted
- Direct costs outside of healthcare: patients and family costs including travel for treatment, professional carers; welfare and disability payments; unpaid carers
- Indirect costs outside of healthcare: patient's ability to work (absenteeism and presenteeism), tax forgone, carer's ability to work
- Quality of life of carers

Inclusion of these attributes is important as these are real and substantial costs incurred by a society. Failure to account for these leads to an incomplete picture of costs and savings of a new medicine, potentially resulting in welfare damaging decisions being made.

ii. **Outline approaches to be used to assess clinical need and provide guidance on how this could be incorporated in a submission to guide PBAC decision-making**

Describe how clinical need can be synthesised and presented in the submission in a manner that can help guide decision-making. In particular, guidelines should describe how input from patients, carers and healthcare providers can be collated and presented as an intrinsic part of a reimbursement submission.

Guidance should also be provided on approaches to determine how patients value medicines (e.g. discrete choice modelling / patient value mapping) and how these could be incorporated into economic analyses.

iii. Give the community the opportunity to place value on patient need

Guidelines should formalise an effective process for engagement and consultation to best determine community views on the potential value of a new medicines. This could be achieved through early stakeholder forums for important new medicines as well as ongoing consultation through the evaluation process.

Importantly, this process should influence PBAC decision-making frame with respect to acceptable ICER thresholds and/or willingness to accept uncertainty.

iv. The review should explore whether the current guidelines adequately support innovation in areas with high unmet need (e.g. rare conditions, reimbursement of new antibiotics, F2 comparators) and if needed, outline solutions to address

Whilst unmet need may indirectly influence the frame through which new medicines are evaluated – for example through higher ICER thresholds – analyses of past PBAC decisions shows that medicines with very high ICERs / high uncertainty rarely receive a positive recommendation. Likewise, proving cost effectiveness becomes extremely challenging when the comparator is an F2 medicine whose price has been dramatically reduced through successive implementation of price disclosure cuts.

This review should assess whether the current framework supports innovation in these situations, and if not, propose approaches to address.

2. Assessment pathways and methodologies to address situations where comprehensive and/or robust data is lacking should be incorporated

Evaluations also inherently disadvantage patient populations where there are challenges in generating sufficient high quality data. The plight of patients with rare cancers and other rare diseases is particularly acute in this regard, as low patient numbers make it impossible to design comparative studies and execute in a timely manner. Likewise, breakthrough medicines are increasingly being expedited through regulatory pathways, resulting in datasets with limited follow-up at the time of making a reimbursement submission. These challenges can be alleviated through the following improvements in the guidelines:

i. Facilitate a greater reliance on surrogate outcomes to accelerate access in situations of high clinical need, with uncertainties to be resolved via managed access programs

Guidance on how access can be accelerated in situations where data is not available or would take too long to accrue would be helpful. This guidance should allow for a greater reliance on surrogate measures whilst outlining how uncertainties can be resolved through managed access programs and/or risk-sharing frameworks.

ii. Use real world evidence to replace / supplement trial based assessments

Guidance is needed on how analyses of non-randomised data (e.g. single-arm studies, observational studies) can be used to replace / supplement randomised clinical trial data in specific circumstances, for example in situation when:

- It isn't necessary to wait for the results of confirmatory comparative clinical studies (e.g. high clinical need and significant clinical benefit for new intervention)
- Randomised clinical evidence will not be forthcoming (e.g. rare conditions)

iii. Give high need, small population therapies early access with post-market evaluation

Promising new therapies in small populations are not well suited to the current evaluation process given paucity of data. Alternative means of access should be explored, such as reimbursement on registration at a price acceptable to Government and Sponsor, with real-world evidence driven re-assessment within a short period inclusive of rebates or premiums where therapies performed worse or better than predicted.

3. Evaluations should be flexible, fit for purpose and integrate seamlessly

The current assessment pathway is inefficient: urgently needed new medicines are routinely delayed by cycles of rejection and resubmission, or in the case of co-dependent submissions, by one Committee (e.g. PBAC) deferring a decision pending the outcome of a separate Committee (e.g. MSAC) who in turn defers back to the PBAC; resourcing and assessment processes for basic cost-minimisation submissions is no different to that of complex managed-access submissions; parallel regulatory and reimbursement assessment is allowed for complex major submissions for new chemical entities but not allowed for minor submissions seeking addition of new formulations.

Whilst this review's primary focus is updating of methodological guidance, an overhaul of current processes is crucial if this review is to provide Australians with the fastest possible access to the medicines that they need. Below are a number of proposals that would help achieve this aim.

i. Reduce red-tape for simple reimbursement submissions

Cost-minimised submissions should be considered through a less complex submission pathway; likewise, biosimilars could easily be assessed as minor submissions. This would free

up significant time that the PBAC secretariat can dedicate to more complex submissions for important new medicines.

ii. Parallel-processing for minor submissions

A parallel regulatory and reimbursement process is currently allowed for more complex major submissions but not for simpler minor submissions. Extending parallel processing to minor submissions would ensure a more efficient and timely process for some new medicines (e.g. biosimilars, new formulations).

iii. Implement a longer, more highly consultative evaluation pathway for the early consideration of important new medicines

Over the past year, several cancer therapies have been evaluated using the managed access programs. These have required far greater flexibility and cooperation than traditional evaluations with breaking data being incorporated much later in the evaluation than usual and Sponsors and the Secretariat interacting frequently to address uncertainties arising from less mature data. Done well, these more comprehensive evaluations could accelerate access as they are far less likely to lead to first time rejection than the current process.

iv. Regulatory and reimbursement processes should integrate seamlessly and continue to evolve in parallel

Parallel TGA and PBAC assessment is a good example of a streamlined assessment pathway that has resulted in faster access to medicines. Opportunities for further alignment and integration of TGA and PBAC processes should be sought (e.g. assessment milestones, Committee meetings, etc.). Likewise, opportunities to create efficiencies in the assessment processes should also be explored with the aim of reducing duplication.

The TGA Review has recently put forward recommendations from its final report to the Government. No changes in regulatory policy have been announced to date, however it is very possible that reforms might be implemented by the time the new draft PBAC guidelines are being considered. It would be helpful for the PBAC guidelines to incorporate changes that allow for more seamless integration between TGA and PBAC processes as these reforms come into practice, in particular with regards to expedited reviews and use of overseas reports.

v. Co-dependent assessment pathway should be further streamlined to avoid unnecessary delays

A review of the current process for the assessment of co-dependent technologies is needed as past co-dependent evaluations have resulted in a substantially longer process for targeted therapies relative to non-targeted therapies. Opportunities for combined MSAC – PBAC meetings and streamlining of the Protocol assessment process should be explored.