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European Federation of Pharmaceutical Industries and Associations

Access to Innovative Drugs

Nathalie Moll, Director General






13 October 2022

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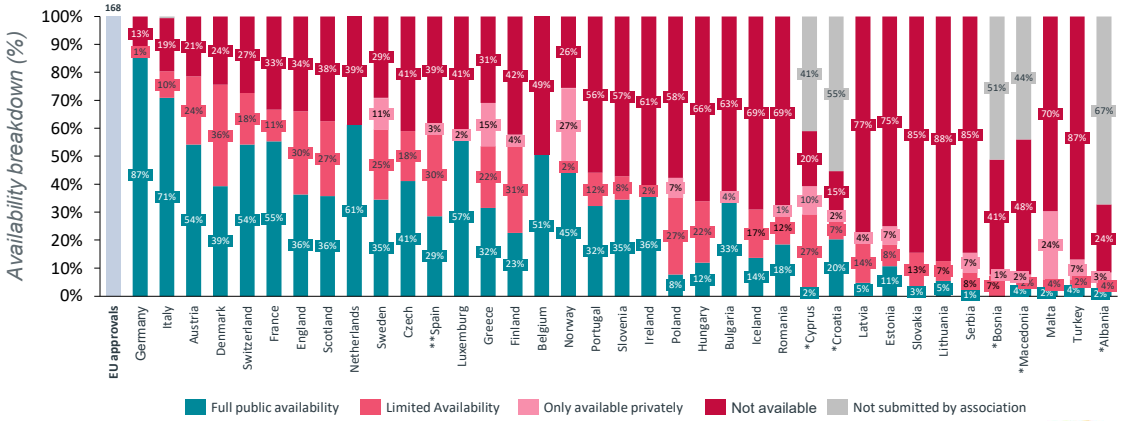
What is driving the debate
Availability of medicinal products in Europe

The time to availability is the days between marketing authorisation and the date of availability to patients in European countries



European Union average: 76 products available (45%), Limited availability (14% of all products). Netherlands did not submit complete information on restrictions to available medicines meaning LA* is not captured in these countries. †In most countries availability equates to granting of access to the reimbursement list, except in DK, FI, LU, NO, SE where some hospital products are not covered by the general reimbursement scheme. *Countries with asterisks did not complete a full dataset and therefore availability may be unrepresentative. **In Spain, the WAIT analysis does not identify those medicinal products being accessible earlier in conformity with Spain's Royal Decree 1015/2009 relating to Medicines in Special Situations

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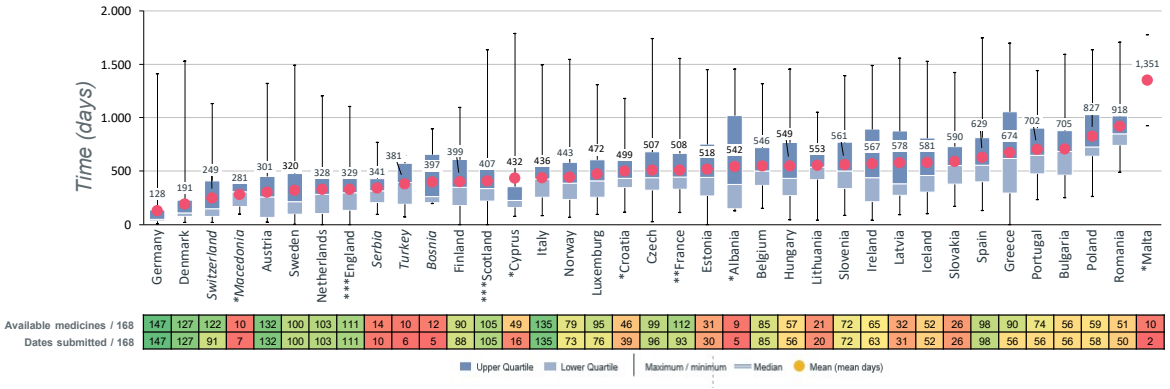
Delays and time to availability
All medicinal products

The time to availability is the days between marketing authorisation and the date of availability to patients in European countries



European Union average: 517 days (mean %) (Note: Malta is not included in EU27 average as only 2 dates were submitted in total) †In most countries availability equates to granting of access to the reimbursement list, except in DK, FI, NO, SE where some hospital products are not covered by the general reimbursement scheme. *Countries with asterisks did not complete a full dataset and therefore availability may be unrepresentative **For France, the time to availability (508 days, n=93 dates submitted) does not include products under the ATU system for which the price negotiation process is usually longer. ***In the UK, MHRA's Early Access to Medicines Scheme provides access prior to marketing authorisation but is not included within this analysis, and would reduce the overall days for a small subset of medicines.

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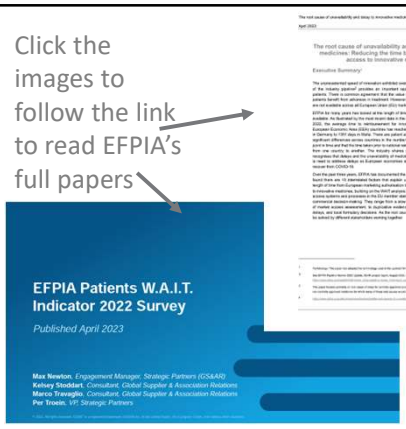
Delays and unavailability

Click the images to follow the link to read EFPIA's full papers



We share the goal of **fast, equitable and sustainable access** to treatments and recognise the disparities and delays in access for patients across Europe. Millions of people across Europe are not always able to access the scientific breakthroughs when they need them. Data from EFPIA's Patients W.A.I.T Indicator show that **market authorisation and patient access can vary from three months to 2.5 years**, depending on the country and region. Addressing these issues requires a shared, evidence-based understanding of the root causes of barriers and delays in access to treatments.

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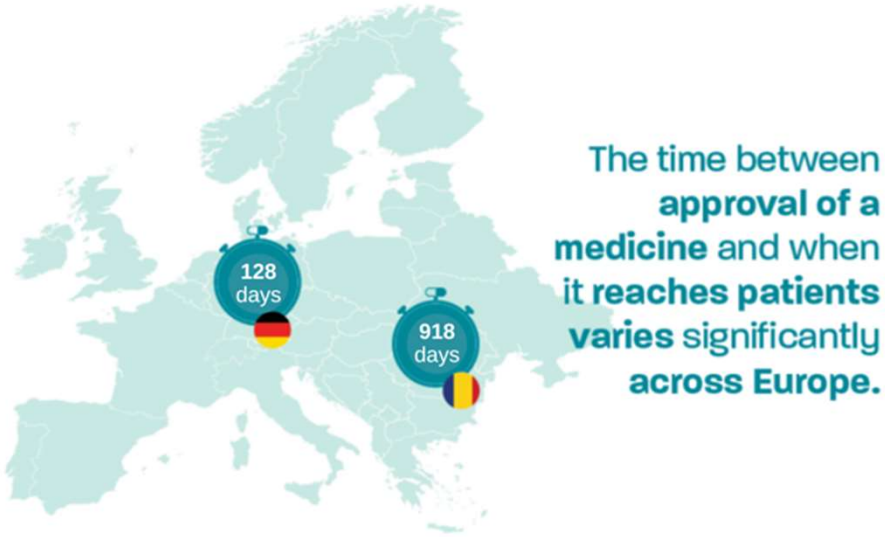

The time between **approval of a medicine** and when it **reaches patients varies** significantly **across Europe.**

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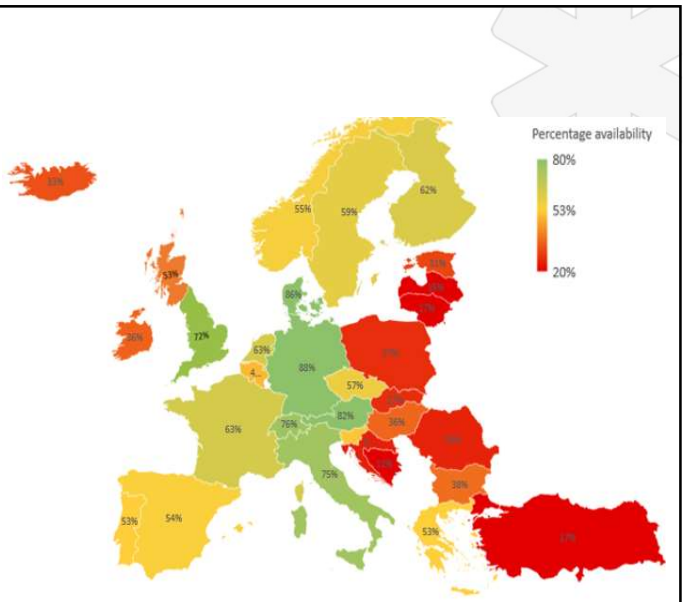
What is the evidence?

- **Wide variations** in availability and delays across Europe
- Although access to **oncology medicines** appears to be improving, access to **orphan medicines** continues to vary considerably across EU Member States
- Even **within one country**, patients can get access to some medicines almost immediately, and wait years for others
- There is little evidence that **delays** are reducing – rather the contrary



Comparing availability across European countries

Source: EFPIA/IQVIA, Patients W.A.I.T. Indicator, April 2021

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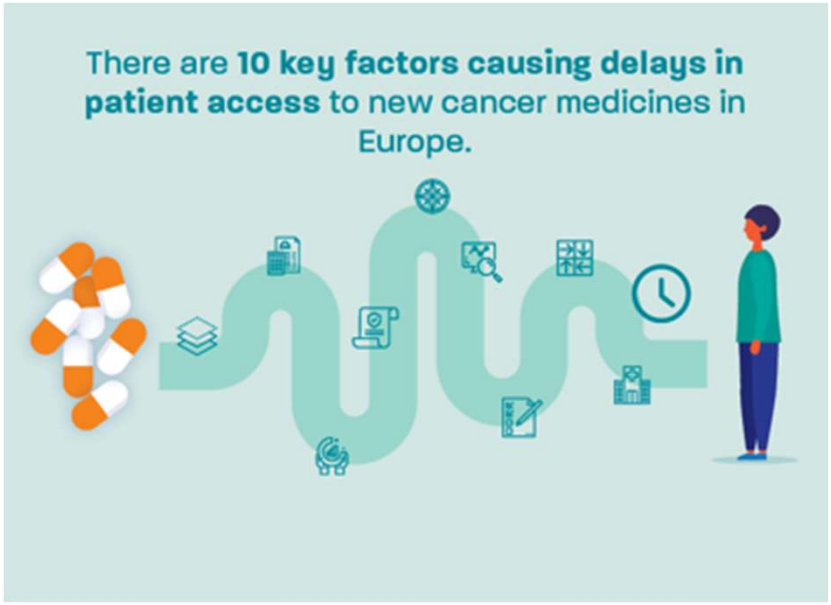

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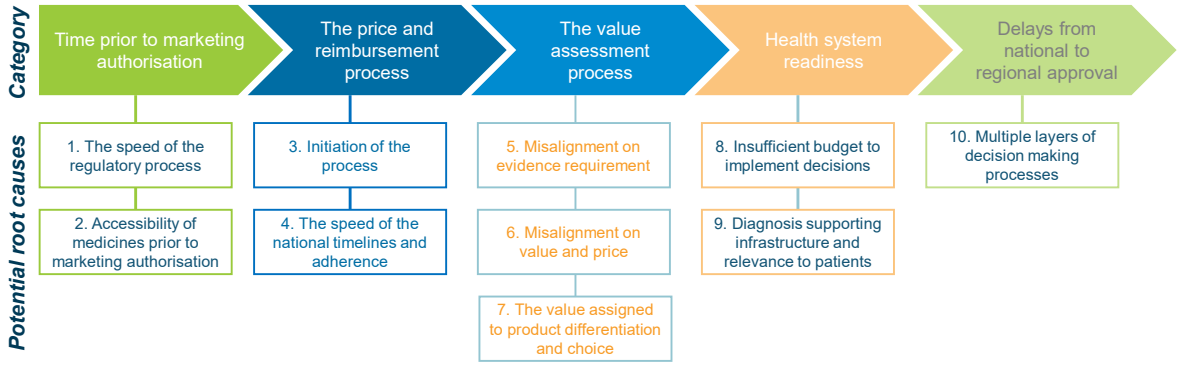
10 interrelated factors that cause access to medicines to be delayed:



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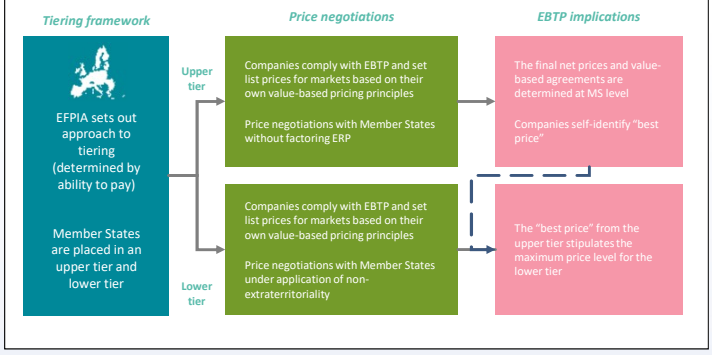
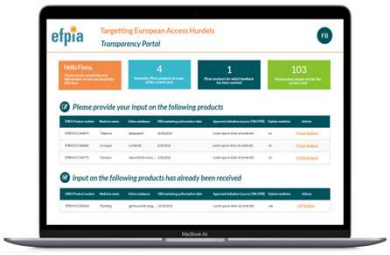
Strong commitment from industry to improve patient access to treatment

Equity Based Tiered Pricing



EFPIA's Access Portal

The Portal **tracks patient access** to newly launched medicines across European markets and highlights root causes behind access delays



Commitment to File

Industry commits to **filing of P&R applications** post EU authorisation in all EU-27 Member States as soon as possible and no later than two years, provided that local systems allow it

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A shared Equity Based Tiered Pricing

Pricing of medicines based on countries' ability to pay (using gross national income in purchasing power parity) to improve patient access (speed and availability) across Europe

Key principles – to be co-created with relevant stakeholders

- The concept of **solidarity** is fundamental: wealthier Member States should not benefit from lower prices ought to be available, in the interests of patient access, to less wealthy countries
- Anchored in **value-based pricing**: pricing of medicines based on value they deliver to patients, healthcare systems and society
- **Part of a broader response** to improve access and affordability
- Application to a product needs **flexibility**
- Role may **evolve over time**, as the differences between countries change

Win-win for patients (reduced delays, improved availability), Member States (price in line with value and ability to pay), EU institutions (better access to medicines) and industry (products in more markets)

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The Joint EU HTA has the potential to accelerate patient access

Joint Clinical Assessment at EU Level

Opportunity	Challenge
Common scientific foundation for P&R decisions for all Member States	Requires creation of a genuine new system that is applicable and supported by all national HTA bodies
Reduction of duplication of evidence submissions	Needs to be sufficiently resourced
Reduction in resource requirements for smaller countries	Needs to include adequate level of manufacturer involvement
Potential to accelerate patient access to new medicines across European markets	Needs to ensure adequate level of data confidentiality

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Challenges remain - variation in evidence requirements is a barrier to patient access

Inconsistency of evidence requirements between EMA and HTA and across national HTA bodies creates duplication and patient access delays

Meeting a wide range of evidence requirements across WHO European Region's 53 countries is a burden for MAH especially in rare disease areas

Level of acceptance of evidence characteristics

Accepted | Often accepted | Case dependent | Often not accepted | Not accepted

Evidence characteristics		MA	HTA						Level of alignment
Population	Population as authorized by EMA								50%
	Biomarkers								100%
	Extrapolation of other populations								33%
Comparator	Selected comparator								100%
	Class effects								33%
	Indirect comparisons								50%
Clinical end points	PFS as endpoint								50%
	Other surrogate endpoints								0%
	Absence of QoL data								50%
Trial design	RWE								100%
	Network Meta-Analysis								50%
	Single armed trials								50%
	Novel trial design								50%
Statistical analysis	Absence of stat significance								67%
	Post-hoc subgroup analyses								83%
	Clinical relevance of effect								67%
Level of acceptance		79%	68%	42%	47%	79%	37%	58%	

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Industry and stakeholder initiatives are leading to progress in patient access

We have successfully worked with healthcare systems across the EU to enable patient access to our CAR-T treatments, using **managed access agreements, including:**

Outcome-based agreements	Value-based agreements	Flexible payment	Price volume agreements	Price by indication
Payment for treatment is agreed subject to meeting individual patient level outcomes	Price for treatment is agreed subject to providing additional longer-term clinical evidence for cohort patient population	Payment in instalments to support cashflow and affordability for the healthcare system	Price for treatment is agreed subject to a quantity of product ordered	Price for treatment is agreed across various indications taking into account value of indications

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Novel payment models can improve access to innovation

Estonia
Indication-based pricing: using data infrastructure for disease areas with small patient populations

United Kingdom
Outcomes-based pricing: NHS paid for patients with a complete or partial response after four cycles of treatment

Netherlands
Indication-based and outcomes based pricing: implemented with sick funds and individual hospitals

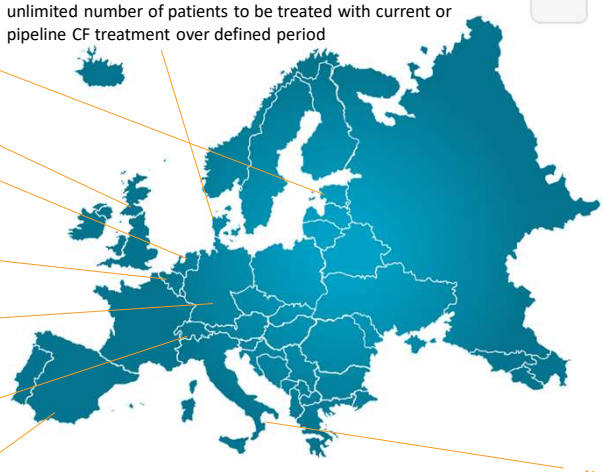
Belgium
Indication-based and outcomes based pricing: physicians required to meet criteria to initiate, prescribe or discontinue in to a sick fund database

Germany
Outcomes-based pricing: rebates given from company if patients die from disease in given period

Switzerland
Combination pricing: payers provide a refund to companies based on the difference in price of the sum of the individual medicines and that of the combination. Breast cancer and myeloma

Spain
Outcomes-based model: companies rebates payers up to 100% for suboptimal or non responder patients with CML

Denmark
Subscription payment model: payers pay a subscription for an unlimited number of patients to be treated with current or pipeline CF treatment over defined period



Italy
Over-time model: for CAR-Ts instalments at administration, six months and a year and only if shown to be effective. National registries allow for **outcomes-based reimbursement, indication** and **combination** pricing

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Varying health priorities across Eastern European Countries

Highest disease burden and and associated health priorities vary across Eastern European countries:

- **Ukraine** – leading cause of death 2022: CVD, followed by COVID-19
- **Slovakia** – leading cause of death 2022: Coronary Heart Disease followed by Dementia
- **Romania** – leading cause of death 2022: Cerebrovascular disease & high blood pressure
- **Serbia** – leading cause of death 2022: CVD, followed by Cancer
- **Armenia** – leading cause of death 2022: CVD, followed by COVID-19
- **Hungary** – leading cause of death 2022: Cancer, followed by ischemic heart disease

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We are on the right path, but further progress is needed – industry stands ready to partner with the stakeholder community

Vision
Every patient in need should have access to our medicines
1

Journey
We need to work together to address existing challenges – it's a journey not a sprint
2

Collaboration
Industry is working with healthcare systems to find new flexible approaches to patient access
3

Focus
We need to find bespoke solutions tailored to countries' need – top-down regional policy will not address individual challenges
4

Framework
Need to develop a framework of core principles that recognises the individual needs of countries and offers tailored solutions
5

Solidarity
Need for further solidarity and collaboration between countries to work together in RWE collection to avoid duplication and enable joined learning
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Lessons learnt from Joint Procurement Initiatives

Challenges posed by Joint Procurement Initiatives

JPA	Gilead provided the only available treatment for COVID through the JPA across the EU during the pandemic
Variation	Despite the urgency and lack of alternative treatment options, difficulty by MS to find agreement on need for collaboration, supply and allocations
Challenge	Difficulty in reaching agreement will be even greater in non-crisis times for treatments for routine use
Beneluxa	Similarly, Beneluxa initiative has not resulted in many agreements yet even given that it involves a small number of similar countries
Challenge	It will be even more difficult to reach agreement if 27 MS are involved of varying sizes and eco strength

Suggested principles for Joint Procurement Initiatives

Access	Overall objective should be enhancing and accelerating patient access
Duplication	Should not lead to additional market access barriers nor duplicate national negotiation processes
Collaboration	Should be confined to countries of similar economic and health-related needs
Participation	Industry participation in the initiative should be voluntary
Confidentiality	Confidentiality of pricing and reimbursement agreements should be guaranteed

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Aligning price, value and budget






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Click the image to follow the link to read EFPIA's full paper

Value-based approach to pricing

The goal of pricing of pharmaceutical innovations is to ensure that patients can access medicines in a way that is sustainable for healthcare systems, whilst also supporting a sustainable stream of innovation that delivers continuous improvements in the treatment options available for patients. Prices send signals to innovators about where to focus their R&D efforts, as well as determine the overall level of investment in health and expected value of innovation in the pipeline. A value-based approach to pricing is based on the principle that prices should reflect the value of a new medicine to 1) patients, 2) health systems and 3) society versus the current standard of care.

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A value-based approach to pricing can deliver the triple win of:

Why: for innovative medicines, prices are set in negotiation between a monopoly seller and a monopsony buyer – these negotiations need to be guided by some set of principles on how prices should be set

Principle: Prices should reflect the value of a new medicine to patients, healthcare systems & society, versus the current standard of care.

Many countries in Europe have introduced elements of value-based pricing, but there are still significant gaps and barriers which disrupt the alignment between value and price.

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What is value?

Value to patients:

- improvements in patients' health, e.g. increased survival, quality of life, functional status and ability to take part in work and daily/social life
- Improvements in process of care, e.g. a pill compared to a transfusion, for example, may save them discomfort, as would decreased travel time to a healthcare provider.

Value to healthcare systems:

- Replacement of a more expensive (or equally expensive but less effective) alternative
- Prevention of complications that would lead to hospitalisation/emergency care
- More efficient patient pathway
- Slower disease progression which means less resources needed for intensive care or social care
- New treatment modalities that allow for home care instead of hospital care

Value to society:

- Patients returning to work
- Lower costs for sick leave or other social benefits
- Reduced burden on informal carers
- Heard immunity from vaccination

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EU member states' consideration of value elements in health technology assessment processes

Considered in value assessment?	Yes	No
Health outcomes	BE FR DE IT NO PL ES SE UK	
Cost of technology	BE FR DE IT NO PL ES SE UK	
Other direct medical costs	BE FR DE IT NO PL ES SE UK	
Treating severe diseases	BE FR DE IT NO PL ES SE UK	
Direct non-medical costs	BE DE FR IT NO PL SE	ES UK
Innovation	BE DE IT PL ES SE	FR NO UK
Indirect non-medical costs	BE FR IT PL SE	DE NO ES UK
Equity	BE PL ES SE UK	NO FR DE IT
Reducing unmet need	BE FR IT ES	DE NO PL SE UK
Health outcomes of carers	FR NO SE UK	BE DE IT PL ES
Indirect medical costs	BE FR SE	DE IT NO PL ES UK
Improvements in the process of care	BE FR IT IT	DE NO PL ES SE UK
Treating rare diseases	NO SE UK	BE FR DE IT PL ES

Belgium | France | Germany | Italy | Norway | Poland | Spain | Sweden | UK

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Pricing approaches & price control measures used by EU member states

Pricing approach or mechanism used?	Yes	No
A value-based approach to pricing		
Alternative pricing approaches		
Measures to control spending on individual products		
External referencing		
Measures to control total pharmaceutical budget		
Budget impact considerations		
Therapeutic referencing		

All countries make:

- some provision to reflect the results of value assessment in their pricing and reimbursement decisions.
- use of other pricing approaches or price control measures that disrupt the alignment between value and price.

The most prevalent of these are **external reference pricing & measures to control overall pharmaceutical expenditure**, both of which are used in seven of nine countries.

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What should healthcare system stakeholders do?

Enhance value assessment:

1. Ensure meaningful involvement of all stakeholders in value assessment
2. Enhance collaboration and share expertise across EU Member States
3. Develop a shared and holistic definition of value
4. Recognise qualitative evidence of value through deliberative processes

Improve the implementation of value-based pricing:

5. Fully embrace a value-based approach
6. Extend value-based pricing to the indication level

Maximise the benefits of value-based pricing through complementary tools:

7. Use outcomes-based managed entry agreements to manage residual uncertainty
8. Enhance data collection infrastructure to allow for iterative assessments of value post-launch
9. Commit to 'Equity Based Tiered Pricing'
10. Promote competition

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Click the images to follow the link to read the full papers

Broadening the perspective on affordability

Health care budgets are under pressure, resulting in reduced access to individually cost-effective therapies because the total cost of care outgrows the available budget. Taking a broader perspective across time and budgets can improve the affordability of pharmaceuticals and safeguard future patient access to valuable therapies.

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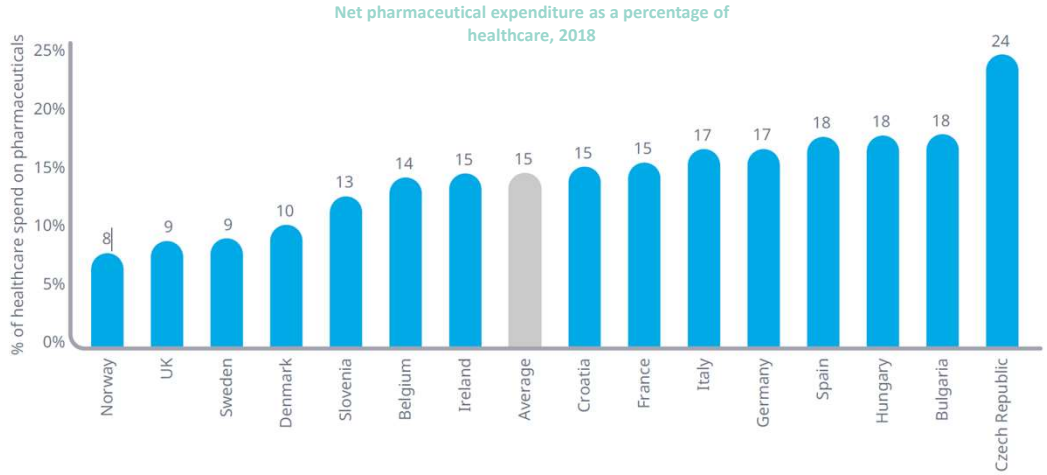
The net pharmaceutical expenditure is an important, but smaller part of the total healthcare costs

Net spending on pharmaceuticals represents between 8% and 24% of healthcare budget in 2018



Source: World Health Organization (WHO), 2018 (extracted on 18 November 2021), WHO SHE 1.0 data (extracted on 18 November 2021); OECD, 2019 (extracted on 18 November 2021).
Notes: Drug spending includes medicines dispensed in both retail and non-retail sectors. Methods for estimating total drug spending on a net basis are detailed in the methodology appendix. Health spending from WHO database. Both the drug and health spend data were adjusted for population, Purchasing Power Parity (PPP) and GDP growth to represent in 2020 values. Czech Republic has low healthcare spend, contributing to the high % pharmaceutical spend.

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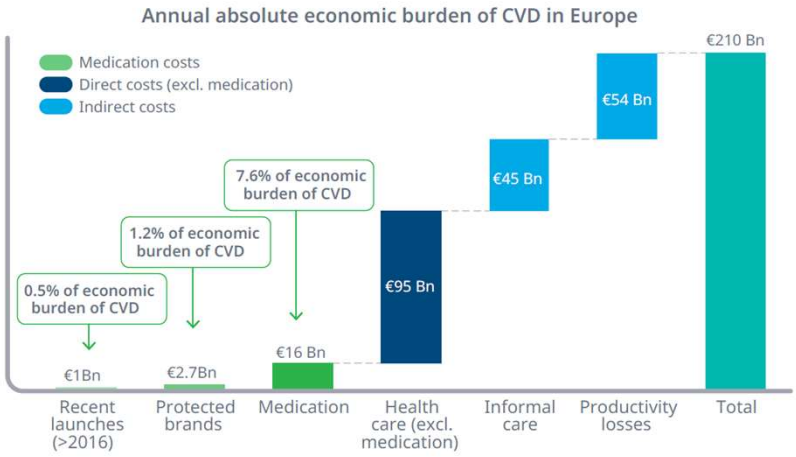
Pharmaceutical expenditure is often small in comparison to societal cost of diseases

In Europe, medication accounts for only 7.6% of economic burden of CVD

CARDIOVASCULAR DISEASE

"Overall CVD is estimated to cost the EU economy **€210 billion a year**. Of the total cost of CVD in the EU, around 53% (€111 billion) is due to health care costs, 26% (€54 billion) to productivity losses and 21% (€45 billion) to the informal care of people with CVD."

European Health Network (2017)



Source: European Heart Network, 2017 report on European Cardiovascular Disease statistics : https://ehnheart.org/cvd-statistics.html#:~:text=Overall%20CVD%20is%20estimated%20to,care%20of%20people%20with%20CVD. (last accessed November 2021); https://knowledge4policy.ec.europa.eu/health-promotion-knowledge-gateway/cost-non-communicable-diseases-healthcare-1_en (last accessed November 2021); IQVIA MIDAS data for ATC-3 Cardiovascular treatments.

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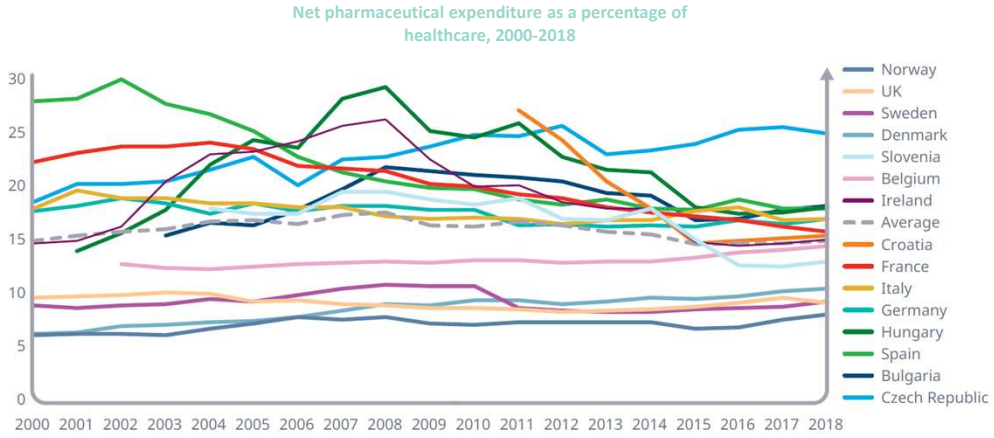
Pharmaceutical expenditure has remained ~15% of healthcare expenditure since 2000

Countries' net pharmaceutical spending has been converging over the past 20 years



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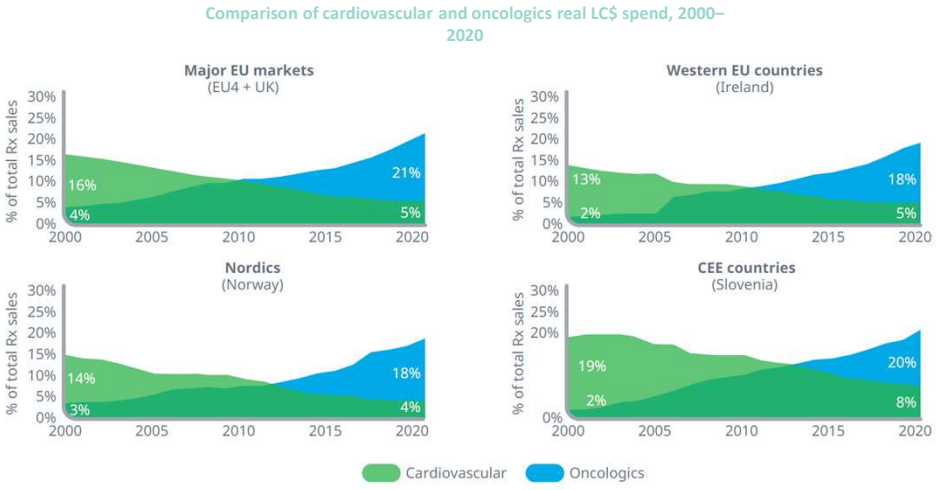
Budget holders who view spend in silos will restrict access when savings are being made elsewhere

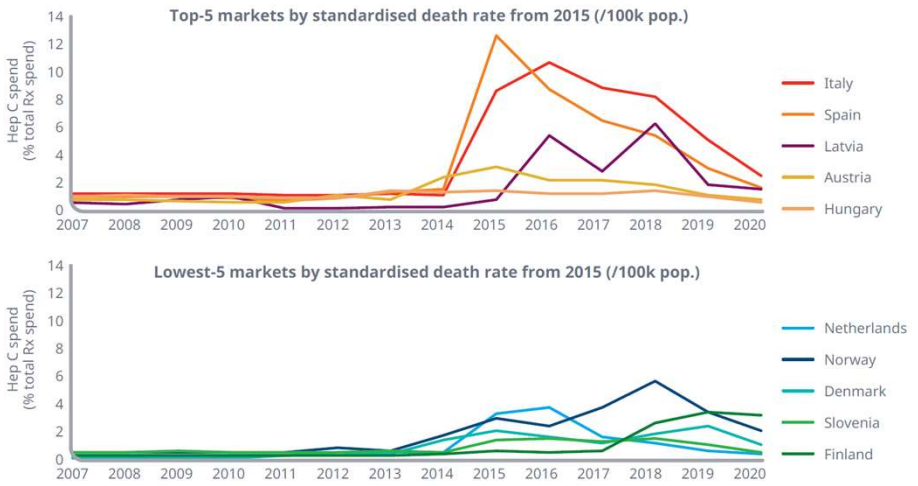
Spending in one area can be directly counteracted by a decline in another



Source: IQVIA Institute MIDAS 25-year data view.

Perceived 'budget busters', such as Hep-C, had a short-lived impact which was outweighed by societal cost

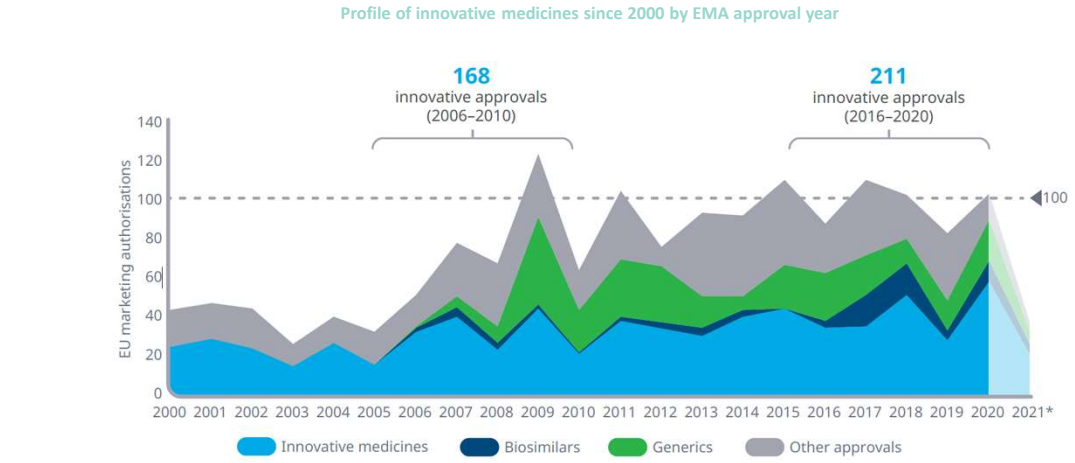
Even real spend on Hep-C treatments is offset by other healthcare and societal savings



Source: IQVIA Institute MIDAS 25-year data view; https://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do; Causes of death – standardised death rate by NUTS 2 region of residence - Viral hepatitis and sequalae of viral hepatitis.

The pharma industry is launching more NASs than ever before, with the majority for smaller disease classes with high unmet need

However, significant biosimilar and Gx approvals balance-out expenditure on innovative medicines



Source: IQVIA whitepaper Perspectives on Innovative Medicines (published in June 2021).
Notes: EMA EPAR list of authorised medicines (includes withdrawn medicines within historic data); Human medicines approvals only, vaccines included. Innovative medicines is based on previous approval for the active substance, multiple indications only included upon initial submission, includes orphan medicinal products regardless of prior approval status. Key: * = Analysis accurate as of April 2021.

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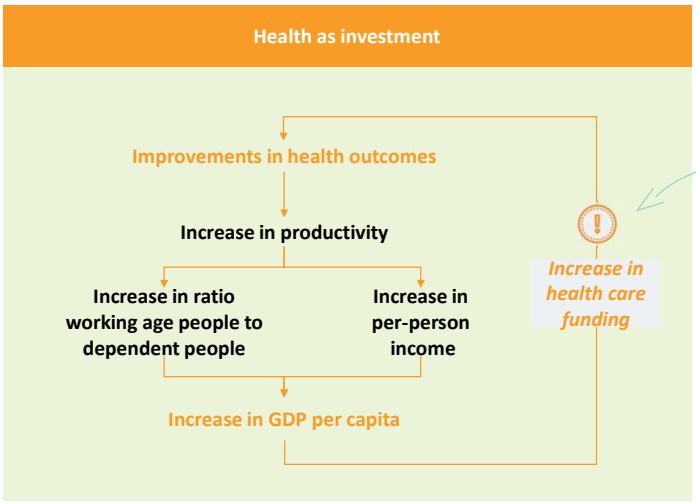
Cost-containment measures targeting innovative pharmaceuticals can exacerbate the affordability challenge



Cost containment risks breaking positive feedback loop

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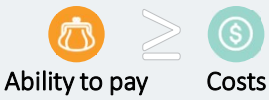
To improve the collective affordability of therapies and pharmaceuticals, ability to pay needs to increase or costs need to decrease

Affordability definition:



Improve affordability:

Increase ability to pay, however:

- Increasing health spending without reducing other government spending **increases overall government spending**
- Increasing health spending by reducing other government spending creates **difficult opportunity cost trade-offs**
- Shifting **away from** principle of **universal healthcare** is unlikely to be politically feasible or desirable

Decrease costs, however:

- Pharmaceutical expenditures are primarily a **necessary investment** in better health outcomes
- Sustainability of the **economic model** for developing innovative therapies is already **under pressure**
- **Share of pharmaceutical expenditure** as a proportion of total healthcare expenditure has not increased

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Taking a broader perspective across time and budgets helps to identify cost offsets – net savings for the system – that can contribute to solving the affordability challenge

COST OFFSETS
Savings or foregone expenditures created by the therapy

Time dimension	*Short term*	*Medium term*	*Long term*
Budget dimension	*Pharmaceutical spending*	*Healthcare spending*	*Beyond healthcare*
Example	Faster dismissals from care location	Reduced need to revisit care location	Increased ability to go back to work

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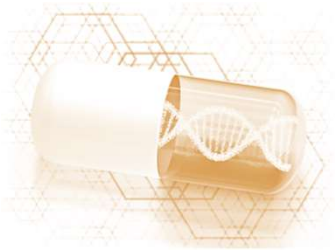
Pharmaceutical spending can improve affordability by generating cost offsets over time

Affordability across time

- Improving **affordability in the long-term** might require **investments in the short-term**
- Investments now pay off in **lower costs** in the future as **cost offsets** are realized
- **Overall affordability improves** if the upfront investment can be financed
  - *E.g. when investments are made into therapies that:*
    - *are preventive or curative*
    - *reduce complications*
    - *slow or stop disease progression*
    - *reduce the need to visit the hospital*

Example: Haemophilia B gene therapy

- Without gene therapy, patients with moderate to severe hemophilia B can cost health care systems more than $20 million over their lifetimes
- A new gene therapy has been found with clinical effectiveness for up to 23 years, resulting in significant cost reductions over time – despite a multi-million price tag for the drug



Source: Lichtenberg, Frank R. "The association between pharmaceutical innovation and both premature mortality and hospital utilization in Switzerland, 1996–2019." Swiss Journal of Economics and Statistics 158.1 (2022): 7.

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Pharmaceutical spending can also improve affordability by generating cost offsets across budgets

Example: Biologics for rheumatoid arthritis

- Disease-modifying antirheumatic drug biologics (bDMARDs) significantly reduce absenteeism from and presenteeism at work
- Society benefits from this through higher productivity and tax incomes, but these benefits are generally not included in cost-effectiveness assessments of new drugs

Affordability across budgets

- Pharmaceutical spending in budget A can generate **cost offsets** for **another budget holder** in budget B, e.g. when a therapy:
  - Reduces the need for nursing care (at home)
  - Enables patients to return to the workforce sooner
- When managed in **siloes** these cross-budget cost offsets are not valued by the budget holders resulting in **underinvestment** from a cross-budget, societal, point of view
- If budgets are managed with a **cross-budget perspective**, cost offsets created are considered and **allocation is optimized**

Source: Lichtenberg, Frank R. "The association between pharmaceutical innovation and both premature mortality and hospital utilization in Switzerland, 1996–2019." Swiss Journal of Economics and Statistics 158.1 (2022): 7.

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Five solutions can be used to take a broader perspective and realise long-term, cross-budget cost offsets that contribute to pharmaceutical affordability

Long-term horizon scanning & multi-year budgeting

Increasing the time perspective for payors in planning and contracting helps to make more efficient assessments of new therapies that include cost offset considerations

Societal value perspective in HTA

Broadening the perspective of Health Technology Assessments to include the societal perspective helps to recognize impact of therapies beyond the care domain (e.g. productivity gains)

Innovative reimbursement agreements

Innovative reimbursement agreements let payors manage risk and costs over a longer period of time and opens the door for health investments

Integrated budgeting

Merging siloed (pharmaceutical) budgets improves allocation decisions by payors as external effects and cost offsets in other budgets can be fully internalized in the decision making

Social impact bonds for healthcare

With impact bonds, effective therapies can be funded by third parties through performance-based contracts, creating a new funding source

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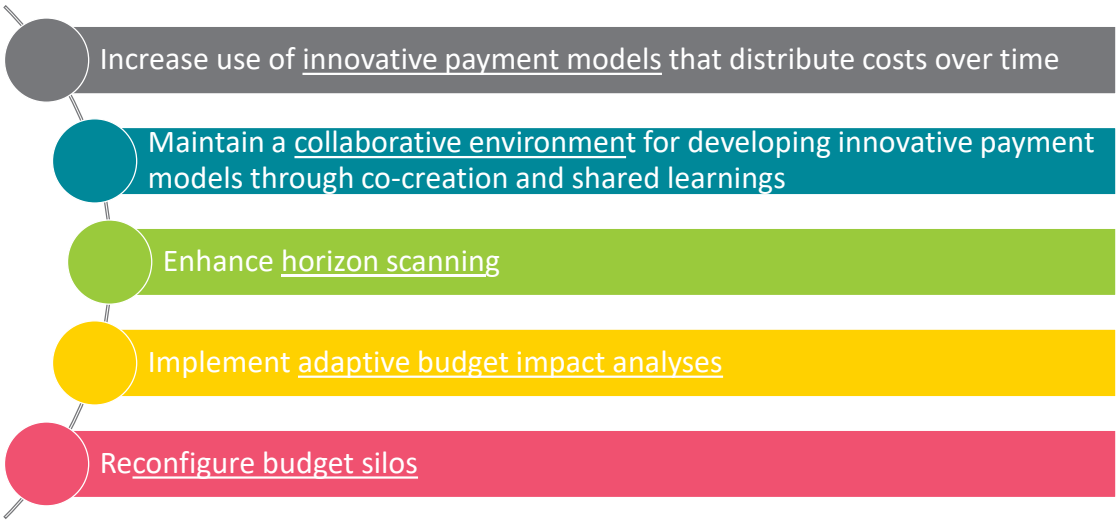
Recommendations: Ensuring sustainable ATMP access for healthcare systems and patients



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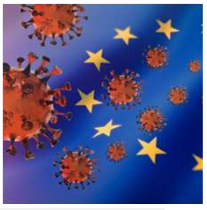
Major revision of EU pharmaceutical laws upcoming and healthcare high up on the Brussels political agenda – how did we get here?

2016 Council conclusions on strengthening the balance in the pharmaceutical systems in the European Union and its Member States

2020-… COVID-19, war, inflation and energy crisis



November 2020 Pharmaceutical Strategy for Europe

2023-… Revision of the EU general pharmaceutical legislation and the orphan and paediatric regulations

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Complementary EU and national responsibilities
Ensuring Europe's competiveness & addressing the needs of patients

1. General pharmaceutical legislation: regulates authorisation, manufacturing, distribution and monitoring of medicines + provides regulatory protection to reward innovative medicines

2. Orphan Medicinal Products + Paediatric Regulation: complement the general pharmaceutical legislation – support the development of medicines in previously neglected areas)

1. **National reimbursement legislation:** regulates access and reimbursement of medicinal products
2. **Health care system readiness:** ensure future proof health systems

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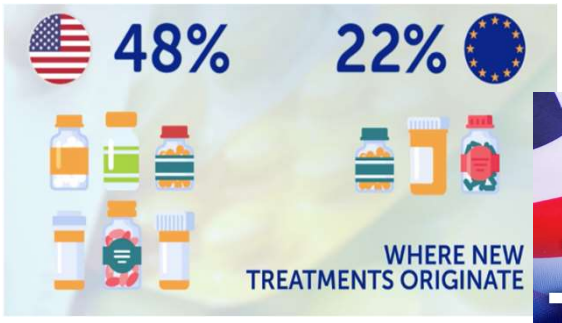
Simultaneously: Mind the gap
Europe's research and development base is gradually eroding



Only through a future-proof regulatory framework, and a robust and predictable intellectual property and incentives ecosystem, can Europe become a true world-leader in medical innovation.

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efpia
European Federation of Pharmaceutical Industries and Associations

Access to Innovative Drugs

Nathalie Moll, Director General






Thank you!

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