Dear Colleagues & Friends,

At last Market Access Day held in December 2012, we had the pleasure to welcome international leading speakers to address the shift from a point decision for regulatory approval, pricing and market access decisions, towards a timeframe that has turned into a window decision. This allows regulators and payers to minimize the risk associated with the introduction of a new product. This also contributes to the increased dialogue between regulators and payers.

Drug market access is currently experiencing a major shift in the decision-making process. Historically, marketing authorization, pricing and reimbursement decisions were taken at a fixed point in time, with a distinct role between the drug regulators and payers. Decisions were usually difficult to reverse unless a serious safety issue emerged.

Today, regulations tend to offer payers and regulators opportunities to review their decisions over time, to minimize the uncertainty existing at time of drug launch (actual health produced by a medicine is recognized as a “proxy of health”). To control uncertainty, regulators instituted the risk management plan (RMP) and conditional marketing authorization. From payers side, pricing and reimbursement decisions are also conditional from additional evidence, and payers refer more and more to coverage with evidence development (CED). This trend is also associated with a closer interaction and collaboration between payers and regulators. This change of paradigm can be seen in several examples where the final decision, considered for an acceptable level of risk, was taken after a substantial time delay following the marketing authorization.

• Case of Risperdalconsta L.P® in France with a decision window of 7 years. The marketing authorization was granted in October 2003. Following the assessment of the Transparency Committee, the pharmaceutical company was requested in February 2005 to evidence the impact of Risperdalconsta L.P® on the reduction of hospitalization. The price was confirmed with a new convention with the company by the end of 2010.
• Case of sitagliptin in France with a decision window of more than 5 years. The marketing authorization was granted in March 2007. Following the assessment of the Transparency Committee, the pharmaceutical company was requested in March 2008 to evidence a favorable impact on the lack of weight gain on patient path and ultimately time to insulin therapy. The coverage with evidence development is expected to be finalized by 2013. A convention with the company was first revised in March 2010 with a price discount.
• Case of sitagliptin in Scotland with a decision window of more than 3 years. The marketing authorization was granted in March 2007 and sitagliptin achieved a step by step recognition by the Scottish Medicines Consortium (SMC) in bitherapy in September 2007, tritherapy in September 2008 and monotherapy in June 2010.
• Case of Duodopa® in Sweden with a decision window of 6 years. The marketing authorization was granted in 2002 and CED agreement was signed with the company in 2003. The drug was delisted in 2007 following inconclusive study results. In 2008, following new positive results, the drug was finally accepted for reimbursement.
• Case of Byetta® with a use restricted in several countries and a decision window of more than 1 year. Payers in Scotland and the Netherlands did not respond well to Byetta® at the first review but revised their decision after a second review, while payers in France and Sweden adopted a more pragmatic approach with coverage with evidence development.

The main issue facing the pharmaceutical companies will be to minimize the uncertainty at time of the drug launch to narrow the decision window. Trial development program is one of the main pillars to narrow the decision window; trial duration (long-term trials) and endpoints (biological versus...
Decision making and risk management

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Decision making is at the basis of human nature. In our everyday life, we all have to make decisions with different level of perceived importance. The perception of the risk linked to the decision depends on and is closely linked to our personality. A psychology research study has identified seven dimensions of personality grouped in two domains: temperament and character. In psychology, the personality results from the interaction between those two domains. Temperament is made of all somewhat automatic answers to emotional stimulations shaping our habits. On the contrary to temperament which is more likely to be from hereditary origin, the character is influenced by socio-cultural learning and grows step by step until adulthood. It reflects the idea we have from ourselves and from people around us. This idea influences our intentions and our voluntary attitudes. The seven dimensions of personalities are novelty seeking, harm avoidance, reward dependence, self directness, cooperativeness, affective stability and self-transcendence.

In drug development, people who make decisions (either in firms or in health authorities) have different profiles of personality. Three stereotypes can be underlined: the engineer, the physician and the bureaucrat.

- The engineer is structured by mathematics. His/her decision making is binary: it is white or black, and it is based on facts.

- The physician makes decisions based on evidence. He/she is a critical thinker who assesses the risk and reward of a decision. This role deeply structures the physician’s personality, with high levels of novelty-seeking and low levels of harm-avoidance. Most physicians make decisions with their emotions. They are often against rules and bureaucracy.

- The bureaucrat often reaches this position because of his/her personality (in general with a good deal of harm-avoidance and a low level of novelty-seeking). S/He considers the engineer as a technician and s/he is ambivalent regarding physicians: fascinated by their ability to take risks and horrified by their oppositions to rules. The bureaucrat often considers himself/herself as the only reliable person (and perhaps sometimes s/he is the most reliable person).

In drug development, these three personalities are evolving in two different contexts: society and institution. Society is more concerned by safety and related risks, than by efficacy. Society becomes irrational when making decisions on health, considering the fact that health has no price and that we should pay for all medicine. Institutions are both pharmaceutical firms and health authorities. Lots of people work in these institutions, which leads to a dilution of responsibilities, a loss of contact with reality, an aversion for risk and an overwhelming weight of bureaucracy. This is a worrying symptom: in his book “The collapse of complex societies”, Joseph Tainter demonstrates, that when the level of bureaucracy is high, it causes the collapse of an organization. Today, decision-making for drug approval is rational and evidence based, putting emotions apart. On the contrary, in Pricing and Reimbursement, decisions are not based enough on reason. Very few guidelines are not harmonized from one country to another.

Future pre-approval drug evaluation should also deal with the emotional aspects of decision making through epidemiology, anthropology, human and social sciences in order to be sure we focus the evaluation of drug on what is important for the patient. This could be the case for example if models or epidemiology studies are requested for regulatory approval and if patient interviews are included in clinical trials. In some countries, patient associations already have an important role in post approval drug evaluation. However, today, these associations are not developed fairly across pathologies (e.g. no patient association exists for schizophrenia patients).
Industry's perspective: managing uncertainty in developing innovative medicines

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Health care systems want safe, effective and qualitative medicines, but they also want value for money. They want innovative medicines to treat medical needs at a good price and they want proof of impact on patients (effectiveness) and society (budget). The industries answer is commitment to demonstrating the added value of their innovative medicines with high quality, transparent data.

The complexity of data needed to demonstrate value is increasing. Regulators previously required data on efficacy, safety and quality, now along with payers request data on the added therapeutic benefit. Payers, providers and patients require information on the value for the health care systems and society. However at launch there are uncertainties about the effects of a product on the patient and on the healthcare system in terms of cost-effectiveness, utilisation and budget impact. Payers therefore increasingly require managed entry agreements, either financially based or performance based, which increases the complexity of the environment.

A broader approach should be considered with an adaptive licensing and reimbursement process, create a new thinking around the drug development process where different stakeholders are involved early in the process. During the explorative R&D phase partnerships between sponsors and health care providers can help to focus on unmet needs. Discussions between company, regulators, HTA agencies and patient groups on study design, relevant outcomes could help to address the different needs of value demonstration. An early access with subsequent reconsideration of access conditions based on additional evidence generation could be granted. HTA could also be made more efficient by decreasing unnecessary duplicative requirements across Europe. This is already the case with the reflection on joint methodological standards within the European collaboration on HTA, and potentially one day joint relative effectiveness assessments to support national decision-making.

Expert Viewpoint

Pricing and reimbursement must always remain national and since they will be based not only on the therapeutic value of the product, but also on the country specific conditions.

Obamacare: Implications for Health Technology Assessment and Regulatory Decision-Making

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In the USA, in 2010, President Obama finally signed a new major healthcare insurance reform, despite efforts since at least 1976 to enact reform. Over this period, two important problems marked the US health care system, namely: (1) Cost control related to the issue of value for money as 18% of the GDP spending is dedicated to health and (2) And uninsured population—of nearly 50 million people currently in US—who have no health insurance coverage. The poor access of the uninsured results in lower utilization, worse outcomes, and greater risk of financial catastrophe--with the loss of “peace of mind”.

The US health care system is characterized by being firstly the most costly in the world and yet it is not yield the best outcomes at aggregate level. In fact, most OECD countries have an actual spending that proportionally correlates to GDP except for USA where spending is far above the expected level. The insurance system in the USA is very complex and encompasses five major different categories. In 2011, employers covered 49% of the population, 5% have their own individual insurance, 16% are on Medicaid and 12% on Medicare leaving 17% of uninsured people in the country. Major government programs exist for the poor (Medicaid), elderly (Medicare), and disabled (Medicare, but the under 65 population mostly depend on private employment-related coverage.

This mixed public/private insurance system has been called fragmented and inefficient, and notably, the private,
employment-related purchase of insurance benefits from a substantial tax subsidy, that favors those favors those with higher incomes and encourages overuse of health care services.

Prescription drugs spending correspond to only about 10% of the National Health Expenditures whereas hospital care account for about 30% and physicians and clinical services use up to 20% of spending. Focusing on prescription drugs primarily -as we do in the field of pharmacoeconomics-is a limited view that is not representative of the whole picture in the US. Clearly, there are cost-effectiveness questions that should also be addressed to these categories. Today, for example, we hardly see any empirical work that measures the QALYs associated to hospital or physician care.

A recent published Congressional Budget Office study has estimated that by 2062, all of the USA GDP will be spent on health care if no reform were implemented. This government projection clearly cannot occur, but it was used to illustrate the unsustainability of recent spending trends.

In 2010, President Obama succeeded to get a health reform (PPACA) to ameliorate the access to affordable health coverage, to improve the quality and delivery of care, and to curb the growth of health care costs. But it is only by 2018 that a reform (the “Cadillac tax”) will start to implement the changes to finally limit or remove the tax subsidy. Immediate effect reforms have already been implemented and among these major provisions, there are: the end of life-time caps, coverage for adults with pre-existing conditions with many efforts already spent on selection criteria. By 2014, the Obamacare will help reduce the number of uninsured people by half but, as yet, nothing has been suggested to cover the remaining 25 million people.

PPACA’s cost containment provisions are modest but could help slow rising costs while sparking improvements in quality of care, as reported by Stephen Zuckerman from the Urban Institute. How will this play out, however, remains an open question.

The US Preventive Services Tax Force recommendations will provide coverage without cost-sharing for several services including non mandatory immunizations. The 2014 insurance mandate has the objective of increasing coverage on both commercial and Medicare/Medicaid sides. Coverage becomes mandatory for employers with 50 or more employees or they will have to pay a $2,000 fine. These provisions have not been adopted yet by the majority as some think it is still complicated.

**Expert Viewpoint**

A major change of potentially great impact will be the establishment an independent body composed of experts and stakeholders called the Independent Payment Advisory Board (IPAB), which will begin recommendations in 2014 to reform Medicare. All guidelines and laws suggested will be intended to control costs with a project to save $15.5 billion. Hospitals are exempt until 2020.

The “Cadillac Plan” Tax which consists of a tax on high cost health plans will begin in 2018. This tax will actually be imposed on people with a very high-cost plan (more than $10,200 for individual coverage and $27,500 for family coverage): the aim is to encourage insured people to find a low cost and more efficient plan. The biggest impact of this plan will be truly appreciated in the second decade of the reform.

Health Technology Assessment in USA is very different from UK as it is decentralized and relies very little on formal HTA. Moreover, an Institute of Medicine study found that the majority of medical practice is not based on a solid based on evidence, suggesting the clinical research efforts should be subsidized. Peter Orszag, former head of the CBO, has hypothesized in 2007 that better information about the comparative costs and benefits could eventually lower health care spending. Since then, the Federal government has paid no more Comparative Effectiveness Research (CER). The Institute of Medicine defined CER as research that generates and synthesizes evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition, or to improve the delivery of care. Under Obamacare, a second independent body called Patient-Centered Outcomes Research Institute (PCORI) was established, as is defining methodological standards for CER with an unbiased peer-review and transparent process. Research findings will also be disseminated. A $150 million/year budget was planned for 2012 and thereafter, which is a significant amount, but unfortunately not enough to fund many large clinical trials. However, PCORI has a number of limitations, the major ones being that it is not allowed to recommend or mandate public or private coverage policies, and it must avoid cost and cost effectiveness.

In conclusion, the US system will not change dramatically
Status quo of drug licensing and market access in Germany - first experience of the Federal Joint Committee (G-BA)

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The trilateral Pharmaceuticals Subcommittee of the G-BA is composed of 3 members from the National Association of Statutory Health Insurance Physicians (KBV), 3 members from the German Hospital Federation (DKG), 6 members from the National Association of Statutory Health Insurance Funds (GKV-SV) and permanent or topic-related patient representatives with no voting rights. The G-BA Chair, deputy and office staff, as well as representatives from MoH and IQWiG are also present in this subcommittee. Medical experts shall be invited upon invitation via Drug Commission of the German Medical Association. This subcommittee is responsible for the preparation of the resolution on the benefit assessment dossier that is now required by the new German Law AMNOC and the final decision is then taken during a plenary session by the Federal Joint Committee.

In Germany, following market authorization, there is a one year free pricing policy. At launch, a dossier of benefit assessment must be submitted to the G-BA and in most cases it will be transferred to the IQWiG. Exceptions are e.g. orphan drugs or drugs suitable for reference price groups. The IQWiG dossier assessment is then published by the G-BA, holder of the final decision, 3 months later on the G-BA website and a hearing procedure starts. Following the hearing, the resolution is prepared during working groups of the Pharmaceuticals Subcommittee, until it reaches the Pharmaceuticals Subcommittee and finally the plenum at the latest after 3 months. The resolution is also published on the G-BA website on the day of the plenary session. Negotiations between pharmaceutical industry and health insurers start after the publication of the resolution and last up to 6 months. In case of new findings, a new assessment is required and an additional price negotiation happens to set a new price for the drug at the end of the procedure one year later.

The resolution made by the G-BA is related to identifying an additional benefit over the appropriate comparator. The latter is clearly defined by the G-BA as (1) a product that already has a marketing authorization for the particular therapeutic indication, (2) a reimbursable product if not a drug, (3) decisions made by the G-BA and IQWiG regarding the comparator will be considered, (4) based on standard of evidence-based medicine and (5) proven in practical applications. The choice of appropriate comparator according to these definitions is made by the G-BA; however, it has raised a few polemic discussions from pharmaceutical industry since AMNOC implementation. The extent of the additional benefit in the resolution is classified into 6 categories from major additional benefit, considerable additional benefit, minor additional benefit to non-quantifiable additional benefit, no additional benefit and less benefit than the appropriate comparator. Since the implementation of AMNOC and as of December 5, 2012, 27 resolutions have been made where 5 active ingredients have shown a considerable additional benefit, 9 were found to have a minor benefit, 1 no additional benefit, 3 a non-quantifiable additional benefit and 7 dossiers were incomplete.

The current model of licensing in Germany is considered adaptive as price negotiations last over time – the CHMP calls it the “Magic moment”. Yet, the G-BA must adapt to licensing authorities and set time limits. Time-limited resolutions depend on current status of studies. If a new study is expected, a longer validity of the resolution is procured. In case of an ongoing study, a shorter validity of resolution is given. A one year time-limited resolution was decided for vemurafenib mainly because of uncertainty of outcome concerns of an ongoing study. Updated results on
overall survival were expected by the EMA on 31 May 2012. On the opposite, a 5 year time-limited resolution was determined for ipilimumab because of uncertainty of the study design and outcome concerns.

The G-BA shall consider coverage with evidence development but the idea raises a few questions related with validity of studies (not enough data are generated), restriction of use for patients, legal framework that is currently lacking in Germany, problems with off-label use, and acceptance of the idea by payers and patients.

The validity of studies depends on the outcomes measured. Randomized clinical trials are indeed preferred but German authorities can sometimes consider observational studies to show a rare adverse event. These studies have, however, a lower level of evidence.

**HTA and collaborations in Europe**

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Directive 2011/24/EU on the application of patients’ rights in cross-border, has created a need for greater coordination of HTA processes, as patients and health professionals move freely between the member states.

First, it will lead to the creation of a permanent cooperation on HTA in November 2013 to facilitate cooperation and the exchange of scientific information among Member States.

Secondly, approaches to HTA collaboration are strengthened into the objective of the EUnetHTA Joint Action 2 (JA2) on Health Technology Assessment (HTA) in order to:

- Reduce duplication of work since different countries could converge in terms of core set of information requirements used for HTA. The development of a core document used as the basis of assessment of a health technology for reimbursement.
- Reduce methodological heterogeneities between local HTA assessments by developing guidelines describing a common methodology of data analysis in the field of rapid relative effectiveness assessment. EUnetHTA has established

**9 guidelines for the Relative Effectiveness Assessment of pharmaceuticals (Choice of comparator, Clinical endpoints, Composite endpoints, Surrogate endpoints, Direct and indirect comparisons, HRQoL, Safety, Internal validity, Applicability).** Public consultation is ongoing on the EUnetHTA website. Final documents will be available in March 2013.

Increase the quality of evidence submitted by initiating « Early Dialogue » between developers and several HTA bodies to address questions relevant for the development plan, e.g. planned phase III studies, as well as cost-effectiveness studies. A draft procedure was set in place, two pilot procedures coordinated by the HAS were conducted in 2012 in order to optimize the procedure for new early dialogues to be held in the framework of EUnetHTA JA2. 6 additional pilots for drugs have already been scheduled in 2013.

A dialogue was also launched between the European Medicines Agency and EUnetHTA to facilitate exchange on the needs of regulators and HTA bodies in two fields: the European Public Assessment Reports (EPAR), and parallel EMA/HTA scientific advice. The new EPAR template was approved by the CHMP in 2010 and an ongoing collaboration provides HTA agencies full access to market authorisation files.

HTA takes into account the local environment of the country in which it is undertaken; however, individual HTA bodies do not always have the capacity to study each health technology so in order to avoid unnecessary duplication and improve the quality and efficiency of national HTA, therefore the creation of a permanent voluntary HTA network and the increasing the timely use of HTA by national health ministries’ present a strong added value for the public health community.

**The event was a valuable opportunity, with interesting speakers and a great chance to meet some important figures from the world of pricing and reimbursement**

Francesca Bruce, Senior Reporter, Scrip Intelligence.
Looking beyond the ICER: early access to medicines and social value judgements in NICE decisions

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The National Institute for Clinical Excellence (NICE) set up in 1995 reviews clinical and economic evidence to recommend on the appropriate use of new and existing medicines within the National Health Service (NHS). NICE’s recommendations lead to a mandatory funding direction for recommended drugs.

NICE’s key procedural principles are scientific rigour, inclusiveness of all stakeholders, transparency, independence, possibility of appeal, and timeliness. The objective is to make new drugs available to the NHS in a timely fashion, while reducing uncertainty regarding effectiveness. To do so, NICE works closely with academic groups that systematically review published evidence as well as unpublished evidence provided by the manufacturer. NICE’s independent advisory committee then consider the evidence provided, with consultations of healthcare professional groups, patients, academia and manufacturers, to give recommendations for the NHS.

There exist two different processes for technology appraisals: single technology appraisals (STA), which have run since 2006 and take an average of nine months, and multiple technology appraisals (MTA). MTAs are appraisals of multiple technologies. They have existed since 1999 and take an average of 15 months to complete.

NICE does not negotiate nor set drug prices. Prices are agreed between the Department of Health and manufacturers as part of the Pharmaceutical Price Regulation Scheme (PPRS). The PPRS aims to balance reasonable prices for the NHS and a fair return for the industry to enable it to research, develop and market new and improved medicines. Since 2009, some degree of flexible pricing has been introduced through patient access schemes. Patient access schemes are proposed by manufacturers to improve cost-effectiveness of the drugs and enable patients to receive innovative medicines. There are several types of patient access schemes. In 2010-11, half of patient access schemes were price discounts, the other half involved rebates or dose caps based on certain criteria (such as effectiveness). The administrative burden of the latter created a shift toward simple discount patient access schemes, which represented 100% of all schemes in 2012.

According to NICE principles, although appraisals must take cost-effectiveness into account, recommendations should not be based on evidence on relative costs and benefits alone. The end-of-life guidance for example allows the committee to give greater weight to QALYs achieved in late stage of a terminal disease, if the life expectancy is inferior to 24 months, the new technology extends life by at least three months, and the patient population is small. NICE also considers innovation when appraising a new technology. When a new technology can be regarded as a “step-change” in terms of outcomes for patients, its innovative characteristics must be taken into account in the cost-effectiveness calculation.

In 2014, it is expected that value-based pricing (VBP) will be introduced in the UK. This will allow higher price thresholds for medicines that tackle disease of high unmet need or high burden of illness, demonstrate greater therapeutic improvement and innovation, and demonstrate wider societal benefits.

Expected benefit from market access agreements at regional level in Spain: hurdles and opportunities

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Catalonia has been managing its own health system (CatSalut) since 1991 and includes nowadays 367 centres of primary health care and 63 hospitals for public use, representing therefore a mixed health model that integrates all available resources into one network.
The current context characterized by budget limitation requires the implementation of innovative measures to guarantee accessibility, equity, quality, safety, effectiveness and improve efficiency. In such context, main stakeholders for market access are the healthcare administration and the pharmaceutical industry.

The Outcomes Guarantee agreement (OGA) is a Government strategy, included in the Catalan Health Plan, section "New purchase model health based on outcomes" and contemplates four steps for the implementation of the strategy: 1. Objectives - to define the drugs profile suitable for OGA as well set up the relationship with Manufacturers; 2. Drug identification - to identify centres for OGA, 3. Define technical and economic conditions of the OGA (risk level, etc.) 4. Define the conditions of the agreement (Figure 1).

**Figure 1: OGA drug Roadmap in Catalunya**

The purpose of OGA is to encourage access to innovative drugs, limit uncontrolled growth of healthcare spending and change the traditional payment type: payment-by-results rather than payment per unit. The benefit for the manufacturer is to avoid the risk of exclusion from Healthcare Regional evaluation and increase knowledge on drug effectiveness. Additionally, OGA will minimise uncertainties of economic and health impact of pharmaceutical innovations, will create incentives to promote the cost effective use of medicines, will give access to new therapies to those subpopulations who are supposed to mostly benefit from the technology and will build expertise in follow-up of clinical trials results.

Limitations of the program include the fact that such mechanisms are complex and not easy to implement on a general basis and may represent significant administrative costs. Therefore, it is currently only applicable to therapies targeting a limited amount of individuals. The first pilot project - between CatSalut, the major Oncological Institution (ICO) in Catalunya and AstraZeneca - relates to gefitinib in lung cancer (NSCLC). The evaluation process scheme is represented in the figure below:

**Figure 2: OGA evaluation scheme for gefitinib in NSCLC**

Results have shown the efficiency of the program, therefore another OGA has been signed between CatSalut, Clinic Hospitals and a pharma company about a biological drug and another OGA is in the process of being signed always relating to an oncology drug.

Following this successful pilot program, guidelines for conducting OGA of pharmaceuticals have been issued. Such guidelines state that it is necessary to identify appropriate situations in which OGA would be useful to stakeholders, guide their decision making process, facilitate the development of efficient operating OGA and define the clinical and economic model (product, clinical process, health model related). The final program for OGA implementation will be issued by June 2013 and will involve key players for Catsalut such as manufacturers, hospital/health purchasers, Health professionals and Universities.
Incorporating patient preferences in regulatory decision making:

**a window of opportunities?**

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Many studies have shown that the valuation of clinical endpoints differs between physicians and patients. As an illustration, a recent study in the case of depression elicited the weights patients and experts attached to different endpoints, and has shown that remission is the most important outcomes for psychiatrists, whereas response is the most important one for patients. This seems understandable as patients are more interested in the short term effect and psychiatrists also consider the long-term consequences.

Since the last 10 years there is a growing body of literature on research into patient preference elicitation methods and their use in decision-making. And regulators increasingly seem aware of the patients’ perspective in regulatory decision making, as evidenced by a recent FDA statement “that they would consider evidence relating to patients’ perspective of what constitutes a meaningful benefit when determining if the device is effective”.

Also, others (e.g. the European Medicines Agency) have concluded that patient preferences need to be included in regulatory decision making, because only patients can provide information about the meaningfulness of endpoints. Primary endpoints in clinical trials are not necessarily the most meaningful for those directly concerned, i.e. the patients. Also, patient preferences are key in ensuring better adherence and compliance. Patient preferences may inform three types of decisions: individual treatment decision, market authorisation and reimbursement decision. Patient preferences can be included in two ways, qualitatively and quantitatively. Qualitative patient data includes patient representativeness in committees, or the use of patient panels to collect opinions. Quantitative patient data involves weighting risks and benefits according to patients’ aversion to risk. These weights can be derived through various, methods: multi-criteria decision-analysis (MCDA) weighting best-worse scaling, and discrete choice experiments. All are grounded in multi-attribute utility theory. From these methods one can derive a marginal utility graph that shows patients’ sensitivity to the different criteria.

The political climate is changing and the role of patient preferences is now acknowledged. There is a window of opportunities for their inclusion in decision-making. However, to be fully accepted in the regulatory process more work needs to be done as there are many issues in terms of the sources of bias in preference elicitation methods, the appropriate way to include patient preferences in the regulatory process and the actual value of patient preference data for patient organizations as an additional source of information to express their input in the process.

**Going Dutch in market access flexibilisation: a mixed blessing**

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In 2006 CVZ (College voor zorgverzekeringen) started Coverage with Evidence Development (CED) programme. The main objective of this programme were to insure an equal and sustainable access to expensive drugs while at the same time collecting additional data to see if real world evidence would have matched clinical data. Pharmaceutical firms were asked to create patient registries to accumulate data that would have been presented in a reimbursement dossier after a 4 years time.

First results were available in 2011, and as of now seven re-evaluations have been completed:
- **Infliximab (Remicade®)** in Colitis Ulcerosa and in Psoriasis
- **Omalizumab (Xolair®)** in persisting asthma
- **Ranibizumab (Lucentis®)** in age-related macular degeneration (AMD)
- **Alfa-glucosidase (Myozyme®)** in Pompe disease
- **Alfa-galactosidase (Fabazyme®, Replagal®)** in Fabry disease
Through this experience CVZ has been able to identify important elements that should also be taken into account when implementing a CED as they might jeopardize the meaningful outcome of the study. For instance 4 years are not always enough to collect all the desired information, especially in the case of orphan drugs. For other molecules, in particular the oncology ones, the treatment algorithm changes faster than the collection of data itself.

Payers and reimbursement authorities that want to implement a CED programme have to bear in mind that becoming flexible means spending enormous efforts in customization, and customization means extra work for the health ministry, extra work for the company and extra work for the treating physicians. CED programmes also require a high level of transparency, but this also means vulnerabilities for payers and reimbursement authorities and finally be prepared to face a huge media outcry, especially in the case of orphan drugs, if you have actually found that a drug is not meeting the requirements and you want to delist it.

Indeed the Dutch first approach with CED has been difficult, mostly because of “difficult to predict” variables, though the CED system has good potentiality and it is too useful to discard it.

For the future, as a lesson, it is fundamental to design databases with more common sense, which creates a sense of cooperation with the doctors and at the same time the authorities should be smart and anticipate the outcomes by proposing a price deal instead of registry when prospects of good results are remote.

Cooperation between all the stakeholders involved is fundamental and it is not a simple thing, because it is a two-way cooperation. It is not only cooperation to expand the existing insured package, but also to make room for new innovation. The different stakeholders shall have to work together in finding ways to actually remove obsolete care from the offered package. Because we have to get that extra money we need from somewhere, because we cannot create money.

In conclusion, the Dutch experience tells us that we have to create smarter registries that were not done before, think about the time needed to create deals and the effort to pay for the follow up of these deals, start patient registries much earlier.

Though, the most important factor, in creating this new world, is collaboration. Collaboration also in the way we collect quality of life data and design outcome parameters. We need the time and we need to collaborate because if we do not, we will all be in trouble. And if we do we will find a way to create a new future.

Market Access Day 2012 saw top-level speakers from various national public institutions and academic organisations in Europe. Here, they presented their perspectives on the market access environment in front of 150 participants from the life science industry, health authorities and the academic world.

The theme of Annual Market Access Day 2012 was reviewing the impact of the paradigm shift on patient access, payer’s new practice, and reviewing the evolution, companies will have to undergo in order to accommodate this new changing environment.
**Students’ Corner**

**1st Annual Alumni Reunion on 13 June 2013!**

We are excited to announce the **1st Annual Alumni Reunion**, which will be kicked off by Prof. M. Toumi, who will give a talk about "**The Market Access 2020**".

After this, EMAUD alumni will get the opportunity to network, enjoy a well-stocked cocktail buffet and live entertainment.

We promise you will have a magical evening!

**Last EMAUD Module 5** focused on Medical Devices, Vaccines & Diagnostics to be held on 10-14 June 2013 will address:
- overview of the market and strategy; mapping of the access process in Europe and outside Europe;
- Definition, regulation, classification, certification; HTA; Vaccines in emerging countries: a worldwide paradigm;
- Specificities for health economics assessment /value demonstration;
- Dealing with innovation and future challenges; Toward a value based pricing for diagnostics and devices.

**Next course session dates:**
- Module 1: October 7-11, 2013
- Module 2: December 2-6, 2013
- Module 3: February 10-14, 2014
- Module 4: April 7-11, 2014
- Module 5: June 3-7, 2014

If you want to register or ask for information for yourself or a colleague, visit the website and go to “**Apply**”

**EMAUD: New website launch June 2013**

Stay on the lookout for the launch of EMAUD’s new website ultimo June. Taking vantage point in the phrase “less is more”, we have given the site an overhaul to increase userfriendliness, simplicity and accessibility. We hope you will enjoy the new design!

**Students: Connect on Linkedin!**

The EMAUD Alumni group is intended as a debating and networking platform for the students and contributors of our educational programme. Be aware of latest news, articles, regulations, job or event opportunities via discussions and connections.

**EMAUD News**

**Save the Date**

**5th Annual Market Access Day**

**3 December 2013, CIU Paris**

From the EMAUD launch and the first **Annual Market Access Day** in 2009, the event has become a true reference. Purely academic with a free participation, the international conference gathers every year leading speakers and industry representatives to discuss the challenges of market access.

We look forward to welcoming you on **3 December 2013 to the 5th Annual Market Access Day** for living discussions.

More to come about the event soon!

**Contact us**

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