



MEDICAL ONCOLOGY GROUP OF AUSTRALIA INCORPORATED

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Introduction

As the peak professional body for Australia Medical Oncologists, the Medical Oncology Group of Australia Incorporated (MOGA) provides the following advice on the timely, affordable and equitable access to cancer medicines in Australia in response to **ACCESS TO CANCER MEDICINES IN AUSTRALIA, Medicines Oncology Industry Taskforce, July 2013, Deloitte Access Economics (The Report)**.

The Report provides:

- a useful summary of the disease patterns and economics of cancer in Australia and internationally; including the current regulatory and reimbursement processes; and related research, professional and systemic issues.
- captures various stakeholder opinions on access to cancer medicines in Australia;
- a broad platform for stakeholders to debate key issues, with a view to developing sustainable solutions that will contribute, in conjunction with other initiatives, to address oncology drugs and treatments access issues in Australia.

Regulatory and reimbursement processes

A rigorous regulatory and reimbursement approval process is fundamental to ensuring the quality, safety, efficacy and cost-effectiveness of medicines used in Australia but many components of the current processes require attention as follows:

- In some instances multiple submissions to the PBAC are required to achieve a PBS listing. Recently some oncology drugs have received positive recommendations from the PBAC but delays have occurred due to Government fiscal considerations, or unsuccessful negotiations between the sponsor and Government regarding price. These delays have negatively impacted on access to key oncology drugs in Australia and questioned the validity of the approval process.
- The report notes from 2005-2011 20% of first time submissions received a positive recommendation. This low success rate demonstrates a significant access gap between TGA approval and PBS listing and, the timeframe to gain listing appears to be increasing. There is an apparent disconnect between the TGA, PBS and MBS listing and approval processes; and, a noticeable lack of continuity in process management to facilitate the access pathway. There is a strong need for process improvements and efficiencies.
- The lack of transparency in the decision making process for regulatory and reimbursement approval is highlighted by the discrepancies in decisions made by the Australian authorities compared to authorities in other comparable jurisdictions. The extent of assessment by the TGA in cases where regulatory agencies in other jurisdictions have already undertaken assessments based on the same laboratory and clinical evidence should be reviewed and streamlined.
- The PBAC has recently requested post-marketing evidence and commitment as a condition for reimbursement approval for ipilimumab and eculizumab. These additional administrative requirements further complicate the approval process and add to the administrative requirements for clinicians.

Coverage of indications on the PBS

The Association is of the view that there is a range of concerns with PBS listed indications as follows:

- Indications on the PBS do not reflect clinical practice, standard cancer care and treatment recommendations. PBS has inadequate coverage of indications that have a sound evidence base, but are outside of TGA-approved indications. TGA indications do not keep pace with evidence development. This is due to many factors including the complexity of the TGA approval process; only drug sponsors can

lodge an application for a new indication; lack of commercial incentives; off-label prescribing is clinically acceptable if supported by evidence; and, new evidence can be developed without the involvement of the original sponsor. Addressing these issues may improve the responsiveness of the TGA registration process to changes in the clinical setting. The PBS listing process can mitigate this issue by moving a restricted listing to a general listing without restriction and this has been particularly suitable for medicines that have had a significant price reduction following loss of market exclusivity (e.g. docetaxel). A number of oncology drugs have been 'de-restricted' (e.g. gemcitabine) but there is currently no formal process whereby this can be enacted.

- Different coverage of on-label and off-label indications in hospital facilities and PBS formularies also affect the continuity and affordability of oncology drugs. Hospital clinicians sometimes do not choose medicines if they are not PBS listed, even if they are the most appropriate treatment options for a particular patient, to avoid the patient having out-of-pocket expenses.

Clinical Trials

The Association agrees that the impact of the current access and approval system in Australia in clinical trials in Australia needs to be addressed:

- Do the current barriers posed by the national system have the potential to "disengage the medicines industry from Australia and to cause them to divert investment to other countries" as noted in the report ? Similarly, do delays " in securing reimbursement also effect clinical trials, as companies may reconsider placing clinical trials and access programs in Australia if there is little or no chance of reimbursement."
- The rationale for the increasing number of special pricing arrangements in Australia needs to be examined. Above all, as it is not known if this is "indicative that the current reimbursement system is not delivering a fair return on innovation" as noted in the report.

Current and Future Landscape

The Report highlights a strong pipeline of cancer drugs that would potentially be available within the next decade. As a large proportion of these medicines will be submitted for regulatory and reimbursement consideration in Australia, the system needs to be able to meet the challenges that the high number of applications will have on the assessment framework, and be responsive and adaptive in its requirements to facilitate access.

Specific Cancer Funds

The Association believes that specific cancer funds need to be strategically planned and implemented in Australia. The Herceptin Program for late-stage metastatic breast cancer is the only national specific fund for cancer. While the Program addressed an important area of unmet need, it has set a national precedent that has implications for the approval and reimbursement system and needs to be reviewed. The UK Comprehensive Cancer Drugs Fund provides a useful model that could apply in the Australian context. However, there are concerns about drug access post 2014 in the UK as well as how such a model could be adapted and funded in the Australian context.

Assessment of co-dependent technology for reimbursement under the MBS

Biomarkers have added complexity to the reimbursement process for oncology drugs in Australia. PBAC approval is contingent upon the co-dependent technology for measuring the biomarker be available via the MBS, following consideration by MSAC; the latter is complex and involves seven stages extending over 51 weeks. Despite ongoing efforts through the development of a co-dependent technology assessment process our understanding is that the requirements to fulfil both the PBAC and MSAC processes has added complexity and evaluation time.

Lack of process differentiation for cancer medicines

The Association agrees that in Australia, unlike comparable countries, cancer drugs are not subject to expedited registration or reimbursement timelines. Eg., the FDA system for therapeutically important medicines to be made available via the Fast Track, Accelerated Approval and Priority Review, on the condition that the sponsor conducts additional studies to further define the degree of clinical benefit. This

system provides a viable model for implementation in Australia and demonstrates how an appropriate framework can improve timely and compassionate access to high priority cancer medicines.

Quality of life outcomes

The Association supports the focus on quality of life (QoL) outcomes when making reimbursement decisions in Australia. However, there are several challenges in measuring quality of life in patients with cancers; using a generic utility instrument to measure the QoL benefits of cancer drugs may undervalue the actual benefits experienced by patients; and, there can be a potential misalignment in QoL preferences between cancer patients, health professionals, and the general population.

International comparisons

The Association concurs with the Report that publicly-reimbursed access to oncology drugs is significantly delayed in Australia compared to other OECD countries. There are increasing instances of access delays in Australia compared with other countries above all with respect to what is recommended in US and European evidence-based cancer treatment guidelines. It is recommended that a comprehensive international comparison study on this access issue needs to be undertaken.

Remuneration for the supply of cytotoxic chemotherapies

The Association concurs that the PBS reform package has progressively reduced the price of some PBS medicines, including some cytotoxics, resulting in decreased remuneration for suppliers. In some instances remunerations previously used to cross-subsidise the provision of chemotherapy services has reduced the capacity of providers to supply certain medicines. At the recent Senate Inquiry on "Supply of chemotherapy Drugs" these and other concerns were raised by the private providers regarding the sustainability of the current funding for the provision of chemotherapy drugs under the PBS:

- Increased costs due to the reduction in remuneration would likely reduce service capabilities resulting in a shift in cancer care to the public health system.
- Rural cancer services would be most at risk because of higher average cost per service unit.
- Need to determine the appropriate source of remuneration to pharmacists to reflect the costs of supplying chemotherapy infusions.

It is clear that the level of remuneration for the supply of cytotoxic chemotherapies needs to be reviewed as this may be inadequate for continued supply of those medicines in Australia.

Access to cancer medicines

The Association agrees that the challenges to accessing new cancer medicines in a timely and affordable manner are increasing, including delays in access in comparison with the US and Europe. However, the causal factors are unclear and warrant detailed analysis. Eg., do the recent protracted processes leading to the approvals/rejections of listing cetuximab, vemurafenib and abiraterone reflect system inefficiency or necessary process requirements? Related questions that need to be addressed include; do sponsors postpone applications in Australia?; is the assessment process for regulatory approval following TGA application too cumbersome and duplicative of processes that have already been undertaken by the FDA and EMA based on the same evidence?; or is the increasingly uncertainty regarding reimbursements in recent years contributing to access issues?

Access to drugs for rare cancers

The Association is concerned that research priorities, commercial imperatives and advocacy favours access to oncology drugs and treatments for more common cancers in Australia. For instance, clinical trials for rare cancers are often conducted through collaborative trial groups with less industry support and the data collected may be less suited to registration and reimbursement requirements. The Australian regulatory process and our Government seem reluctant to fund effective treatments for rare cancers even though the overall impact on the health budget would be minimal. It is recommended that our national systems for research and development, oncology drugs regulation and reimbursement needs to be supportive of drug development and access for rare cancers.

Evidentiary requirements

The Association concurs that evidentiary requirements in Australia do not adequately reflect the needs of oncology drugs and treatments as follows:

- There is a need to determine what Australians considers an acceptable level of funding for oncology drugs, treatments and caring for patients nearing end of life, including those with advanced cancers.
- There is a need to review and harmonise evidentiary requirements in Australia and overseas; and address concerns including “are the Australian evidentiary requirements...always...deliverable?”
- For diseases with significant unmet clinical need and technologies that have proven to be efficacious and safe, making decisions based on surrogate endpoints may be appropriate, on the condition that the sponsor has the obligation to undertake Phase IV post-marketing evaluation.
- The evidence base for cancer medicines may have some levels of uncertainty. The current system has a low level of acceptance for uncertainty, and has not implemented any process or practical solutions to address this. Hence, the current system may not be sufficiently sensitive to assess the complexity of many cancer treatments, particularly those intended to treat small patient populations with rare cancers.
- The requirement for providing evidence from parallel randomised controlled trials (RCT) (the “gold standard”) may not be realistic, above all in oncology. In reality, if an RCT design has not been undertaken evidence from the ‘next best’ possible trial design should be accepted and provide guidance for facilitating access.

Value, Price and Cost

The Association believes that access issues surrounding the value, price and cost of cancer drugs need review as follows:

- The Australian system favours a user pays approach that discriminates against patients without the ability to pay for non subsidised oncology drugs and treatments. Regrettably, access arrangements are dependent on where a patient lives, who their physician is, their access to specialised cancer treatment and their level of private health insurance. The interplay of these factors means that access is inequitable.
- Oncology drugs are expensive to develop, manufacture and purchase. Maintaining a viable medicines industry in Australia by providing sufficient commercial incentives for industry to pursue drug development and marketing is crucial. However, industry needs to provide greater transparency regarding how drug prices are set in Australia and globally; including justification of high prices, and what are perceived as unrealistic price expectations, with the provision of clear ROI and manufacturing data.
- Industry in Australia are affiliates of global companies, and as subsidiaries have limited influence over the development of new cancer medicines, both in terms of trial design and price setting, particularly for those intended to treat a small group of patients.
- Measuring the “value” of a clinical benefit is difficult in oncology. The small numerical benefit means that the cost effectiveness calculation may not find it ‘value for money’ from a population perspective, notably as the current measurement technique is insensitive to detect improvement in quality of life outcomes in cancer patients. Furthermore, to better reflect perceived societal preferences for funding end-of-life medicines, the assessment of the value of cancer medicines in other international jurisdictions has allowed for downward adjustments to the cost-effectiveness ratio.
- In Australia setting reimbursed prices for new oncology drugs with reference to older comparators is problematical and may be an obstacle to access. Generic competition following patent expiry and PBS reform has combined to reduce the price of generic medicines. In some cases, reference pricing methods have resulted in a price that fails to demonstrate cost-effectiveness of a new drug to the PBAC, or that is viable for the sponsor to list the on the PBS.
- The system should be structured to guarantee the supply of generic cancer medicines, which are more costly in Australia than in other countries, including identifying appropriate remuneration to ensure consistency of supply.
- The different coverage of on-label and off-label indications in hospital and PBS formularies may also affect the continuity and affordability of treatment and needs to be addressed.
- Delayed access to reimbursed cancer drugs and treatments means that the system is more reliant on compassionate and early access programs and these have their own associated problems including

operational and funding demands on hospital resources that need to be considered. The related equity issue that also arise because not all cancer patients (e.g. those from regional and rural areas) receive treatment at a major treatment centre where such programs are commonly available also require attention.

- The barriers to access cancer drugs and treatments due to state/federal funding arrangements need to be reviewed and addressed.

Conclusion

ACCESS TO CANCER MEDICINES IN AUSTRALIA, Medicines Oncology Industry Taskforce, July 2013, Deloitte Access Economics (The Report) provides stakeholders with a good starting point to debate key concerns that will lead to the development of sustainable solutions to address oncology drugs and treatments access issues in Australia.

Australia has performed well in providing affordable and equitable access to oncology drugs and treatments but the system faces significant challenges from the growing burden of cancer, the emergence of many new cancer treatments and the expectation that these new advances should be made available in a timely manner. In this context the Association makes the following recommendations with regard to oncology drugs and treatments access in Australia:

- The governance culture and silo-approach within various authorities and government departments need to be challenged and a single, co-ordinated agency and decision-making process with supporting legislations is required to achieve greater process efficiency. Eg., align with models and practices in other jurisdictions with a decision making framework based on health technology assessment; linking the price of a drug or a test to the health outcomes achieved in clinical practice.
- Procedural and structural improvements to streamline current regulatory and reimbursement processes and associated departments/authorities are necessary, notably for medicines with co-dependent diagnostic tests; including harmonisation of evidentiary requirements between regulatory and reimbursement authorities; and, how best to prioritise healthcare resources in view of the different value perceptions of clinical benefits. Eg., undertaking a regular audit and de-listing of utilisation outside of PBS approved indications; establishing a single set of requirements to obtain ethics approval for undertaking clinical trials; extend the current two-week timeline for comments on PBAC agenda items.
- Resource allocation should be equitable and made with consideration to: population burden of disease; severity of disease, including consideration for end-of-life needs; unmet clinical need, above all where there is no alternative treatment; wider perspective in assessing economic merits, including costs for families and carers; and patient's productivity if a drug improves functionality; including ensuring adequate national investment in the treatment of rare cancers.
- Ensure a rigorous, national regulatory and reimbursement but, above all, compassionate assessment process for oncology drugs and treatments, without undue political interference and that ensures drugs and treatments in Australia are priced at a level that is affordable and sustainable to the system, providers and end users.
- Ensure Australia's attractiveness and competitiveness for undertaking clinical research for both clinicians and industry.