Cancer medicines

Roche Australia (Pharmaceuticals) Policy Position

Summary

- Challenges in the assessment and reimbursement of innovative cancer medicines are delaying access to advances in treatment and creating inequalities between patients.
- These issues can be attributed to a "one-size-fits-all" approach to assessing the value of medicines and risk-averse management of uncertainty.
- The Pharmaceutical Benefits Scheme (PBS) requires urgent review to ensure the system is "fit-for-purpose", aligned with community values and efficiently engages all stakeholders early on in the process, to avoid the delays of multiple submissions.
- Roche does not advocate that cancer treatments should inherently be held to different standards than other specialty medicines. Nevertheless, as cancer is frequently life-threatening, patients need all stakeholders to collaborate urgently to find solutions.

Background

Cancer is a complex disease, requiring intensive scientific exploration and investment in order to discover, develop and bring much needed treatments to patients. Cancer is not one disease, but many, and over 200 types of cancer have been identified so far[1]. It accounts for more than a third of the burden of premature death[2], yet in 2008-09, cancer received only 7% of Australian health expenditure on chronic disease[3].

Roche is a leader in the field of cancer therapeutics, with 10 registered cancer medicines in Australia, and with more than 30 drug combinations and over 20 novel "immunotherapies" for cancer in the pipeline[4].

Roche position

Roche's approach to cancer therapeutics is based on the improved understanding by the scientific community of the molecular basis for cancer, including how tumours develop and spread. As a leader in personalised healthcare, with expertise in both medicines and diagnostics, Roche has developed many cancer therapies that can be targeted based on a patient's cancer type. By supporting improved clinical decision-making and treatment options, Roche can help physicians to initiate targeted and effective treatment, thereby enhancing patient well-being and decreasing the total cost to the healthcare system.

Innovation in cancer treatment is often incremental and the place of medicines in therapy (and their value) may evolve over time. A cancer medicine is often first introduced in late-stage disease, where the area of unmet need is greatest. Over time, as these medicines are studied and used at earlier

stages of disease and in other conditions, and with evolving real-world evidence through use of registries, their full value becomes apparent[5]. The value of a medicine also continues beyond patent expiry, when generic and biosimilar* competitors drive down the price markedly. The lifetime value of the medicine may include many years of improved health benefits at a very low cost to payers. Without the initial introduction of a medicine, which depends on a company being able to achieve a return on investment, the full long-term value of the medicine may never be realised.

Challenges in the assessment and reimbursement of innovative cancer medicines are delaying access to advances in treatment and creating inequalities between patients. This applies to all innovative medicines to some extent, yet cancer faces particular challenges related to the pace of innovation in this area, and the complexities of clinical evidence and limited patient survival times in end-of-life settings. While Roche does not advocate that cancer treatments should inherently be held to different standards than other specialty medicines, cancer medicines pose specific challenges that require urgent policy reform.

Australia lags behind other developed countries in terms of access to cancer medicines. Australia was recently ranked 12th out of 13 highly-developed countries for uptake of new cancer medicines, with reimbursement the most likely restriction[6]. An international comparison of 10 cancer medicines in 2012 showed Australia only funded 46% of the approved indications (i.e. types of cancer and patients) for these medicines, around half of the indications funded in the USA, Sweden, Germany, France and Italy[7]. A recent study showed that cancer medicines in Australia experienced the most significant delays between registration and reimbursement out of all therapy areas[8]. Not only have success rates for reimbursement submissions diminished in recent years, Roche has made the difficult decision to never make submissions to the Pharmaceutical Benefits Advisory Committee (PBAC) for some of its medicines in light of the challenging process.

This creates serious inequalities between patients: in time to access treatment, where patients who need innovative therapies now are disadvantaged compared to those who will be diagnosed in the future when these medicines are eventually listed; and where patients requiring the same targeted cancer medicine will have different levels of access because of the organ where their cancer first occurred. These challenges are primarily due to the limitations of health technology assessment (HTA) of medicines in Australia, as performed by the PBAC. More and more Australia stands alone in continuing to apply a "one-size-fits-all" approach, regardless of medicine or therapeutic area, with a narrow focus on incremental cost effectiveness ratios (ICERs) and budget impact.

The PBAC approach becomes especially challenging when new therapies are added to the existing standard of care. In metastatic breast cancer, Roche performed a calculation to show that a

* A similar (but not identical) copy of a medicine produced by biological means.

medicine that adds half a year of life and improves quality of life in comparison to the standard of care, was not considered cost-effective even at $4 a vial, or the equivalent of the price of a cup of coffee, under the current PBAC methodology[9]. An ICER-based system with an undifferentiated threshold, by virtue of the mere methodology applied, may never show an acceptable outcome for combination treatments, given the increased cost associated with the extension of treatment duration and follow-up, despite the value to patients.

All HTA must grapple with uncertainty around value, yet the PBAC's low tolerance in this area usually results in a rejection, potentially multiple re-submissions and access delays for patients. One particular challenge is the PBAC's preference for the use of overall survival (OS) data to minimise uncertainty around clinical benefit. Cancer medicines are typically approved by health regulators such as the Therapeutic Goods Administration (TGA) on the basis of progression-free survival (PFS), i.e. the medicine significantly extends the time for the cancer to recur following treatment response. Demonstrating OS in cancer trials is more complex, as it looks at survival of patients beyond progression of their cancer, which is influenced by their subsequent treatments. A significant impact comes from the ethical imperative to give access to the new medicine or regimen to patients enrolled in a clinical trial whose disease progressed while on the comparator treatment arm of the trial. This approach is known as "cross-over". This ethical requirement masks the ability to measure the OS associated with the experimental medicine/regimen versus the comparator in the trial. Consequently, it leads to clinical uncertainty, as trial patients in both treatment arms receive the experimental treatment at some time.

The responsibility rests with both the developers of new medicines and the PBAC to find constructive solutions to address uncertainty. In order to improve timely access, Roche supports a more dynamic approach to HTA through the appropriate use of managed entry schemes for innovative medicines. Earlier and increased engagement between expert clinicians, academics (including evaluation units), the PBAC, patient organisations and companies could also help address technical and methodological issues in advance of a first PBAC submission and allow for consistency and agreement on treatment algorithm, comparators, evidentiary requirements, as well as economic model inputs and structure.

The Australian HTA system must become increasingly flexible, taking account of the value of medicines to patients, carers, clinicians and society, as well as the evolving value of a medicine over its lifecycle, and adopting a willingness-to-pay in line with other developed countries. Roche is concerned that in some cases medicines are rejected in order to apply pressure on companies to lower prices. Delaying cancer patients timely access to therapy in order to attempt negotiation of significantly lower prices than in other developed markets is out-of-step with community values and comes at an unacceptable cost to patients with life-threatening conditions.

While no country's HTA system is "perfect", there are important lessons from other well-established systems. Other countries routinely consider indirect costs and benefits (such as patient and carer work productivity), involve citizens in decision-making and adopt a fit-for-purpose process for medicines for the treatment of rare diseases or with low budget impact[10].

The PBS requires urgent review to consider these important issues. As policy review and change takes time, Roche encourages the government to look at models that would provide interim access to patients awaiting new cancer therapies. As cancer is often life-threatening, time is critical for patients and delays must be addressed.

This position paper was adopted by the Roche Australia (Pharmaceuticals) Leadership Team on 15 May 2015 and entered into force the same day

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