Nordic Rare Disease Summit

12-13th - April 2021

An Assessment of Alignment of Nordic P&R Systems with ORPH-VAL Principles

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Overview and Recommendations

Introduction

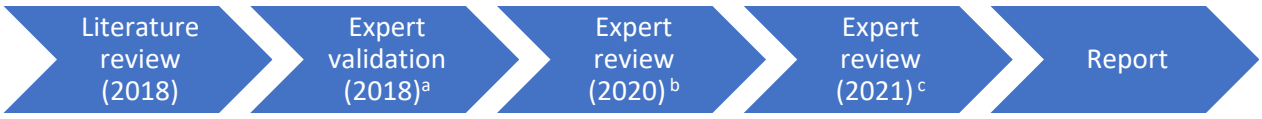
The European Working Group for Value Assessment and Funding Processes in Rare Diseases (ORPH-VAL) is a collaboration of rare disease experts comprised of patient representatives, academics, regulators, payers and industry. It was formed in 2015 with the objective of improving patient access to orphan medicines by establishing common principles to underpin pricing and reimbursement (P&R) processes in Europe. In January 2017 the group's recommendations were accepted for publication in the Orphanet Journal of Rare Diseases.

The working group is undertaking formal assessments of the alignment of national P&R systems with ORPH-VAL's nine recommended principles, in order to see where there is alignment and to identify potential improvements to those systems.

As part of the **Nordic Rare Disease Summit** to help improve patient access to orphan medicines, an assessment of the alignment of Nordic P&R systems for rare disease treatments (RDTs) with the ORPH-VAL principles has been conducted as a basis for discussion on opportunities to improve access.

Nordics assessment

In December 2018, an in-depth review was conducted of the alignment of current P&R systems in Sweden, Norway, Denmark and Finland with the nine ORPH-VAL principles. This review encompassed desk research and expert validation via interviews. To incorporate any policy changes in these countries, the review was updated in 2020 and again in 2021 via desk research, interviews and consultation with local P&R experts.



a) Validation consisted of interviews with local industry P&R experts & Payers in the individual Nordic countries
b) Validation consisted of interviews with local industry P&R experts to identify the most recent changes
c) Validation consisted of desk research and validation with local industry P&R experts

Overview of Nordic country pricing and reimbursement systems for RDTs

The way RDTs are assessed depends whether they are delivered in the inpatient (hospital) or outpatient setting. In **Demark** and **Norway** RDTs go through the hospital route only. In **Sweden** and **Finland** RDTs can be assessed through either route. The HTA process and responsible bodies differ depending on which route is used. Regardless of the delivery setting, there is no formal distinction between RDT and non-RDT assessment in any of the Nordic countries.

P&R processes in **Sweden**, **Norway, Denmark** and **Finland** all use a cost-effectiveness approach, but have no fixed cost/QALY threshold. **Sweden** and **Finland** are flexible in their willingness to pay for ultra-

RDTs and may accept higher ICERs. **Norway** also allows some flexibility in willingness to pay for RDTs, but in practice they are often rejected for failing to demonstrate cost effectiveness.

In **Finland** and **Denmark** RDTs are funded nationally, while in **Sweden** funding is national or regional depending on the route selected for assessment. In **Norway**, RDT funding has recently been shifted to hospitals.

Possible areas for improvement in the Nordic countries

Based on the in-depth review from 2018 and updates in 2020 and 2021, three common areas for potential improvement were identified:

1. **Value assessment processes should consider all RDT specificities in a consistent way**

Value assessment processes should explicitly consider factors associated with RDTs, such as the rarity of the condition, disease severity, availability of existing treatments, and societal burden. In the Nordic countries these considerations are not always comprehensively included in the decision-making framework, and more formalized and consistent consideration of these criteria could improve patient access. This focus could be achieved through the creation of RDT-specific assessment pathways, or the introduction of special and specific criteria for RDTs within existing frameworks.

In addition, it would be helpful to have more explanation of how these rare disease specific considerations impact decisions. For example, in all Nordic systems there is recognition of disease severity in assessment criteria, but lack of clarity on its importance in the final reimbursement decision. Greater clarity could be achieved by stipulating the relative importance weights given to different decision criteria for RDTs, or by using more deliberative decision processes.

Similarly, there is a need to account for the greater evidential uncertainty in rare diseases. The flexibility in interpretation of data should be considered in light of the rarity of the condition and the relative paucity of available evidence on disease outcomes. Flexibility in methods – such as indirect comparisons and extrapolation of surrogate endpoints – should be allowed, and guidance provided on best practice for such analyses in small populations.

2. **More consistent disease-specific expertise should be incorporated in current processes**

In rare diseases the relative absence of information about the condition raises the need for the involvement of disease-specific experts. Patients and doctors can provide critical insight on disease burden and endpoints, interpretation of treatment benefit, and understanding of patient experiences, preferences, needs and values.

Nordic countries mostly do include physician and patient input into their decision processes, but often in an informal manner, where the relevance of patient and physician testimony is sometimes unclear. This is particularly true for the patient perspective.

Patient and physician involvement in the HTA appraisal and decision-making process should be more structured and consistent. Where possible, multiple disease-specific physician experts should be consulted during the appraisal process and should participate in decision meetings. Disease-specific patient groups should be assisted to produce written submissions that are incorporated into the appraisal process, and individual patients should be allowed to testify at the decision meetings. Rare

disease patient representatives (not necessarily from the disease under assessment) should have voting roles in appraisal committees.

3. **RDT assessment processes should be adaptive and subject to the need and availability of information over time**

Given the inherent uncertainty associated with rare diseases, and the inevitable imperfection of data at the time of launch, P&R processes should be adaptive, allowing revision of decisions over time as real-world evidence accrues.

Currently in the Nordics some countries have experimented with contractual agreements that incorporate elements of conditional reimbursement or outcomes-based payment, but in practice such approaches are seldom used.

Countries should put in place sufficient resource and expertise to allow for adaptive P&R processes for RDTs in situations where the level of uncertainty necessitates it. Adaptive processes should be focused on the generation of additional evidence, either from ongoing clinical trials or through real-world data. Real-world evidence should, whenever possible, be generated though supra-national registries allowing better and quicker understanding of the clinical profile of the treatment.

The process for adaptive decision making should involve all relevant stakeholders, including physicians and patient experts, and clarity should be given about responsibilities within the agreement. P&R decisions should be able to move both upwards and downwards as new evidence becomes available.

Summary

One of the goals of the Nordic Rare Disease Summit is to help improve patient access to RDTs. The assessment of alignment of Nordic P&R systems for RDTs with the nine ORPH-VAL principles highlights three common areas for potential improvement:

1. Value assessment processes should consider all RDT specificities in a consistent way
2. More consistent disease-specific expertise should be incorporated in current processes
3. RDT assessment processes should be adaptive and subject to the need and availability of information over time

These can be the subject of informed discussion at the Summit between stakeholders who share the same goal of ensuring sustainable access to medicines for patients with rare diseases.

Appendix

ORPH-VAL PRINCIPLES	Sweden		Norway	Denmark	Finland	
	Outpatient	**Inpatient**	**Hospital**	**Inpatient**	**Outpatient**	**Inpatient**
Principle 1: OMP assessment should consider all relevant elements of product value for OMPs in an appropriate multi-dimensional framework	✓✓	✓- ✓✓*	✓	✓✓	✓✓	✓✓
Principle 2: Pricing and reimbursement decisions should be founded on the assessment of OMP value for money and adjusted to reflect other considerations beyond product value	✓✓✓	✓- ✓✓✓*	✓	✓- ✓✓	✓✓	✓✓
Principle 3: All official regulatory and health technology assessments of OMPs undertaken at the European level should be acknowledged by national health authorities	✓✓✓	✓✓	✓✓	✓✓	✓✓✓	✓✓✓
Principle 4: The assessment and appraisal of OMPs in Europe should incorporate rare disease expertise including both the healthcare professionals' and patients' perspectives	✓✓	✓✓	✓✓	✓✓✓	✓✓✓	✓✓
Principle 5: To accommodate uncertainty, value assessment and pricing and reimbursement decisions should be adaptive subject to the need and availability of information over time	✓✓	NA	✓	✓✓	✓✓	✓✓
Principle 6: All eligible patients within the authorised label of an OMP should be considered in the reimbursement appraisal although different decisions on access may apply to different sub-populations	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓
Principle 7: Funding should be provided at the national level to ensure patient access to OMPs	✓✓- ✓✓✓	✓- ✓✓*	✓✓	✓✓	✓✓✓	✓✓
Principle 8: Evidence-based funding mechanisms should be developed to guarantee long-term sustainability	✓✓	✓✓	✓	✓✓ - ✓✓✓	✓✓	✓✓
Principle 9: In the future there should be greater co-ordination of OMP value assessment processes at a European level	✓	NA	✓✓	✓	✓✓	✓✓

** Greater alignment if P&R decision relies on an HTA by TLV*