Specialised Healthcare Alliance
FOR EVERYONE WITH RARE AND COMPLEX CONDITIONS

Achieving fairness for all

Principles to help determine when and how to make treatments for rare conditions available

Introduction

The Specialised Healthcare Alliance (SHCA) represents patients with rare and complex conditions, many of whom require sometimes-sophisticated medical treatments on a short term or an ongoing basis. Although the conditions are 'rare' on an individual basis, the collective burden of these conditions is great – with Rare Disease UK estimated that one in 17 people are set to be affected by a 'rare' condition at some point in their lives.[i] The patients we represent look to the NHS to ensure that decisions about which treatments are made available on the NHS are taken:

- Collaboratively, with patients' views fully taken into account – and seen to be taken into account
- Fairly, so that patients are not denied access to treatments simply because their condition happens to be rare: the UK's Strategy for Rare Diseases has itself recognised that there are "*particular challenges that occur when evaluating treatments for rare diseases"*[ii]
- Equitably, so that patients in one area of the country do not receive a different standard of care to patients in other areas of the country

In the last two decades, great improvements have been made in each of these areas – and particularly with respect to equitability, with (for example) more and more decisions taken nationally by NICE and NHS England rather than locally, stopping so-called 'postcode lotteries' from emerging and becoming entrenched.

This progress is to be welcomed. However, in recent years, concerns (which are described in this paper) have begun to become more widespread about the fairness of the current approach the NHS takes to deciding when treatments should be made available, and the degree to which patients' views are taken into account by it – particularly for treatments for rare conditions. This is partly due to the growth in treatments for rare conditions resulting from the rewards put in place in 2000 by the EU's orphan drug legislation, which we welcome and which we expect to be maintained.[iii]

The patients we represent share these concerns wherever they live in the UK, but this report – which is intended to help policymakers address the concerns being voiced – focuses only on the system which is operated by the NHS in England (although some of the conclusions we reach are applicable not just in England, but in Scotland, Wales and Northern Ireland – and internationally). This report sets out:

1. The current system and the challenges it faces, informed by a survey of our members which took place in April and May 2018
2. How some other countries take decisions on treatments for rare conditions, and what we can learn from them
3. Suggested principles which should guide the development of the NHS's approach to deciding when and how to make treatments for rare conditions available

1. The current system and the challenges it faces

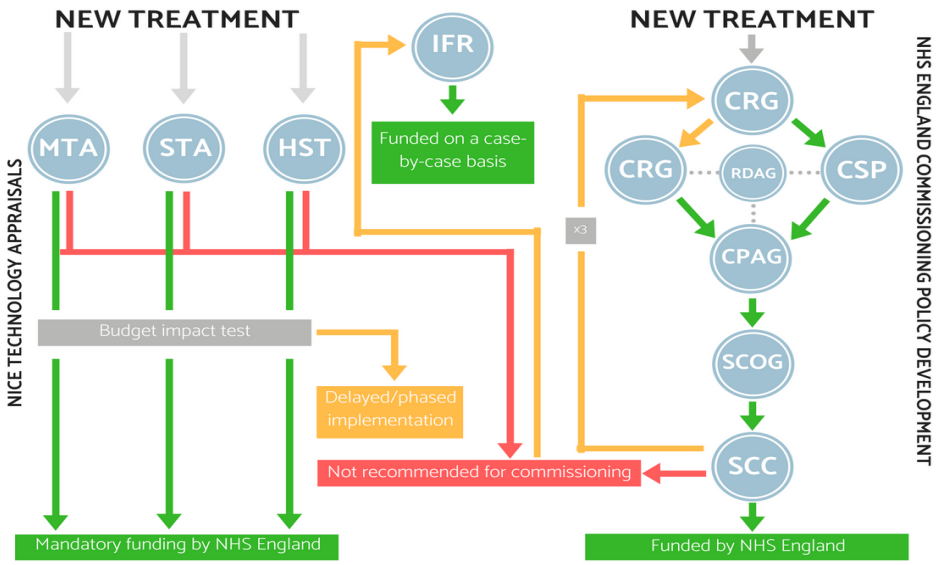
There are currently multiple routes through which decisions about the treatments that should be made available on the NHS are taken. Those which our members are most concerned by are summarised in figure 1, and are:

- The NICE technology appraisal process, which considers treatments referred to NICE by the Government both for more common conditions (through its multiple technology assessment (MTA) or single technology assessment (STA) routes), and for ultra-rare conditions (through its highly specialised technology (HST) route)

- NHS England's 'commissioning policy development process', which considers treatments not reviewed by NICE through a complicated process involving a 'Clinical Reference Group (CRG)', a 'Commissioning Support Programme (CSP)' led by NICE, a 'Clinical Priorities Advisory Group (CPAG)' itself informed by a Rare Disease Advisory Group (RDAG), and finally formal decisions taken by a Specialised Commissioning Oversight Group (SCOG) and ultimately NHS England's Specialised Commissioning Committee (SCC)

- An 'Individual Funding Request' (IFR) process, which is overseen by NHS England and which considers funding on a case-by-case basis for treatments

Figure 1: ***Pathways to reimbursement for rare disease treatments, Incisive Health (2018)***



As figure 1 demonstrates, taken together these routes form the parts of a highly complicated and confusing system, which applies different methodologies, processes and timelines depending on which route is taken. Although the routes differ, challenges common to all include:

- The relative lack of information on new treatments for rare conditions which national bodies can consider

  Treatments for common conditions typically have a wealth of data which support their use, particularly from clinical trials, which compare how well they work with how well other treatments work. However, treatments for rare conditions tend to have less data comparing them with other treatments, which means that both NICE and NHS England are more uncertain about the effect that these new treatments will have. Although NICE has partly overcome this challenge in respect of treatments for both rare and common cancers, by allowing their 'conditional' use in the NHS whilst more information is gathered, no such arrangements are in place for drugs for other rare conditions

- The ability of charities to make the case for treatments for rare conditions on behalf of patients

  Just as rare conditions affect small numbers of patients by definition, the charities which support patients with rare conditions and their families (many of which are members of the SHCA) also tend to be small. This creates challenges when these charities are invited to submit evidence by NHS England or by NICE to their respective processes, since charities sometimes have no experience of the processes which they are invited to contribute to, and of the ways in which their evidence can be taken into account – and, as stated above, no single route is the same as another. On occasion, charities can even be overlooked by NICE and NHS England entirely, and are never asked to contribute their views

- The relative price of treatments for rare conditions

  Because treatments for rare conditions are, by definition, used in small numbers of patients, their cost tends to be higher than for treatments for more common conditions. This means that the NHS can deny treatments to patients with rare conditions which are of equal clinical effectiveness to those for more common conditions, simply because the treatment is used in smaller numbers of patients[iv]

Although the above challenges are common to all routes used to determine whether new treatments for rare conditions can be used in the NHS, some are particularly problematic in respect of NHS England's commissioning policy development process:

- In respect of the relative lack of information, there is no clear mechanism used by NHS England to accommodate uncertainty in the effectiveness of treatments for rare conditions. In our members' survey, when asked what they felt was the most significant challenge they faced in NHS England's commissioning policy

development process, the greatest proportion of our members (almost 30%) responded to say that NHS England needed to apply more flexibility when considering treatments for rare conditions[v]

- NHS England continues to modify and change its commissioning policy development processes, including for gathering the views of patients. For example, in its initial period of operation, NHS England considered new treatments on a once-yearly basis, and has now moved to a twice-yearly basis. In addition, NHS England has only recently begun inviting the views of NICE, and it remains unclear how to feed views into both NICE and NHS England and how these views are taken into account.

Box 1: some feedback from our members on NHS England's commissioning policy development process

"The process is as clear as mud."

"The process suffers either from a lack of transparency or poor communication."

"We believe more clarity is needed on how our evidence is used in the final decision making."

"There should be a place for patient evidence to inform decision-making during the prioritisation process."

Although improvements have and are being made, the points at which charities can submit evidence remain unclear, and a description of whether and how this evidence is taken into account is never made public. In our survey, more than half of our members reported to us that they found the process for submitting evidence to NHS England be challenging, and almost half felt that their evidence was undervalued.[vi] Furthermore, details of NHS England's entire decision-taking process remain vague – and no detailed summaries of the thinking behind NHS England's decisions are ever published, illustrated by the comments in Box 1

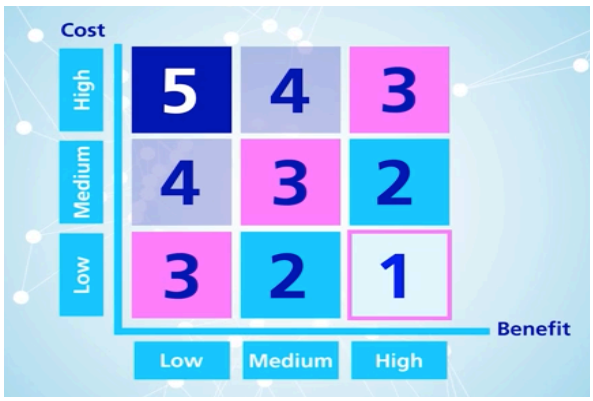
- In respect of the relative price of treatments:
    - NHS England assesses treatments based on a crude 9-box grid (figure 2) – which has been criticised as arbitrary (see box 2) – and which considers the 'cost per patient' of a treatment and accords a higher priority to those treatments which have a lower cost (even though these are likely to be for treatments for more common conditions).

Box 2: one response to our members' survey

"I find the scoring system used rather arbitrary, and I think there is insufficient weight given to contributions by clinicians."

This process applies no weighting for the rarity of a condition, resulting in discrimination against patients with rare conditions. (For its part, NHS England insists that RDAG is able to offer advice which allows NHS England to apply flexibility for treatments for rare conditions, but no details of how RDAG's advice has affected a decision have ever been published)

Figure 2: the prioritisation grid used by NHS England



- NHS England has a fixed amount of funding available for the treatments that it considers through its commissioning policy development process – which in both 2016/17 and 2017/18 was £25 million.[vii] Because NHS England's process is not led by patient demand but rather by the availability of this funding, it is possible (for example) that treatments considered 'priority 2' when money is available might be approved for use in the NHS, but that at another point in time when money is scarce 'priority 2' treatments might be rejected. The priority accorded to a particular treatment can also vary depending on whether it is considered at the same time as a small number of relatively expensive treatments, or a large number of relatively inexpensive treatments.

  The process is, in effect, a lottery – with the chance of a treatment being approved contingent both on the other treatments that happen to be being considered at the same point in time, and on the resources that NHS England happens to have at a particular point time

NICE's processes also face particular challenges:

- In respect of the relative lack of information, and as stated above, although NICE recommends the 'conditional' use of treatments whilst more information is gathered for treatments for rare and common cancers, it does not do so for any other treatments

- In respect of the relative price of treatments, and although NICE operates the 'HST' system which allows greater flexibility when considering treatments for ultra-rare conditions, it otherwise assesses all treatments through either its STA or MTA routes – which are used both to assess treatments for patients with rare conditions and common conditions. It does not have any process specifically for treatments for rare (as opposed to ultra-

Box 3: one response to our members' survey

"Unfortunately, the majority of treatments for rare diseases fall somewhere between the QALY threshold of an STA and a HST: too specialised for STA appraisals but not rare enough for HST. NICE should consider another tier"

rare) conditions, which almost half of our members reported was the most important reform that NICE could make to its processes[viii] (as described by one of the respondents to our survey in box 3)

Finally, in the case of IFRs – which are the route of last resort for patients with rare conditions whose treatments have not been made available through any other means – concerns exist in particular over the lack of transparency of the process or of the decisions made, with:[ix]

- Over 40% of our members wanting to see greater flexibility when considering requests for treatment for rare conditions in the IFR process
- Over 60% of our members finding it challenging or very challenging to access information on the IFR process
- Over 80% of our members reporting that they are either not very or not at all confident in the decisions made through the IFR process

There is evidence to suggest that these challenges, taken together, are having a direct impact on levels of access to treatments for rare conditions for patients in England. For example, recent analysis undertaken by the Office for Health Economics shows that, for all treatments for rare conditions licensed for use in Europe between 2001 and 2016: [x]

- Just 47 per cent were made available on the NHS in England routinely, compared to 81 per cent made routinely available in France and 93 per cent made routinely available in Germany
- For treatments which were ultimately made available, the NHS in England took almost 9 months longer on average to arrive at its decision than France and Italy, and almost 28 months longer than Germany

2. Lessons we can learn from other countries

The fact that other countries have a better record of making treatments for rare conditions more widely available than England means that NHS England and NICE should be open to learning the lessons of the approaches they take. Although there is no 'perfect' system that NHS England can emulate easily, other countries do follow processes which overcome the challenges noted above.

- France applies a system where, in the case of many medicines for rare conditions ('orphan medicines'), and to compensate for the relative lack of information to compare them with other treatments, their benefit is considered proven if their total cost to the healthcare system is expected to be less than €30 million a year[xi]
- In Germany, a similar approach is taken, whereby the benefit of orphan medicines is considered proven if the total cost to the healthcare system is

expected to be less than €50 million a year. In addition, subsequent price negotiations take place only once an orphan medicine is in use, which means that there is presumption in favour of access to medicines for rare conditions[xii]

The NHS in England can also look to examples closer to home. For example, in Scotland:

- The Scottish Government has been able to address challenges in finding funding for new treatments, at least in part, by establishing a 'New Medicines Fund' for rare conditions, paid for by the pharmaceutical industry's contributions to the 'Pharmaceutical Price Regulation Scheme (PPRS)'[xiii]

- The Scottish Medicines Consortium applies a similar procedure for treatments for rare conditions as for treatments for more common conditions, but it recognises that less information may be available for the former than for the latter, and therefore gives patients and clinicians a stronger voice in decision-taking through its Patient and Clinician Engagement (PACE) process[xiv]

- Further reforms are now being considered, in response to the Scottish Government's 'Montgomery Review', to allow the NHS in Scotland to use more treatments on a conditional basis whilst more evidence about their use is gathered[xv]

3. Principles to guide future reform

Although other countries have found ways of overcoming the challenges in determining whether to make treatments for rare conditions available, this report deliberately steers away from proposing specific solutions (which other organisations, including Genetic Alliance UK, are developing[xvi].). Instead, we seek only to set out some principles which should guide those seeking to reform the system, informed by our work.

The principles we believe should guide any changes are:

1. <u>There must be a 'premium for rarity'</u>

   NHS England and NICE must ensure that all treatments of equivalent clinical effectiveness are made available in a fair and equitable way whether they treat people with more common conditions, or people with rare conditions. Given treatments for rare conditions tend to be more expensive than treatments for more common conditions, this requires offering a 'premium' for rarity (which could involve accepting that a clear patient benefit is proven in the case of an 'orphan medicine', as happens in other countries).

   However, at present, NHS England's processes do not offer any such premium for rarity (although NHS England does suggest that RDAG is able to advise when necessary), and existing NICE processes offer a significant premium only for treatments for ultra-rare conditions – not for treatments for rare conditions

2. In the event of uncertainty, the presumption should be in favour of access

   At present, except in respect of cancer treatments, when either NHS England or NICE face uncertainty in whether a treatment will be effective, they err towards denying access to patients. This discriminates against treatments for rare conditions in particular, where information about their effectiveness tends to be less comprehensive than for treatments for common conditions simply because fewer patients can be treated with them. It is also the opposite approach to that taken in Germany (and under consideration in Scotland) where treatments are made 'conditionally' available whilst further information about their effectiveness is gathered. NHS England and NICE should adopt these 'conditional' approaches when assessing treatments for rare conditions

3. The patient voice must be heard

   Although NICE's processes offer clear points when patients can contribute to decisions about the treatments that should be made available on the NHS (and support through its Patient Involvement Programme[xvii]), NHS England's processes fail to do so. In addition, there is scope for both NICE and NHS England to offer better support to those charities who rarely engage with their processes. The PACE system in Scotland provides a practical example of one way in which such a principle could be delivered upon

4. Decisions must be made transparently

   Patients lack confidence in decisions when they do not know how they are made. The lack of transparency is a particular issue for NHS England, which takes decisions at meetings which are both closed to the public and for which no details of the discussions which take place are ever published – and which is a cause of particular concern for our members. This means that patients gain no understanding of how decisions have been arrived at, and have no knowledge how the evidence they submit is taken into account. NHS England must learn from best practice (including from NICE), and improve its processes in this respect

5. The NHS must work with pharmaceutical companies to enable it to take consistent decisions over time

   As stated above, NHS England's commissioning policy development process is a lottery – because its budget for new treatments is relatively fixed over time, whilst the demands placed on this budget (in terms of the number and cost of treatments that it must fund) changes over time. The pharmaceutical sector and the NHS must work together to address this funding challenge, not least by exploring the opportunities through PPRS agreements to find ways in which funding for treatments for rare conditions can be separately identified, and which allow this funding to change in line with the demands for it (perhaps using the approach which has been adopted through the New Medicines Fund in Scotland)

Conclusion

Although NHS England faces challenges in how it determines which treatments for rare conditions should be made available, over the course of the last two decades it is undoubtedly the case that decisions are now made more collaboratively, equitably and fairly than before.

We have no doubt that the NHS will now continue to improve in the way it takes these decisions, and that in doing so it will address the continuing challenges we have set out, and the concerns that our members have raised. We therefore urge both NICE and NHS England to consider the principles we have outlined when considering and implementing any improvements that need to be made.

October 2018

Appendix – about the Specialised healthcare Alliance

The Specialised Healthcare Alliance is a coalition over 120 patient-related groups and 10 corporate supporters, which campaigns on behalf of people with rare and complex conditions.

The secretariat to the Specialised Healthcare Alliance is currently provided by Incisive Health.

References

[i] Rare Disease UK, What is a rare disease?; accessed 10 September 2018
[ii] Department of Health (2013), *The UK Strategy for Rare Diseases,* available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/260562/UK_Strategy_for_Rare_Diseases.pdf,
[iii] European Commission (2018), *Orphan medicinal products,* available via: https://ec.europa.eu/health/human-use/orphan-medicines_en, accessed May 2018
[iv] eg see this: https://academic.oup.com/qjmed/article/107/3/241/1570371
[v] SHCA members' survey, April-May 2018
[vi] SHCA members' survey, April-May 2018
[vii] Parliamentary Question asked by Mark Tami, 17 May 2018
[viii] SHCA members' survey, April-May 2018
[ix] SHCA members' survey, April-May 2018
[x] OHE Consulting Ltd, *Comparing access to Orphan Medicinal Products (OMPs) in the United Kingdom and other European countries,* 2017
[xi] International Journal of Public Health, Orphan drug considerations in health technology assessment in eight European countries, July 2014
[xii] International Journal of Public Health, Orphan drug considerations in health technology assessment in eight European countries, July 2014
[xiii] as described in Scottish Government, Fund for new medicines doubles, 18 May 2015
[xiv] HIS / SMC, Patient and clinical engagement process; accessed 7 September 2018
[xv] Letter from Shona Robison to the Health and Sport Committee, 17 May 2018
[xvi] Genetic Alliance UK (2017), *How do we fix this mess? What is the future of access to rare disease medicines in the UK?,* available via: http://www.findacure.org.uk/wp-content/uploads/2017/12/2.-Nick-Meade.pdf, accessed July 2018
[xvii] NICE, Patient involvement programme; accessed 10 September 2018