Transparency Issues in HTA

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Definition of HTA

A multidisciplinary process using explicit and scientifically robust methods to assess value of health technology.

The process is supposed to be comparative, systematic & transparent - involving multiple stakeholders.

The purpose is to inform health policy and decision-making to promote an efficient, sustainable, equitable and high-quality health system.
HTA Dossiers Differ from Regulatory Dossiers

There are 4 important ways that clinical data in HTA dossiers can differ from the clinical data presented in regulatory dossiers; these differences need to be considered:

- Into **sequencing** of when data is put in the public domain (either by HTA agencies or through conferences or manuscripts)
- Into **decisions** as to what requested analyses can be done
- Into **harmonization** across different country settings of whether or not subpopulation and comparator choices have impacts in other settings.

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**What becomes public**

Re-analyzed data in German dossiers is public 3 months after submission. Transparency initiatives in other countries (eg Australia, Canada) could have overlapping subpopulation implications.

**Subpopulations**

HTA often requires restricting the analysis to specific subgroups (eg excluding certain concomitant medications, or including only certain comorbidities), or separating out these subpopulations – even if not prespecified in protocol. These may be country-specific.

**Choice of comparator**

HTA often requires comparisons to a therapy that may not have been tested in the trial – so use of indirect or modelled comparisons may be required. May vary by country.

**Granularity of Statistical Analysis**

The level of detail of inferential analysis required often goes beyond what the protocol has been designed to do – introducing the possibility of bias, imbalance, and Type I/II errors.
Structure of an AMNOG Dossier

Module 1: Executive Summary
- General information about the drug
- Approved indications

Module 2
- Appropriate comparative therapy
- Number of pts. with meaningful additional benefit
- Costs of therapy for the Statutory Health Insurance
- Requirement for a quality-assured application

Module 3 A-Z (per indication)
- Systematic overview regarding the medical and additional medical benefit (description of the methodology and results)
- Patient groups with meaningful additional benefit

Module 4 A-Z (per indication)
- Statistical re-analysis of RCT data
- Publicly available 3 months post CHMP

Module 5 (Attachments)
- Full text of quoted sources
- Clinical study reports
- Assessment report of the regulatory agency
- Files documenting the procurement of information
- Common technical documents (CTD 2.5, 2.7.3 and 2.7.4)
- Checklist for formal completeness

4 Dimensions – Mortality; Morbidity; QOL; Safety

English extract available in the public domain
German full report available in the public domain
Transparency Initiatives by Country

- **Canada (CADTH)**
  - "disclose all relevant information provided" – CSR, CTD, QoL, new data, ITC, …..may allow redactions similar to Australia

- **Australia (PBAC)**
  - "Standardize Redactions" in Public Summary Documents – ranges for economic/financial information, but all clinical evidence to be published except for "academic exceptions" and "patient privacy"

- **Germany (G-BA/IQWIG)**
  - Full dossiers become public with all subpopulation and subgroup analyses

- **UK (NICE)**
  - Under review

- **US (ICER)**
  - Under discussion
Why be worried?

What are our obligations with overlapping subgroups? A hypothetical example

Country A
Requires subgroup analyses split by over/under 70
(and also by race, gender....)

Country B
Requires subgroup analyses by over/under 65
(and also by race, gender....)

Country C
Requires subgroup analyses by over/under 50
(and also by race, gender....)

When all these are public....
Indigenous populations between 50-65, 65-70 are also derivable.
Are there principles we can define?

Redact?

When overlapping subgroups in different jurisdictions would yield fewer than X (X=10?) patients?

Can we align with ongoing work on data sharing in the regulatory space, and rules that have been articulated there?

How different are these discussions in the HTA space than the regulatory space?
THANK YOU