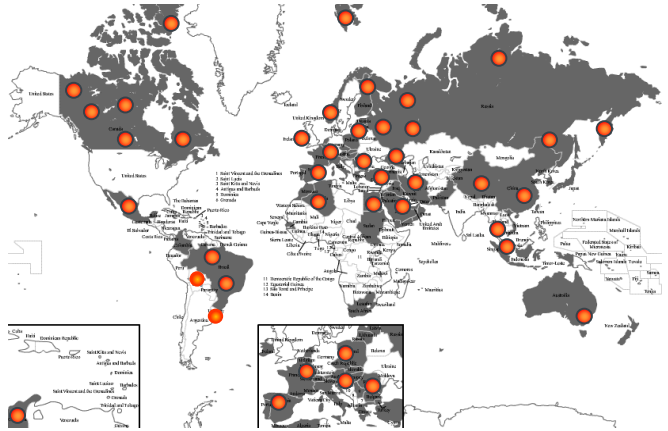
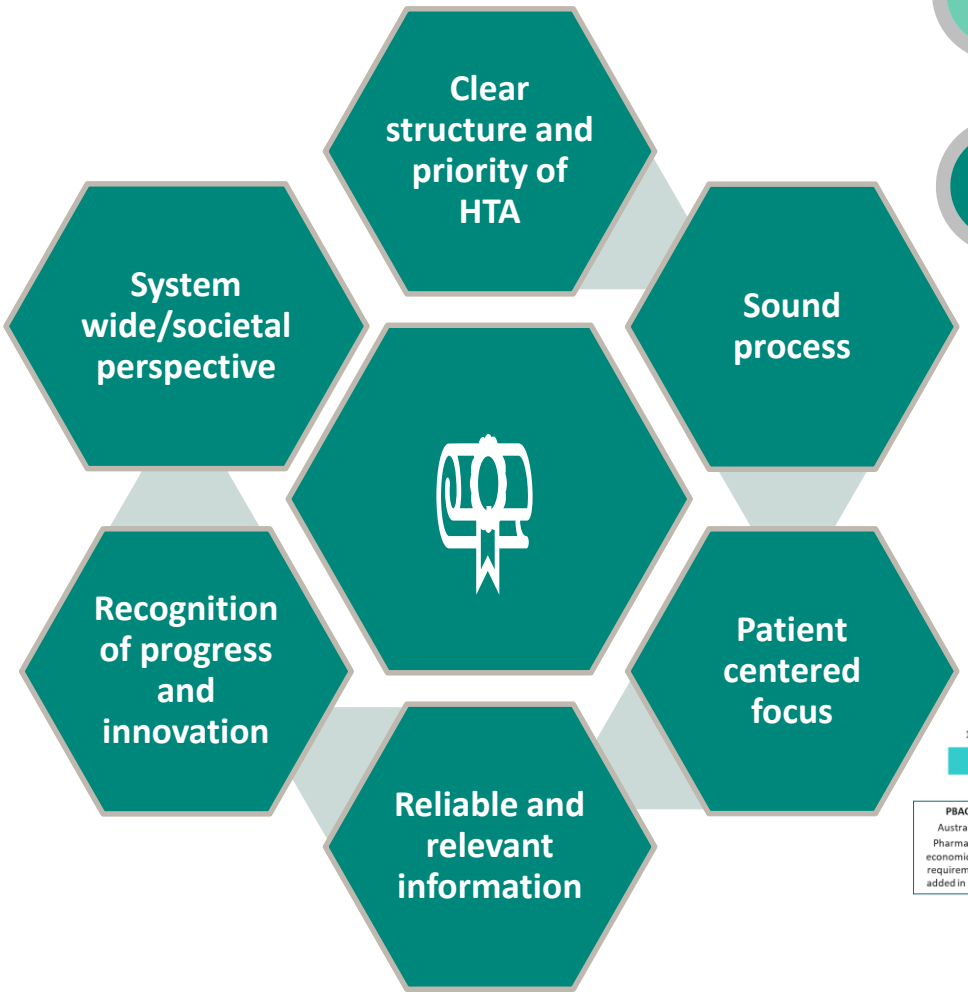
Transparency Issues in HTA

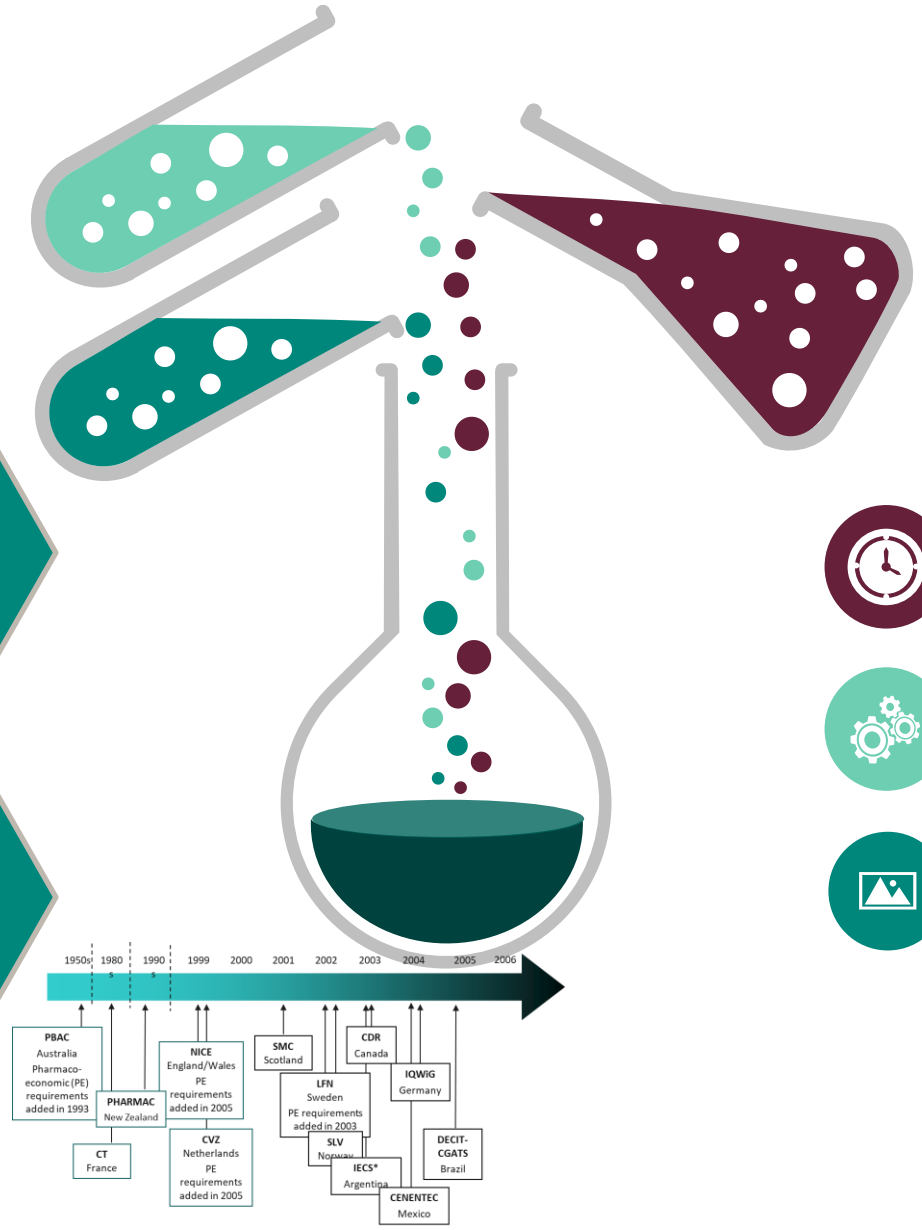
Lara J. Wolfson
Executive Director & Head HTA Statistics
Biostatistics & Research Decisions Sciences (BARDS)

30 June 2020

HTA & The Drive for Transparency







Definition of HTA

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

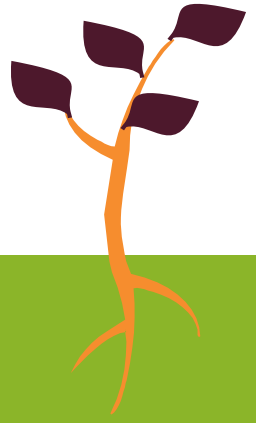
The process is supposed to be comparative, systematic **& transparent** - involving multiple stakeholders.

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.



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

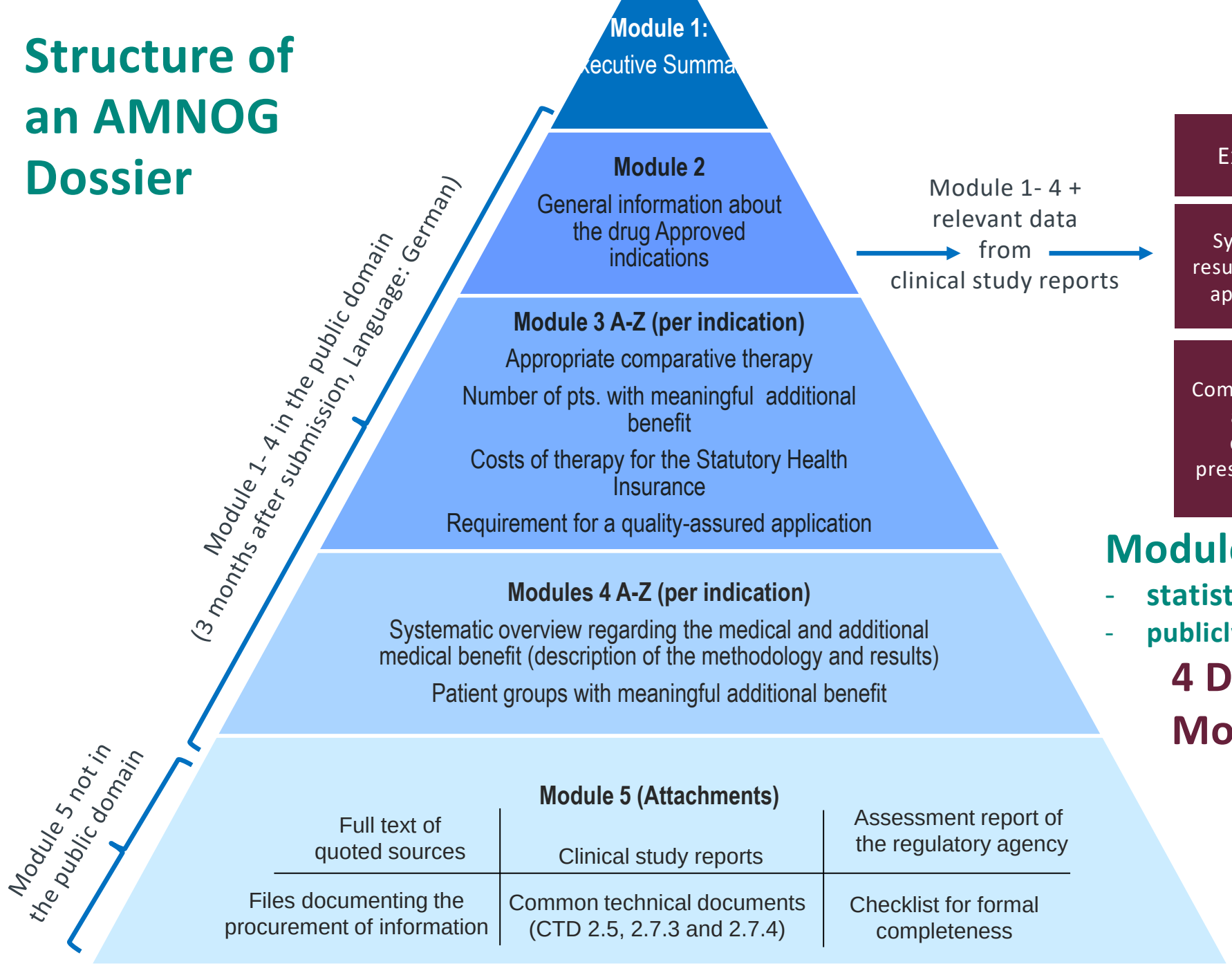
Choice of comparator

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- 4 + relevant data from clinical study reports

- Executive summary
- Systematic review from results on added benefit vs. appropriate comparator
- Comments on methodology and explanation for deviation from data presentation in the dossier

English extract available in the public domain

German full report available in the public domain

Module 4

- **statistical re-analysis of RCT data;**
- **publicly available 3 months post CHMP**

4 Dimensions – Mortality; Morbidity; QOL; Safety

Transparency Initiatives by Country

Germany (G-BA/IQWIG)

Full dossiers become public with all subpopulation and subgroup analyses

UK (NICE)

Under review-

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"

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