CRA Insights:
Life Sciences

CRA Charles River Associates

June 2014

Access to medicines for multiple sclerosis: Challenges and opportunities

Study reveals inequities in access to treatment across Europe

Overview

A recent study by Charles River Associates examines the extent to which access to multiple sclerosis (MS) treatment has changed in Europe, particularly as a number of new MS treatments have recently been launched. The study, which updates the Kobelt and Kasteng report of 2009,[1] reveals that inequities in access to disease modifying drugs (DMD) which are used to treat MS still exist across Europe, with significant variations by country and within countries. Kobelt and Kasteng (2009) found that access to MS treatment varied across Europe with a range of 6% to 58%, while CRA found a range from 13% to 69%, indicating that inequalities in access have increased. In this edition of *Insights*, we summarise the key findings, examine how access to innovative treatments for MS varies across European countries, the factors leading to this and explain how policy measures could improve access.

Key findings

- Variations exist both across countries as well as within countries at the regional level. Access in historically poorer performing areas has improved; however, access remains stronger in historically better performing regions. Overall, patients in Western European countries have better access to treatment, but there are some exceptions. For example, access is as high as 69% in Germany, but only around 21% in the UK and 13% in Poland.
- People with the most common type of MS, namely relapsing remitting MS (RRMS), generally have much better access to disease modifying drugs than other patient sub-groups. Access is also highly inequitable across Europe based on the composition of products being used. Specifically, Scandinavian countries provide better access to innovative second line treatments, whereas Eastern European countries focus more on established treatments.
- The study suggests that the primary factors influencing access to innovative treatments range from differences in diagnosis and clinical management of the disease, to the reimbursement process as well as the relative affordability of MS drugs across countries.

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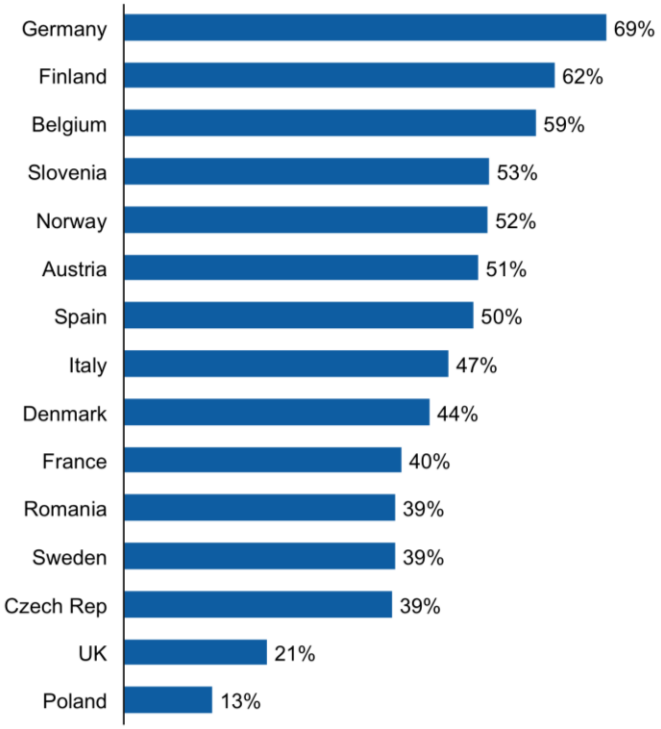
[1] Kobelt and Kasteng (2009), "Access to innovative treatments in multiple sclerosis in Europe," a report prepared for the European Federation of Pharmaceutical Industry Associations (EFPIA). Available at: http://www.comparatorreports.se/Access%20to%20MS%20treatments%20-%20October%202009.pdf. We refer to this as the "Kobelt report."

Patient access to innovative MS treatments

To understand access to innovative MS treatments, we estimated the number of patients with MS (using disease prevalence data) and compared this to those patients who are receiving treatment (i.e., patients with access to DMDs).[2]

We observed that inequalities in access to treatment have increased in Europe since 2008 with marked differences in access to DMDs between Member States (largely between Eastern and Western Europe) as well as within countries at the regional level. Whilst access to treatment in previously poor performing countries such as the UK and Eastern European countries (e.g., Romania, Czech Republic) has increased marginally since 2008, some of the best performers have increased patient access much more significantly. Whereas Kobelt found a range of 6% to 58% for the set of countries, we find a much wider range from 13% to 69% as illustrated in Figure 1, with Germany and Finland topping the chart and the UK and Poland remaining the countries where patient access to MS treatment is the lowest.

Figure 1: Proportion (%) of all MS patients receiving DMDs in 2013



Source: CRA analysis using IMS 2013, local MS societies, and the Atlas of MS 2013

Notes:

1. The Spanish MS society reports that the total MS patient population is higher (i.e., 46,000 instead of 43,000). The result of this would be to lower our access calculation to 46%.
2. According to the Swedish MS Society (SMSS) guidelines, treatment is only provided to patients suffering from relapsing remitting MS (RRMS) and not to patients with progressive forms of MS (PPMS, SPMS) since current DMDs have no or only limited proven efficacy on disease progression for these patients, which reduces the figure for the total number of patients on DMDs.

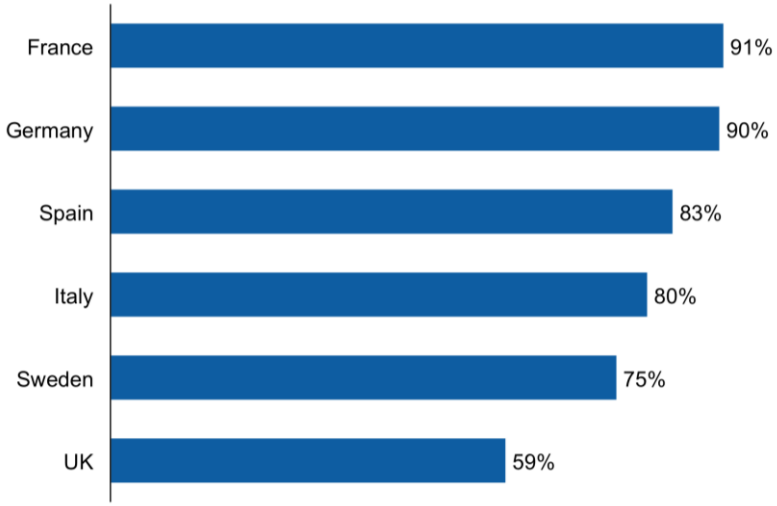
[2] In order to identify the number of patients currently on treatment, we used data on volume of medicines used in each country (using IMS reported unit sales in 2013, or using an alternative data source).

Better access for some

It is, however, important to note that the calculation of access depends critically on the definition being used. As only patients with relapsing remitting MS and secondary progressive MS (SPMS) tend to be eligible for DMDs, a better measure of access would account for the types of patient.

Whilst only limited data is available on access to DMDs for specific sub-types of MS patients, some country studies have looked at the level of access for different sub-populations. Figure 2 shows that the RRMS patients generally have much better access to DMDs than other patient sub-groups (i.e., primary-progressive multiple sclerosis (PPMS), primary relapsing multiple sclerosis (PRMS) and SPMS) with access ranging from 59% in the UK to 91% in France. This is likely to be particularly important where a country's national treatment guideline focuses on a particular MS patient sub-population such as in Sweden.[3]

Figure 2: % of RRMS patients receiving DMDs

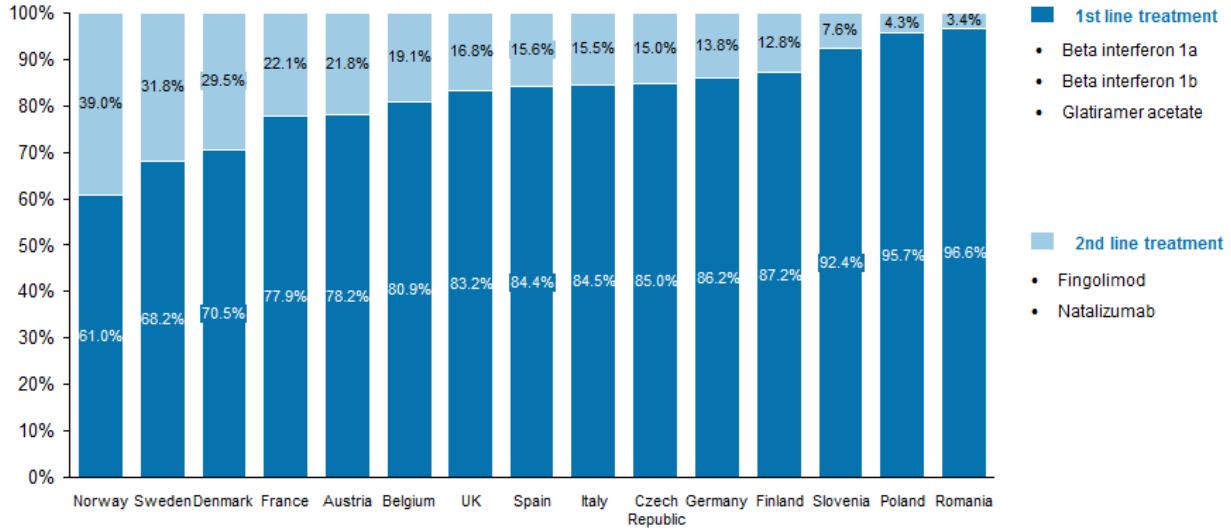


Source: CRA analysis using Datamonitor (Multiple sclerosis survey – November 2011) and CRA calculation based on IMS data for Sweden for RRMS-treated patients only.

In addition, in light of the new drugs which have been approved for treatment of multiple sclerosis since the Kobelt report, it is interesting to distinguish between the access to particular types of products. There are currently five DMDs used as first line treatments for RRMS (the key subcategory of MS requiring DMDs), of which four are interferons, and two more innovative DMDs used as second line treatment. As illustrated in Figure 3, we observe that the Scandinavian countries provide better access to innovative second line treatment than other countries in Europe (Norway 39%, Sweden 32%, Denmark 29%), whereas Eastern European countries have significantly lower proportions.

[3] According to the SMSS, approximately 75% of patients with relapsing remitting multiple sclerosis meet the criteria for therapy, as opposed to a small percentage of those with secondary progressive multiple sclerosis. As a result, Sweden has set a target of treating 75% of patients with RRMS, suggesting that high levels of access are being achieved.

Figure 3: Proportion of all MS patients receiving innovative treatments (%)



Source: CRA analysis using IMS 2013 (Austria, Belgium, Denmark, Finland, Germany, Italy, Poland, Spain, Sweden), GERS (France), Farmastat (Norway), MS National Programme (Romania), Central and Eastern European (CEE) average (Slovenia)

Determinants of access to treatment

There are a variety of potential explanatory factors that might have an influence over the reimbursement and prescription of innovative treatments for MS patients that could potentially vary across countries. These include:

- Diagnosis and clinical management of MS;
- Differences in the reimbursement process and patient eligibility for treatment;
- The affordability of MS drugs; and
- The use of patient registries or databases.

Diagnosis and clinical management

In many countries, MS remains largely misunderstood with even general practitioners admitting their knowledge is limited, which means diagnosis and clinical management of MS can vary within countries and across the continent. Several clinical management factors have a potential impact on access to treatment, including:

- Availability of qualified healthcare professionals such as specialised MS centres, availability and density of neurologists and number of specialised MS nurses; and
- Differences in clinical management of MS and the existence and impact of treatment guidelines for MS.

We found a correlation between the level of access and healthcare infrastructure, as proxied by the number of neurologists who are typically the main decision makers for a patient's MS treatment.

Reimbursement process

Despite similar Health Technology Assessments (HTA), a number of countries restrict the use of the medicines by reimbursing only certain patients who meet strict eligibility criteria. Although all first line products are reimbursed in most countries, there are restrictions imposed on the use of the medicines. These reimbursement restrictions could be another factor contributing to the following countries being amongst the lowest with access to MS DMDs—Poland is at the bottom with 13%, and Romania and Czech Republic are at 39%. In Western European markets, recent HTA decisions are relatively similar across countries. The biggest impact appears to be in the delays that these reimbursement restrictions cause to patient access.

Affordability

Access could depend on the affordability of medicines (and associated medical costs). Disease modifying drugs have become relatively more affordable in new member states largely due to an increase in healthcare spending combined with a decrease in the relative price of DMDs. However, we do find a relationship between affordability and improved access. Although affordability and a corresponding increase in access has improved over the last five years, affordability is still higher in western European markets and appears to continue to act as a barrier to access in CEE markets.

Patient registries

The data and information on MS gathered as part of this report clearly indicate that no one country provides an adequate level of data or information on MS and that the availability of data varies widely within regions and between countries. A number of countries in Europe have developed patient registries. The objective is to improve the knowledge and management of MS, and as a tool to raise awareness of MS among both clinicians and the general public. These patient registries help to collect secondary data related to patients with a specific condition and play an important role in improving the management of care, as well facilitating post marketing surveillance.

Policy implications

A number of policy changes may help reduce the variations in access, including investment in healthcare infrastructure, the development of national strategies to prioritise and streamline disease management, the use of clinical guidelines, the optimisation of budget management and reconsideration of policies that prevent prices from reflecting the income level of each market.

Reducing the variations in access within a country also has policy implications. For example, in the UK there have been calls for a neurology “tsar” to help address the variations in service provision for people with MS.[4] Requiring local payers to follow a national strategy will provide consistency in reimbursement decisions and help streamline disease management.

To read a copy of CRA’s full report, entitled “Access to medicines for multiple sclerosis: Challenges and opportunities,” click **here**.

[4] The Neurological Alliance, “Neurology tsar to be appointed,” December 19, 2012. Available at http://www.neural.org.uk/updates/217-Neurology-tsar-to-be-appointed.

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