THE HEPATITIS C TRUST RESPONSE TO NHSE SUBMISSIONS TO NICE

The Hepatitis C Trust would like to begin by making it clear that we believe that NHS England is seeking to single out people living with hepatitis C to bear the consequences of its failure to budget competently for the introduction of new drugs of which it has been aware for at least 2 years. Through a mixture of inflammatory language, factual inaccuracy and exaggeration, highlighted below, it is seeking to persuade NICE to act, in an unprecedented way, both *ultra vires* and against the evidence to the clear detriment of a patient group already very significantly disadvantaged. This is manifestly unfair and, in our view, illegal and contrary to both Government policy and the NHS constitution and we object to it in the strongest possible terms.

We would also like to reiterate what is stated in the covering letter from NHSE that 'comments from the CRG' are NOT comments from the CRG but from certain members, and that no consensus view has been reached from the clinical body because there was much disagreement regarding NHS England's approach among this stakeholder group. Anyone who has not read the covering letter will be completely misled. Indeed our CEO, who is a member of the CRG, dissociates himself completely from the comments attributed to the CRG.

The last of our general comments is that this consultation is the latest in a series of manoeuvres by NHSE that have very significantly delayed the introduction of highly effective, cost-effective new drugs that will reduce the burden of liver disease in England and significantly reduce the incidence of liver cancer. We are not aware that NHSE has ever employed such tactics before, and it is difficult to conceive of a treatment that eliminates a major cause of an untreatable cancer being delayed in this manner. Once again, patients with chronic hepatitis C are being hugely disadvantaged.

NHSE COMMENTS ON SOFOSBUVIR-LEDIPASVIR

1. However, NHS England understand that new data in specific patient groups is continuing to emerge and it would seem prudent to allow for a more extensive time period to enable NHS England to assess the emerging evidence under an evaluative process that can be managed centrally rather than dictated by statutory guidance.
Such an approach is not usually adopted because it would mean very long delays in the introduction of new technologies. Why are HCV drugs being singled out for the delays this would entail?

4. & 8. NHSE propose either watchful waiting or treatment sequencing or both. Watchful waiting assumes that the only morbidity of HCV infection is liver disease. We know from countless studies it is not. There is ample evidence of extra-hepatic impact, including psycho-social impact. Any prioritisation of patients for treatment must take account of urgent need which must be broadened far beyond fibrosis score to include such situations as:

- a woman who has unsuccessfully tried treatment and does not wish to risk maternal transmission or who has had a complicated pregnancy as a result of HCV and now wants another child but will not take the risk of those complications again
- someone with co-morbidities like cryoglobulinemia
- someone infected through the NHS
- someone who has lost their job because they revealed they have HCV or been discriminated against in other ways
- someone with debilitating symptoms (debilitating fatigue is a priority indication in the latest April 2015 European Association of the Study of the Liver HCV treatment guidelines)
- someone whose life is severely impacted by their fear of transmitting their HCV to people they love such as children
- someone who is severely burdened by stigma associated with HCV

As regards treatment sequencing, we strongly object to making patients go through an extremely unpleasant therapy first, particularly one with the risk of permanent harm (such as thyroid dysfunction), simply because it is cheaper, while denying them cost-effective treatment that is not nearly so unpleasant and seems to have no long-term risks. On that logic, is NHSE intending to reuse disposable syringes from now on and only use new ones if the old ones are too blunt or clogged to work properly? We also ask NICE to consider the legal position where someone does develop a permanent condition such as thyroid dysfunction as a result of having to do interferon before being allowed access to the new drugs. Furthermore, the long-term costs of interferon have never been quantified properly so it is far from clear that this is cost-effective as a strategy.

5. The argument that cost-effective interventions may displace *more* cost effective interventions applies across the whole of health. Why pick on people with HCV? The £20,000 QALY threshold may be too high to be affordable but that is a system-wide

argument that has no place in a TA. Furthermore holding it at that level was a key plank in the PPRS agreement with industry and is a matter for Government.

6. In answer to Question 6, NHSE again highlight issues around capacity, citing this as a continuing constraint to the offer of treatment to all eligible patients. In its response to NICE's consultation on the proposal to extend the deferred funding period for Sofosbuvir however, NHSE argued for a delay on the basis that this would allow it the time to plan efficient and properly audited care and thereby improve its capacity, meaning therefore by the end of July. Its failure to build up the expected capacity by this point should therefore not be accepted as a reason for delaying yet more technology appraisals for a range of other drugs. In any case, as NHSE states itself, the feedback from clinicians, who have the on-the-ground knowledge, contradicted NHSE and suggested the infrastructure was already in place.

NHSE CLARIFICATION

Background

NHSE appears to be asking NICE to replace STAs with a MTA. The question about whether this succession of new technologies should be addressed through a series of STAs or with a MTA was debated at each of the scoping workshops (which NHSE chose not to attend). STAs were chosen as the way forward partly to give patients access to the medicines as quickly as possible. Since this has already been decided, we think that comments on the need for a MTA by NHSE are irrelevant to what is being discussed, and to our knowledge no example exists from another disease area of a STA that is already underway being paused in order to seek a rule change midway through the process, paving the way for a MTA.

Prioritisation strategies

NHSE states, 'it is estimated that 70% of patients will not develop cirrhosis, and among the 30% who do, time to progression is 40 years on average'. As with many of the other figures included by NHS England in its response, this is not referenced and more importantly these figures are very much open to dispute. For example, a meta-analysis of published studies showed that the prevalence of cirrhosis after 20 years of infection was 16% (Thein et al Hepatology 2008;48:418-38). The prevalence after longer durations of infection is unknown but one study in elderly Pakistani men infected in early childhood showed a prevalence of cirrhosis of 71% in those infected for over 60

years (D'Souza et al.Clin Gastroenterology Hepatol 2005;3:910-17). We agree that there is uncertainty about the long-term natural history of chronic hepatitis C infection and that the lifetime risk of cirrhosis is unclear, as is the rate of progression in elderly patients. However, it is known that the disease accelerates with ageing and unreferenced, highly selective quotations are not appropriate for an organisation committed to evidence based medicine.

NHSE asks NICE to re-do its cost-effectiveness for people with F0-F2 on the grounds it will introduce a policy to treat people with F3. This is clearly an attempt to find a group of patients for whom generally cost-effective treatment is not cost-effective, a principle that could be applied throughout the system with totally unacceptable results. There will always be some patients for whom something is not cost-effective, perhaps because they have co-morbidities or are older or have genetic variants. NICE has always assured us this is not an approach it wishes to take in TAs. Are people with hepatitis C to be singled out?

Furthermore, one of the huge benefits of the new treatments is their short duration (8-12 weeks) potentially allowing the treatment of groups who may not remain in the treatment pathway for long, such as people who inject drugs (PWID) and prisoners. There is absolutely no guarantee, as NHSE implies, that watchful waiting will ever present another chance to treat them. Even patients with stable lifestyles may withdraw from follow-up after prolonged attendance at hard pressed liver clinics – and the costs of watchful waiting and the impact on patients has not been considered by NHSE.

There is no guarantee that if NICE allows NHSE to balance its budget by treating as many patients as it feels like each year , given the number of new infections and indications of the numbers it currently wants to treat, NHSE will EVER treat the majority of people with F0-F2 before they get to F3. In other words the message will be 'you are not sick enough to get treatment', apparently ignoring the principle of increased prevention in the case of hepatitis C patients in contrast to what is being applied in the rest of the NHS. It also disregards the fact that many people have extra-hepatic morbidity as outlined above in our response to NHSE's response on Sofosbuvir-Ledipasvir as well as the fact this is an infectious disease that can be cured with a short course of very tolerable treatment.

For the above reasons we believe NHSE's claim that up to 70% could be overtreated if access is determined by cost-effectiveness to be highly speculative and we urge NICE to give it very little weight.

Questions specific to the appraisals

Q1. NHSE states: 'However, if a hypothetical but unrealistic 100% of the estimated 80,000 population with confirmed chronic hepatitis C comes forward for treatment our analysis suggest budget impact up to circa £1.9 billion.' NHSE says it is unrealistic but includes it anyway. This is unnecessarily inflammatory and manipulative (it is the sort of thing you might expect from a patient organisation!).

NHSE's estimates of numbers coming forward for treatment do not seem to be based on any evidence and again, are not accompanied by references and therefore cannot be fairly challenged. We are also confused as to why NHSE has decided to use list price for new drugs but discounted prices for interferon. This is inconsistent. We are aware that industry has already discussed with NHSE the sort of discounts that would be available and we are aware that in many EU countries negotiations with the companies have led to 'volume based discounts' which ensures that if numbers presenting for treatment exceed expectations a 'price cap' reduces the overall budget impact. NHSE has well developed structures for managing the flow of patients with non-life threatening disorders and we see no reason why local prioritisation and case load management strategies can not be introduced for hepatitis C. As an aside, NHSE proposes apparently to treat everyone for 12 weeks, including who have G3 and no cirrhosis with interferon and ribavirin. This contradicts NICE's TA on these drugs.

We are extremely concerned that NHSE says it cannot afford to treat just 7,000 patients. Clearly it can afford it (it has a budget of £98 billion, 10% of which is a budget for medicines). It is simply choosing to spend it elsewhere so that the quoted £285million exceeds whatever amount it has arbitrarily decided to allocate to hepatitis C. NICE with its cost-effective approach is designed precisely to prevent this entirely arbitrary type of resource allocation. According to the latest IMS data, a spend of £285 million would rank 20th in drug spend by disease area; even a spend of £518 million, NHSE's estimate for treating 20,000, would only rank hepatitis C 9th, so why is hepatitis C being singled out as exceptionally expensive and exceptional rationing being proposed? Furthermore, throughout the discussion from NHSE there has been no mention of the cost savings that will accrue to the NHS from reduced rates of liver cancer, reduced presentations with

decompensated cirrhosis and, ultimately, the cost savings from preventing hepatitis C transmission, reflecting NHSE's desire to base decisions entirely on their current year budget, an extraordinarily short-sighted way of running a health system that we urge NICE to reject.

Q2. NHSE says it has not budgeted for these new drugs because the budget was set in December 2014. We are aware that clinicians met NHSE representatives in December 2013 to outline the issues around the new drugs and the ballpark costs have been have been known since the beginning of 2014 so NHSE have had ample warning. Could someone please explain to us patients how this is not gross negligence on the part of NHSE and why we should be chosen to make the sacrifice for this abject failure of planning?

NHSE says that to fund the new drugs it would have to make reductions elsewhere (even though NHSE says it would be inappropriate to say where). If there is an overspend, reductions should be shared equally between disease areas, not concentrated purely on hepatitis C patients. This brings us to the crux of what is unfair about NHSE's approach with regards to hepatitis C treatment. Drug expenditure is, inevitably, fluid. Older drugs become cheaper with time and, as patents expire and generics become available, prices fall dramatically. These discounts are offset by new innovative drugs that are, initially, expensive. We are aware of a number of drugs (particularly in the HIV and HBV field) where expiry of patents will lead to significant price reductions in the foreseeable future – why is NHSE moving the cost savings to other disease areas and not providing therapy for patients with hepatitis C? This also disregards the PPRS, which is supposed to allow for innovative new treatments to be provided through the NHS.

NHSE says: 'Table 1 shows the health forgone from activities that are likely to be displaced in the NHS from funding the new hepatitis C treatments assuming a budget impact from those products of £300 million and £700 million using the opportunity cost calculator.' Despite the caveat that this is for illustrative purposes only and will not necessarily happen, the implication of the words 'likely to be displaced' is that if people with hepatitis C are given cost-effective drugs, we will be responsible for between 1,500 and 3,500 deaths. This is absolutely outrageous. I cannot describe how disgusted we are by this. Thank you, NHSE, for providing the detail of just who we will be killing. Perhaps NHSE would like to spell this out in a patient leaflet to go with the drugs so patients can be reminded every day just who they are killing by taking cost-effective drugs. *Any* displacement could be considered in this light. Has this ever been done before? Have cancer patients been told how many people they

may be killing? Not only is NHSE trying to make a special case of people with hepatitis C, it is using very special tactics to do so. Just suppose this had been done with the cancer drugs fund …

By implication NHSE is suggesting that NICE too may be responsible for these deaths if it does not allow NHSE to ration the new drugs. We consider this to be an attempt to put wholly unacceptable pressure on an independent organisation and we hope that NICE will censure this publicly on June 23rd and discuss this with Ministers. It is particularly unacceptable because it is an attempt by NHSE to shift the blame for its failure to budget properly.

Q3. NHSE says: 'NICE recently issued guidance which stated that 'If there is more than one NICE-approved medicine for the condition, providers and commissioners must not recommend that any one of them is used **routinely** in preference to the others (unless an order of preference is stated in the TAs or HSTs). Similarly, they must not recommend that a medicine that has not been assessed by NICE is used **routinely** in preference to a NICE-approved medicine.' By issuing STAs for the different treatments that are available NICE is effectively forcing NHS England down a treatment line which may not be in the best interest of patients or the NHS as a whole.' We cannot comment on this because we are unable to understand the point.

Q4. NHSE has chosen to take the upper figure of £772 million to illustrate that it cannot afford NICE to issue TAs in the normal way. Leaving aside the incomprehensible failure to budget for hepatitis C drugs and questionable costing, this is still a major exaggeration. This is predicated on 32,000 being treated, when NHSE says that only 28,500 in total are in touch with services and that 20,000 is beyond the current capacity. Indeed we estimate that 15,000 is about the current capacity, based on a capacity to date of around 5,000 for IFN/Ribavirin treatment with an average treatment duration of say 36 weeks (half G3 at 24 weeks and half G1 at 48 weeks) compared to 12 weeks for the new treatments, allowing for the added time for working up new initiates to treatment. Since much of this capacity is staff and clinic space, the ability to increase this in the short term is limited and we do not believe NICE would expect NHSE to go to extraordinary lengths to increase capacity in the short term. We are also convinced from surveying our constituency that most patients are prepared to wait if there are real capacity issues (for a reasonable time), whereas they absolutely do not think they should have to wait for cost-effective drugs purely because NHSE says it cannot find the money.

Questions not specific to hepatitis C

Qs 5-7. NHSE is asking NICE to consider 'affordability'. Changing the healthcare system in this way may indeed be necessary but this is something to be decided by Government, ideally after significant public debate, not in the middle of three TAs. NHSE admits in an internal document on managing the introduction of the new hepatitis C drugs that NICE can only consider cost-effectiveness and not affordability and is therefore knowingly asking NICE to act *ultra vires*.

What NHSE appears to want is that at some threshold (£70 million is suggested by NHSE with absolutely no evidence or justification) NICE will hand over to NHSE the decision as to who to treat and with what. Certainly that is what NHSE is asking for here for people with hepatitis C. The problem with that approach is that it is arbitrary, non-transparent and in the hands of unelected people. What is affordable in a given disease area will depend on what budget is allocated to that area. How will that be decided? How will the most disadvantaged fare? NHSE says it cannot afford to treat 7,000 people with hepatitis C this year. Next year how many will be affordable or will it be 2,000?

There is a particular statement we find extremely sinister stating: '*This is of particular concern if this is done without a public debate not only about the benefits of the treatment recommended and the needs of that patient population but also about the benefits of other treatments and needs of other patients.'* This suggests NICE would like to see the public debate whether people with hepatitis C are worthy of treatment or whether the money should go elsewhere. The whole point of NICE is that it operates an evidence-based system that is fair and transparent and therefore allows access to cost-effective drugs for disadvantaged groups, irrespective of how popular they are with the public.

CONCLUSION

To abandon people with hepatitis C in the undoubtedly worthy cause of trying to help NHSE with the financial problem it faces as a result of its failure to budget properly for completely foreseeable costs would, we consider, be both *ultra vires* and perverse and we urge the committee to withstand the unprecedented pressure being applied.