

Solving the challenge of combination treatments: Competition law roundtable on access to combination treatments in the UK

Wednesday 10 November 2021, 13:00 – 15:00, held virtually (MS Teams)

Meeting report

Introduction

This report provides a summary of a competition law roundtable on solving the challenge of access to combination treatments in the UK. The event was co-hosted by Takeda UK Ltd. and the Ethical Medicines Industry Group (EMIG) and took place on Wednesday 10 November 2021.

All of the perspectives captured within this report have been anonymised and attendance at the roundtable does not indicate endorsement of Takeda's proposed solution.

Those in attendance at the roundtable have been given the opportunity to comment on this report.

Attendee list

The following individuals and organisations were present during the meeting:

Participants

- Victoria Barrett, Head of HTA and Market Access Policy (ABPI)
- Farasat Bokhari, Associate Professor in the School of Economics and Centre for Competition Policy (University of East Anglia) – partial attendance (last 25 minutes)
- Carla Deakin, Programme Director, Commercial & Managed Access (NICE). Observer
- Tamsin Hall, Legal Counsel (Amgen)
- Chris Henshall, Independent consultant in health, research and innovation policy
- Stijn Huijts, Partner (Geradin Partners)
- Professor Carole Longson, Life Science Adviser (NICE). Observer
- Eric Low, Independent Consultant and Chair of Takeda UK's Combination Treatments Advisory Group
- Anna Mitchell, Partner, Global Antitrust & Foreign Investment Group (Linklaters)*
- Helen Robertson, Legal Director (Janssen UK)

Speakers

- Leslie Galloway, Chairman (EMIG)
- Chris Pike [Chair], former Competition Expert (Organisation for Economic Co-operation and Development (OECD))
- Andrew Taylor, Partner (Aldwych Partners)

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- Susan O'Reilly, Head of Legal UK and Ireland (Takeda)
- Tanja Podkonjak, Director of EUCAN Oncology Access and Reimbursement Policy (Takeda)
- Emma Roffe, Oncology Country Head – UK & Ireland (Takeda)

- Danielle Smith, Head of Professional Relations and Patient Advocacy (Takeda)
- Helen Taylor, Programme Realisation Manager (Takeda)
- Jacob Westin, Head of Legal Nordic & Europe / Canada Region Competition Law Specialist (Takeda)

* Anna Mitchell was on maternity leave at the time this report was drafted and has not had the opportunity to provide comment as a result.

The roundtable report has also been shared with the following representatives who were unable to attend the meeting:

- Professor Eyad Maher Dabbah, Chair of Competition Law and Policy and Director of the Institute for Competition and Consumers (ICC) (Queen Mary University of London)
- Professor Sean Ennis, Director of the Centre for Competition Policy and Professor of Competition Policy at Norwich Business School (University of East Anglia)
- Dr Anthony Hatswell, Director (Delta Hat Limited)

Purpose

The purpose of the roundtable was to consider combination treatment access challenges and to solicit feedback on a proposed solution developed by Takeda UK in collaboration with external stakeholders from academic, clinical, legal and patient communities. To ensure the discussion represented and reflected a range of perspectives, participants included experts on competition law and health technology assessment (HTA), covering academia, legal firms, pharmaceutical companies, trade associations, and the National Institute for Health and Care Excellence (NICE).

The roundtable covered the following:

- An overview of the challenges posed by combination treatments in the context of the current NICE and NHS England (NHSE) methods and process as well existing competition law hurdles
- An overview of the Takeda solution, namely the components described in the [Voluntary Arbitration Framework for Combination Therapies](#) whitepaper, including how the solution was developed
- A facilitated discussion to solicit specific feedback, with a predominant focus on the Voluntary Arbitration Framework
- Summary of discussion and next steps

Takeda's approach to developing the solution and its components are contained within the two Whitepapers: [An Attribution of Value Framework for Combination Therapies](#) and the [Voluntary Arbitration Framework for Combination Therapies](#) which can be accessed on the Takeda UK website via the embedded hyperlinks above.

Summary of the key discussion points

The following are the key discussion points from the roundtable and further details around the discussions can be found later in the report.

- Until the challenges associated with access to combination treatments are addressed, patients may be unable to benefit from them due to delays in access or no access at all. It is therefore important that all relevant stakeholders come together to find transactable and implementable solution(s) (*see chapter 1*)
- Takeda's proposed solution is made up of two component 'Frameworks' that are intended to be used together
 - i. the Value Attribution Framework (to attribute value to each component treatment in a combination)
 - ii. the Voluntary Arbitration Framework (to ensure compliance of inter-company dialogue with competition law) (to propose a framework in which companies may feel comfortable to engage with each other directly)
- The presenters emphasised that Takeda's proposed solution is just one of several solutions being developed by industry and other stakeholders, but all progress on this important topic is welcomed to develop a tapestry of solutions. Takeda is not the only organisation exploring solutions and work is underway to generate alternative and complementary solutions. For example, the ABPI is currently in discussions with the Competition and Markets Authority (CMA) about their own potential solution (*see chapter 2*)
- Whilst participants were not asked to endorse Takeda's proposed solution, participants present commented that it was an extremely well researched and designed proposal that conceptually addresses all of the known challenges that are preventing access to combination treatments. It was added that the Voluntary Arbitration Framework Whitepaper presented a thorough assessment of all of the challenges that have to be considered in the development of a solution and as such the document provides significant value to the wider debate on enabling access to combination treatments (*see chapter 3*)
- The group discussed whether the 'public interest' test – where an anticompetitive agreement is permissible if the beneficial effects of the agreement outweigh the adverse effects arising from a loss of competition – and its potential applicability to concerns around direct negotiations between manufacturers - could be applied in order to allow direct negotiations between manufacturers. It was suggested that whilst some information sharing was an 'objective necessity' to enable access to combination treatments, the 'public interest' test would not apply in every circumstance and determining the extent of both beneficial and adverse effects could be time consuming and burdensome as each case would need to be evaluated individually. Therefore the group saw a benefit to an established, approved framework which addressed competition requirements minimises competition risk without the need for this assessment in each case (*see chapter 3*)
- Questions were asked about the complexity of the proposed solution and whether simpler alternatives could be considered. It was noted that with any solution there is a careful balance that needs to be struck between the benefits that patients get from combination treatments against the potential costs to competition perceived competition risks of information sharing, and determining this balance can be challenging and resource intensive. Therefore, the Takeda solution was designed to be a standard operating procedure that is applicable in every scenario, including for risk-averse participants, and provide certainty of compliance with competition law a way forwards that is acceptable to manufacturers and their internal processes (*see chapter 3*)
- The group queried the level of incentives in the proposed process to encourage manufacturer participation in the solution, particularly the backbone manufacturer. It was noted that a range of incentives and requirements to participate have been incorporated into the solution, such as proposals on non-uniform pricing, mandatory long-term participation through an agreement such as the 'Voluntary scheme for branded medicines pricing and

access' and the prospect of increased revenue through the expanded use of the backbone treatment (see chapter 3)

- The group discussed the relevance of non-uniform pricing, and there was general consensus that this was a fundamental requirement for any proposed solution (see chapter 3)
- Questions were raised about the role of and criteria for the Arbitrator, including who could fulfil the role and whether an Arbitrator was always necessary. It was discussed that an Arbitrator might not always need to be present during negotiations, although this requires further consideration. The group suggested that an Arbitrator would need relevant knowledge of HTA processes and competition law but would not need to be an expert in these fields to effectively carry out the role as their main objective is to help the parties to reach an agreement (see chapter 3)
- The concept of 'clean teams' was discussed, and participants discussed whether internal or external clean teams would be appropriate for inter-company dialogue. There were a variety of perspectives on this issue from the group and there was consensus that the makeup of clean teams would likely need to reflect the specific circumstances of the negotiation and that a set of criteria should be developed and externally validated to govern the selection of clean teams. These criteria could be reviewed on a case-by-case basis by pharmaceutical companies to decide on the appropriate type of clean team required (see chapter 3)
- The risk of foreclosure emerging from the implementation of the solution was raised if the agreement of a commercial deal between manufacturers could impede new market entrants. Some thought that this risk is unlikely due to the incentives that exist to encourage the backbone treatment manufacturer to participate. Moreover, it was further countered that the current situation facing combination treatments is a form of market failure and not having a solution that enables new treatments to enter the market is a bigger challenge than the risk of foreclosure (see chapter 3)
- Participants sought clarity on the application and extent of the remit of the solution, and whether it should apply to all combination treatments. It was advised that the Framework is targeted at combinations that are likely to be not cost-effective at zero or near to zero price (see chapter 3)

Detailed report of the roundtable

1. The challenges posed by combination treatments: a presentation by Helen Taylor (Takeda) and Andrew Taylor (Aldwych Partners)

To introduce the roundtable, Helen Taylor (Takeda) and Andrew Taylor (Aldwych Partners) presented an overview of combination treatments, the challenges they present to the system, the HTA environment in England, and the competition law considerations underpinning the challenge. The views expressed below are those of Helen Taylor and Andrew Taylor, and not necessarily representative of all participants.

Background to the combination treatments challenge

- Combination treatments are becoming increasingly common as the understanding of complex diseases increases, and there is acknowledgement that they can often lead to improved patient outcomes, survival, and quality of life
- They are currently most common in oncology, although increasingly this is becoming an approach that is being employed in other disease areas

- Delivering patient access to these treatments presents a challenge to HTA systems as combination treatments can often face cost-effectiveness barriers even if the new add-on treatment were to be given away at zero price
- There is consensus within key stakeholder groups, nationally and internationally, that solutions for accessing combination treatments need to be quickly found for the benefit of patients, now and in the future
- This challenge is not new and was identified by NICE's Decision Support Unit (DSU) in 2014. Since this report, work to assess the challenges presented by combination treatments has accelerated although no solutions have been agreed
- Without a solution, patients may be unable to benefit from the potential of combination treatments if they continue to face cost-effectiveness challenges

An introduction to combination treatments

- Combination treatments combine two or more individual treatments, comprised of a backbone treatment and an add-on treatment. A backbone treatment can be a single treatment or an existing combination
 - The backbone treatment, which is already recommended and available to patients, tends to be the existing standard of care
 - The add-on treatment is added to the existing backbone to form the combination. The add-on manufacturer is responsible for trialling and launching the combination (*see more detail below in chapter 2*)
- The backbone and add-on treatments are often produced by different manufacturers, so compliant collaboration is essential to ensure patients benefit from combination treatments
- The benefit of a combination treatment is that it can extend and/or improve the lives of patients compared with the backbone treatment / standard of care alone. However, even before the cost of the add-on treatment is considered, the longer duration of use of the backbone treatment can increase the cost of the combination treatment to the healthcare system and exceed the cost-effectiveness threshold

Overview of health technology assessment

- In England, new treatments go through a process called health technology assessment in order to be recommended for use on the NHS
- This process is overseen by NICE. NICE is the independent executive non-departmental public body of the Department of Health and Social Care (DHSC) that is responsible for issuing recommendations on the use of medicines and treatments within the NHS in England. It does this by considering the clinical and cost-effectiveness of medicines to ensure their use represents a good use of public money
- For a medicine to be approved, NICE uses a cost-effectiveness threshold of £20-£30k and it must be assured that a medicine is within or below this threshold before it can issue a positive recommendation
- If NICE does recommend a treatment, responsibility for funding it falls to NHSE, another executive non-departmental public body of DHSC, and they are legally obliged to provide funding within three months or earlier. For cancer medicines, funding is made available from the point of a positive NICE Final Appraisal Determination (FAD)
- Whilst NICE is independently responsible for arriving at a decision on a medicine's cost-effectiveness, NHSE (as the payer) is often involved in commercial discussions with manufacturers during the NICE appraisal process. Any discount agreed as part of the

appraisal process remains confidential and is not disclosed to the public, if it remains simple in nature

- In the case of a combination treatment, it is the responsibility of the add-on manufacturer to take the medicine to NICE and have commercial discussions with NHSE. The manufacturer of the backbone treatment is not required to re-negotiate their price nor are they a part of the add-on manufacturer's commercial discussions
- As a result, under the current system, it can be extremely challenging to secure a positive recommendation for a combination treatment as the expectation is placed solely on one manufacturer to provide a discount, with no knowledge of the confidential discount already applicable to the backbone treatment
- This challenge is compounded by the existing approach taken by NHSE which does not normally allow blended pricing or pricing by indication (as set out in its 2021 Commercial Framework). In other words, any discount offered to NHSE must apply across every indication it is used in, either as part of a combination or as a monotherapy. This can make offering significant discounts unviable
- A solution that compliantly brings all manufacturers associated with a combination treatment to the table to discuss pricing specifically for the medicines in combination is therefore required

Existing competition law hurdles

- As part of any solution that involves inter-company discussions, it will be critical that mechanisms are introduced that ensure all interactions between companies are not in breach of competition law are lawful. At present, there are three competition law-related considerations that need to be taken into account:
 - Firstly, it was considered that under existing competition law, manufacturers may be unable to agree prices for treatments used in combination as this may also fix the price of the treatments when used as monotherapies (often the components of combination therapies are also used as monotherapies). These alternative uses may also be in competition with each other. Allowing combination specific non-uniform pricing therefore seems critical if manufacturers are negotiating the prices for treatments when used in combination
 - Secondly, competition law prohibits the exchange of pricing or other sensitive commercial information that could impact competition between the manufacturers when supplying their treatments as monotherapies
 - Thirdly, over and above mandatory compliance with competition law, different manufacturers have further layers of internal processes and compliance requirements, which may be set at local, regional and international levels, that also need to be considered

2. Takeda's approach to finding a solution: a presentation by Tanja Podkonjak (Takeda)

Tanja Podkonjak (Takeda) provided attendees with the background to Takeda's proposed solution, including the multi-stakeholder work that has underpinned its development, and the rationale behind Takeda's approach and philosophy. Tanja also provided a brief overview of the proposed solution in preparation for the group discussion.

During her presentation, Tanja Podkonjak highlighted the following:

- Takeda has been looking into the challenges posed by combination treatments since 2016 and held a Parliamentary roundtable to explore this issue in detail. However, the issue was first described by NICE's DSU in 2014. Since then, international consensus has emerged that a fair, implementable and transactable solution needs to be found – as shown in concurrent work being developed by other interested parties
- Despite there being international interest, no known attempts had been made to have succeeded in fully solving the problem. Consequently, Takeda sought to develop its own solution, with input and advice from an Advisory Group of experts from legal, economic, academic, patient and clinical communities. This work culminated in the development of two Whitepapers setting out a proposed solution for improving access to combination treatments – the two distinct Frameworks that make up the solution are intended to be used together:

1. An Attribution of Value Framework for Combination Therapies

The Value Attribution Framework proposes an economic methodology that aims to define a fair division of value across the treatments in a combination by assigning a relative value to each treatment based on the health benefit. It takes into consideration health-economics methods used by NICE in making decisions about access to new treatments.

2. Voluntary Arbitration Framework for Combination Therapies

The Voluntary Arbitration Framework proposes a standard operating procedure to support compliant dialogue and agreement between pharmaceutical companies on the value attributed to each treatment within a combination. It takes into consideration competition law and current NICE/NHSE methods and processes in making decisions on access to new treatments.

- The two Frameworks were developed based on a series of key requirements that the Advisory Group identified, which a solution must satisfy. These were:
 - Deliver improved patient access to combination treatments
 - Be compatible with the existing NHSE commercial framework and NICE methods and processes
 - Adhere to existing cost-effectiveness thresholds
 - Address competition law constraints
 - Encourage manufacturers to work together
- For the purpose of this discussion and relevance to the expertise of the participants, only the Voluntary Arbitration Framework was presented in detail

- The Voluntary Arbitration Framework was developed in line with the current NICE STA process and consists of the following four elements:
 - 'Clean teams'
 - Non-uniform pricing
 - A long-term commitment to participate
 - The option of Arbitrator oversight
- The solution has been developed in accordance with current NICE methods and processes and is intended to be flexible enough to adapt to any future changes to NICE or NHSE processes (e.g. the new NHSE Commercial Framework and potential changes adopted through the NICE methods and processes review ongoing updates to NICE's methods and processes and the evolution of NHSE's Commercial Framework).
- Takeda is not the only organisation exploring solutions and work is underway to generate alternative and complementary solutions. For example, the ABPI is currently in discussions with the Competition and Markets Authority (CMA) about their own potential solution to enable direct company dialogue

Further detail on the background, rationale and development of Takeda's proposed solution can be found in the [An Attribution of Value Framework for Combination Therapies](#) and the [Voluntary Arbitration Framework for Combination Therapies](#).

3. Refining the proposals and gathering feedback: group discussion

After listening to the presentation on Takeda’s approach to developing a solution and the key elements that comprise it, the Chair invited Susan O’Reilly (Takeda) to open the discussion to attendees. Specifically, she asked attendees to provide their high-level feedback on the solution before inviting comment on the specific principles and concepts underpinning the solution.

Overall, participants welcomed Takeda’s commitment to driving the agenda by putting forward a potential solution. In particular, there was general consensus that Takeda’s approach to interrogating the challenge before building a solution was highly commendable. Consequently, it was noted that Takeda’s solution, conceptually, is comprehensive and has struck the right balance between being published in a timely manner and being robust. It therefore provides significant value to the wider debate on enabling access to combination treatments.

With a view to strengthening and finalising the solution, participants posed a series of questions and challenges including suggestions on how the solution could be developed further. Takeda colleagues provided answers and responses and noted that they are committed to a solution being found, irrespective of where it comes from, and open to working collaboratively with all relevant stakeholders to do so. The questions and challenges can be broadly split into the following themes:

Benefits of collaboration outweighing restrictions to competition

- A discussion was held on the applicability of the ‘public interest’ test for combination treatments, which might apply where the benefit to patients of access could outweigh any likely harm that would arise from a loss of competition. The ‘public interest’ test in competition law covers both “exemption criteria” and the “objective necessity test”, each of which could have the result that a restriction on competition would not be unlawful. It was noted that this is an existing consideration that can be applied by the CMA when investigating potential anti-competitive behaviour; this could mean that some aspects of Takeda’s solution are not required (for example, clean teams). It was noted that this concept might specifically apply when the add-on treatment and the backbone are complementary and not in competition
 - Takeda’s solution does not include consideration of the ‘public interest’ test as it was judged that the applicability of the ‘public interest’ test for each combination treatment will be different depending on the scenario. It was also noted that it would be the responsibility of manufacturers to ensure that they self-assess the validity of this exemption. The challenge with relying on this approach is that, in order to allow all manufacturers to conclude that it is safe to directly collaborate without risk of breaching competition law, an assessment of the competition and the patient benefit issues would have to be taken prior to each negotiation in each indication and treatment

The complexity of the process

- Participants welcomed the robustness of the solution, although some queried whether it might be overly complex to implement for every combination treatment appraisal. It was questioned whether there might be circumstances where a simpler process could be adopted whilst achieving the same outcome (for example, when the backbone treatment and the add-on treatment are complementary and not in competition)

- Prior to developing its solution, Takeda undertook a deep dive into the challenges and hurdles hindering the approval of combination treatments
- It was added, in certain cases where the risk of an anti-competitive outcome is minimal (e.g. when component medicines are not in competition), that aspects of Takeda's solution might not be required. However, it was cautioned that, even in this situation there remains a risk of anti-competitive behaviour as the manufacturers are likely to be in competition in future, or in other indications or disease areas. Takeda's solution is able to mitigate this risk, even where the risks might appear to be less pronounced
- There was a discussion on whether the competition law hurdles could be avoided altogether through joint ventures or the creation of a 'true' combination (bringing together the components of the combination together into a single product)
 - It was noted that this solution is not feasible for combination treatments as the problem is most acute when two or more branded (on patent) medicines, that are produced by different manufacturers, are involved
 - Moreover, it was argued that the development timelines of the components that make up a combination are often not aligned. In other words, when the backbone therapy is launched it is intended to be used as a monotherapy; it will only become used as part of a combination over time when other manufactures develop complementary add-on products. These add-ons are then specifically trialled in combination with the backbone versus the backbone on its own. Because the backbone is already sold as a monotherapy, it is not possible for the add-on manufacturer to acquire the product to produce a 'true' combination
- A question was also posed as to whether the UK could look to learn from the approach taken to medicines pricing in other European markets. In particular, it was noted that the NHS is a 'price taker' (where manufacturers set prices and NHSE / NICE then decide whether to take it at that price) whilst in other countries the payer is a 'price maker' (where the system evaluates the clinical effectiveness of medicines and then determines what price it is willing to pay). Consequently, it was considered whether the NHSE and NICE, by changing its traditional approach, could adopt a form of value attribution methodology to split the overall costs of a treatment into prices for each component, and therefore avoid the need for the full arbitration process to be applied
 - Takeda's proposed solution has been designed to fit within and alongside existing NICE and NHSE methods and processes and consequently any proposals which would require a significant change in approach from the system, such as a change in methodology or willingness to pay thresholds, were not seen as viable. In the UK, there is consensus that this challenge is one for industry to solve and not the responsibility of NICE or NHSE. This has also been agreed at an international level amongst other HTA bodies

The incentive for manufacturers to participate in the process

- The group also raised a query about whether there were sufficient incentives for manufacturers to be involved in the process, given the expectation that they would have to provide a discount and would need to resource the formation of a clean team
 - Takeda responded by outlining the mechanisms that have been proposed as part of the solution, which are designed to encourage but also mandate participation in the process. This is comprised of five elements:

1. The Voluntary Arbitration Whitepaper introduces the concept of manufacturers being both 'drivers' and 'passengers'. Whilst it is likely that the backbone manufacturer (the passenger) may 'lose out', while the add-on manufacturer (the driver) may stand to 'gain', it is likely that a manufacturer will perform both roles over the longer-term. This is because combination treatments are becoming increasingly common, and a manufacturer will likely have both backbone and add-on treatments in its portfolio and pipeline. There is therefore an incentive to cooperate when you are the passenger as you will require cooperation in future when acting as a driver
2. The Whitepaper also proposes including the solution within future 'Voluntary scheme for branded medicines pricing and access' agreements between industry and government. These five-year schemes include a series of expectations and commitments governing both industry and the healthcare system. By incorporating the solution into the voluntary scheme agreement, manufacturers that sign up to the scheme would also be committing to the solution. This would make participation in the solution mandatory for all scheme signatories
3. Whilst participation would be mandatory, the outcome of the solution would remain voluntary, as with existing commercial negotiations and NICE processes. Incorporating an ability to withdraw from negotiations, and as such the outcome of the solution, is necessary to secure widespread industry buy-in into the proposals
4. The use of non-uniform pricing provides manufacturers with the confidence that any discounts they provide will only apply when the product is used specifically as part of the combination, meaning that the price of the product in other indications is protected
5. Finally, as the backbone manufacturer, by actively participating in the process, there is an improved prospect that the approval of the combination will extend and/or expand the use of their product, meaning there is the opportunity for increased revenue

The importance of non-uniform pricing

- There was broad consensus among those who were present, from a competition law perspective, on the importance of enabling non-uniform pricing for combination treatments to avoid the unintentional manipulation or fixing of treatment prices when used in other indications or diseases, which can undermine competition. It was noted that, regardless of the design of the ultimate solution adopted, non-uniform pricing must feature
- With this in mind, a question was posed as to whether the agreement of non-uniform pricing in isolation was sufficient to overcome the combination treatment challenge. This is because the add-on manufacturer would be allowed to provide a confidential discount on its treatment that would be capable of achieving cost-effectiveness for the entire combination
 - Takeda noted that non-uniform pricing in isolation would be unlikely to overcome the non-competition law-related challenges that are associated with combination treatments. This is because the onus would fall solely to the add-on manufacturer to provide a discount, even if it could be demonstrated that the add-on delivers significant value as part of the combination, as there would be no requirement for the backbone manufacturer to re-negotiate. This is particularly challenging given that the costs of researching, developing and trialling the combination fall to the add-on manufacturer

- In addition, NICE's DSU paper from 2014 makes clear that it is possible for a combination to not be cost-effective, even if the add-on treatment is given away for zero price. As such, it is not necessarily the case that unilateral action could overcome the cost-effectiveness challenge

The criteria for determining the Arbitrator

- The group discussed the Arbitrator concept and queried who could fulfil the role of the Arbitrator and what expertise they would need. During this conversation, it was mooted whether an existing, rather than new, organisation could fulfil the Arbitrator role, with the ABPI proposed as a possible contender
 - The group discussed that the Arbitrator would need to be responsible for delivering on two objectives: ensuring the negotiations remained compliant from a competition perspective and enabling the attainment of a positive agreement between the manufacturers involved. As such, it was suggested that the Arbitrator would need to have knowledge of competition law and HTA processes and be seen as independent
 - In response to the suggestion of the ABPI being the Arbitrator, the Switzerland experience was highlighted whereby the Swiss trade association had piloted fulfilling a similar role. It was commented that in Switzerland this had failed to work optimally due to the scalability of this approach. It was also questioned whether an industry association could legitimately fulfil an independent role
 - Takeda committed to further exploring the requirements of the Arbitrator

The role of the Arbitrator

- Participants questioned whether an Arbitrator was always necessary, or at least if they always needed to be present during clean team negotiations, particularly if the risk of a competition law breach was determined to be minimal. Instead, a proposal was suggested whereby a code of practice could be agreed across industry, governing the behaviour of clean teams, with a mechanism for escalation to an Arbitrator included if required
 - In response, Takeda noted that the arbitrator concept had been designed based on the Prescription Medicines Code Of Practice Authority (PMCPA) model whereby industry is responsible for self-regulating its conduct. The PMCPA model begins with inter-company dialogue and only goes to the independent body for arbitration if the inter-company dialogue breaks down
 - Consequently, Takeda agreed to consider this suggested proposal further. However, it was noted that, whilst from a competition-specific lens, an Arbitrator might not always be necessary, the Takeda model was designed to take into consideration the broader reasons why an arbitration process would assist in helping to secure a successful outcome to combination treatment negotiations (for example, to act as a mediator during negotiations). A decision on refining the role of the Arbitrator will therefore need to be taken holistically

The criteria for determining clean teams

- Takeda's external clean teams concept was discussed and a series of questions were posed in relation to who could participate within a clean team and the expertise needed by these individuals
- There was consensus that it would be vital that clean teams had sufficient expertise in health economics and pricing to be able to discharge their duties effectively. However, a

question was raised about whether in-house clean teams would be more appropriate given a) their existing expertise and b) the resource burden associated with assembling an external team, particularly for small companies

- Takeda responded by noting that internal clean teams had been considered in the drafting process, but they had been discounted as it was felt that it was unlikely that individuals within internal teams could be identified who had sufficient subject matter knowledge whilst still meeting the requirement to be separate from decision-making processes (which is a requirement to avoid undermining competition law)
- In response, the group discussed their perspectives on the viability of internal clean teams although there was some differing opinions. Some argued that it could be done internally provided the individuals selected had no decision-making influence and there were no other conflicts of interest, while others remained concerned that there was no precedent for internal clean teams outside of mergers and acquisitions and the risk of anti-competitive behaviour was greater, meaning that an external clean team was required
- A middle ground was also proposed, which questioned whether a clean team made up of both internal and external stakeholders could address the competition concerns whilst still controlling costs. It was agreed that this possibility would be explored further, and that Takeda would compile suggested criteria for clean teams that could be externally validated
- It was added that it would ultimately be for each manufacturer involved in the negotiation to determine their level of comfort with utilising an internal clean team, taking into consideration the financial and reputational risks of a potential breach of competition law
- In reply to the concern about the resource burden of external clean teams, Takeda highlighted that many companies already use external Market Access agencies to complete their economic models and, given these agencies will already be familiar with the information needed, the additional cost of these agencies to conduct clean team negotiations should not be cost prohibitive. It was added that there would also be sufficient expertise within these companies to comprise a clean team

The role of clean teams

- Participants also sought clarification on the remit of clean teams, in particular whether clean teams would have a role interacting with NICE and NHSE. Concern was raised about the burden this could place on the system and the potential delays that this could introduce in the NICE process
 - Takeda clarified that the introduction of clean teams would not alter the responsibility of the add-on manufacturer to engage with NICE and NHSE, and NICE would not be expected to alter its process or negotiate directly with clean teams

The risk of foreclosure

- A number of participants also raised the issue of foreclosure as a potential risk associated with the solution
- Foreclosure – acting to impede or stop new products or competitors from entering the market – would occur if a manufacturer of a new add-on treatment, could not work with the manufacturer of a backbone therapy as a result of a commercial agreement associated with a pre-existing combination treatment. The OECD has published a report referencing this,

stating that companies are in breach of competition law if the products in a competition are complements but the combination is used to foreclose access to a product of a competitorⁱ

- The likelihood of foreclosure occurring was considered low by some due to the benefits to the backbone manufacturer of cooperating with new add-on manufacturers, including extending the use of its own product and the associated opportunity for increased revenues
- As a result, some in the group also countered that because the benefits in resolving the current market failures associated with combination treatment benefits are high, it would not be proportionate to alter the Voluntary Arbitration Framework on this particular point. In any event, any foreclosure risks could be mitigated by internal legal review of prospective individual agreements between add-on and backbone manufacturers. This is not necessarily an issue for the Framework to manage
- the primary issue is that the existing challenges associated with combination treatment access is already a form of market failure, and not having a solution that enables new treatments to enter the market is a bigger challenge than the risk of foreclosure

The application and remit of the process

- The group also queried the extent of the remit of the process and whether it should apply to all combination treatments. Concern was raised that, if this was the case, this could be burdensome for the system and individual manufacturers
 - In response, Takeda advised that not all combination treatments will require the utilisation of the solution as it will only be used when it is clear that a treatment may face cost-effectiveness challenges. It was noted that there could be a role for the Arbitrator in horizon scanning to decide whether a combination treatment was a candidate for consideration. This should limit the burden on manufacturers and the system
 - It was also noted that the process had been designed to avoid interfering or creating additional burden for NICE or NHSE. The add-on manufacturer will continue to be responsible for leading stakeholder engagement, all interactions with NICE / NHSE and for the existing touch points in the NICE process (i.e. prior to NICE commencing the review, in response to the Evidence Review Group report, and in response to a potential negative Appraisal Committee Decision)

4. Summary of discussion and next steps

The Chair closed the meeting by summarising the key themes of the discussion that arose, and Leslie Galloway thanked participants on behalf of EMIG and Takeda. Helen Taylor (Takeda) then briefly outlined Takeda's planned next steps.

Next steps

Helen Taylor noted that a non-attributable report of the roundtable would be developed and circulated for input. She added that further feedback from those in attendance would be welcome throughout 2022.

In early 2022, all feedback from across Takeda's stakeholder discussions will be reviewed and, if deemed necessary, there is the potential to publish an addendum to the proposed solution that incorporates the proposed feedback captured during the roundtable discussions. Takeda wishes to encourage feedback, critique, and debate of the proposed solution to meaningfully present an implementable and transactable solution that represents perspectives from all stakeholders.

Materials developed throughout Takeda's stakeholder discussions, including this summary report, will be made accessible on the Takeda UK website: <https://www.takeda.com/en-gb/what-we-do/combination-treatments/>.

ⁱ OECD (2020) Addressing challenges in access to oncology medicines