The root cause of unavailability and delay to innovative medicines: Reducing the time before patients have access to innovative medicines

Report summary

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Contents

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Contents

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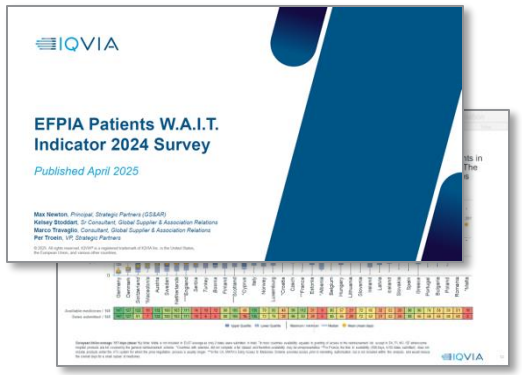
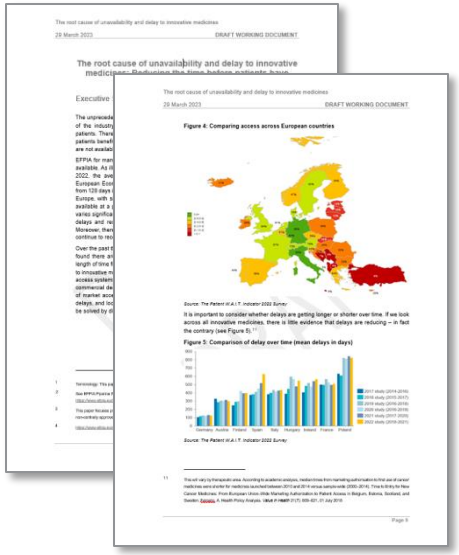
The report explains the root causes of unavailability of products across European countries

The W.A.I.T. Indicators & Root Causes

EFPIA Patients W.A.I.T. Indicator – IQVIA report



The root cause of unavailability and delay to innovative medicines – CRA report



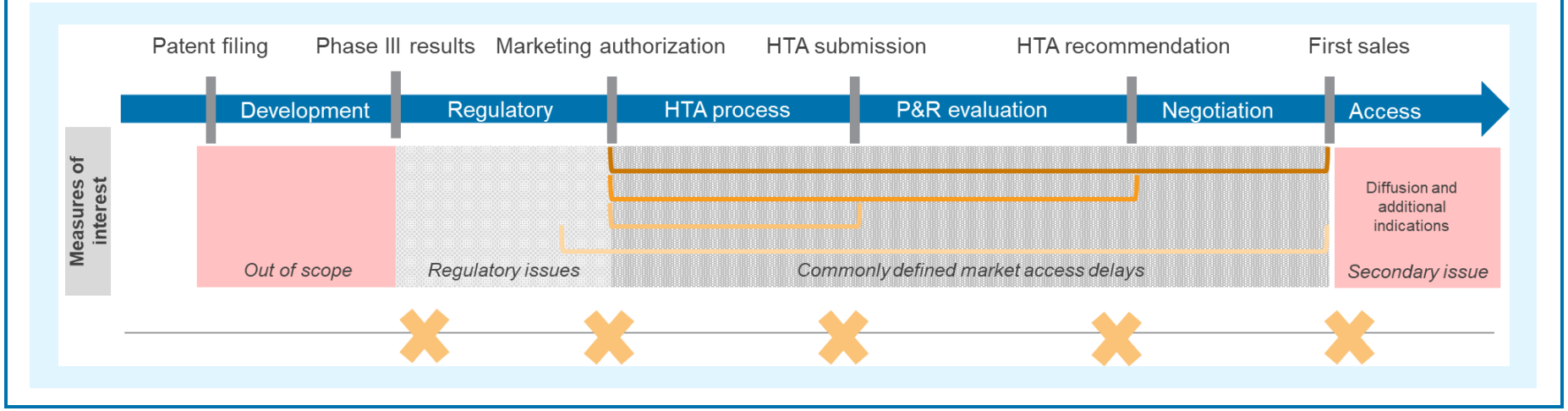
Focus of this report

- The unprecedented speed of innovation exhibited over the last five years and the promise of the industry pipeline provides an important opportunity to improve outcomes for patients
- There is common agreement that the value of innovation is only realised when patients benefit from advances in treatment
- However, a significant number of medicines are not available across all European Union (EU) markets
- EFPIA has studied this through the W.A.I.T. Indicator Survey for many years and has asked CRA to support an analysis of the root cause of delays in availability of medicines in the EU
- This report summarizes the sixth edition of the root cause analysis, first released in June 2020 and used as a basis for discussion with several EU and national policy-makers and stakeholders

What do we mean by availability and delay?

- In the European Union, once a new treatment has gone through a process of research and development lasting ten years on average, three further milestones have to be reached prior to patient access
- It is important to distinguish between a number of different time points:
  1. The length of time between application for and the granting of **marketing authorisation**
  2. The length of time from market authorisation to **application for price and reimbursement**
  3. The length of time from application for price and reimbursement to **decision on value assessment**
  4. The length of time from decision on value assessment to **reimbursement decision**

Types of delay in the availability of medicines

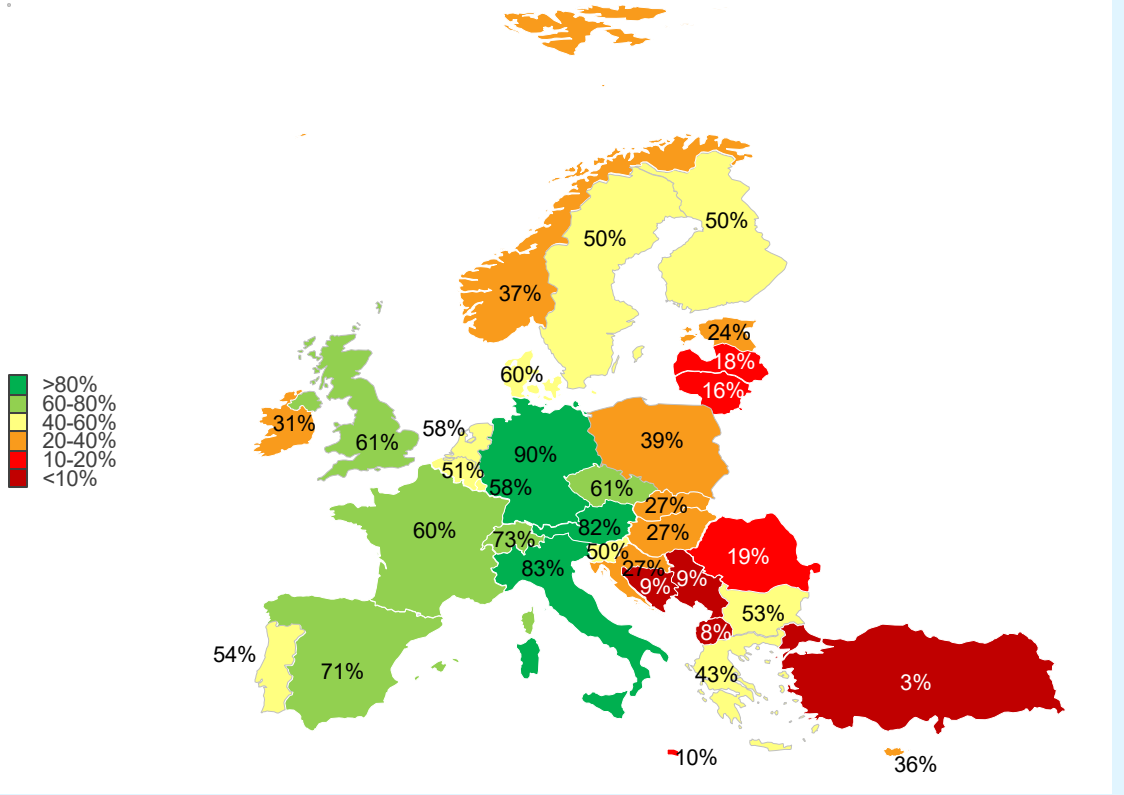


Source: CRA analysis

What is the evidence on unavailability and delays?

- There is wide variation in time to availability and available across Europe
- There is also evidence that shows systematic differences between different types of medicines
  - The availability of **oncology medicines**, although remaining higher than for all medicines, has decreased over time
  - For **orphan medicines**, the rate of availability remains consistently lower, with long delays and low rates of availability in CEE and Southern Europe
- Even within one country, patients can get access to some medicines almost immediately, and wait years for others
- Across all innovative medicines, there is little evidence that delays are reducing – in fact the contrary

Comparing availability across European countries[1]



Sources: [1] Patient W.A.I.T. Indicator 2024 Survey

Contents

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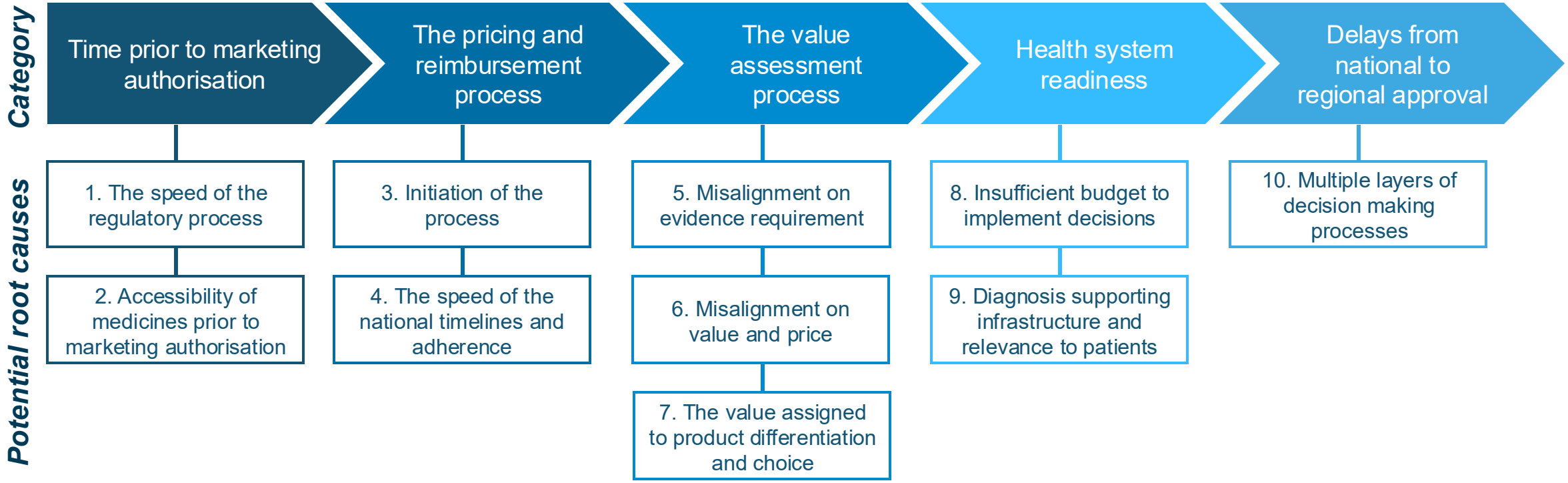
We find and document 10 interrelated factors that explain unavailability and delays



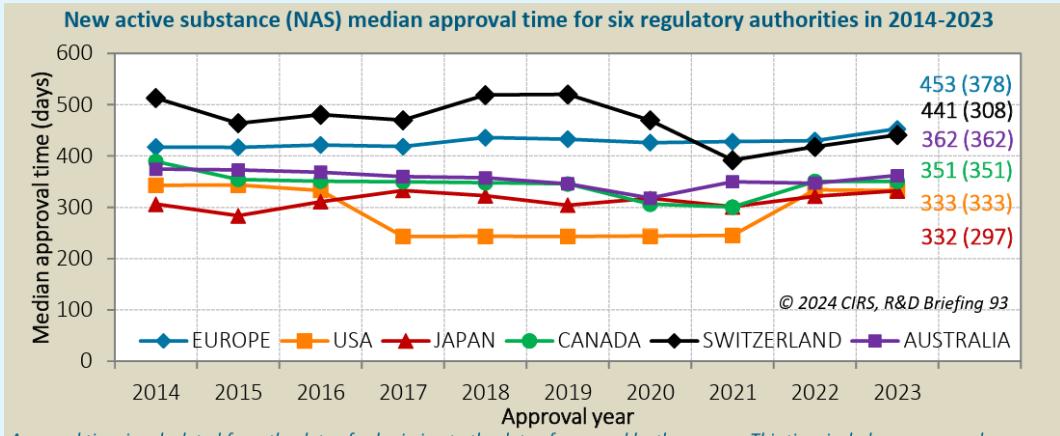
- These causes are **rooted in the medicines access systems and processes in the EU member states** and the corresponding impact on commercial decision-making
- In reality, there are many interconnected factors that could explain unavailability and it is not possible to untangle their impact with perfect precision: **the environment affects commercial decisions**

Source: CRA analysis

The speed of regulatory process

- Although this not is captured in EFPIA's W.A.I.T. indicators, the time from application to granting of marketing authorisation has been examined in many different papers
  - Evidence consistently shows that the EMA is slower than the FDA
- To highlight this disparity, many studies have focused on cancer medicines, for example:
  - A 2025 study reviewed 152 novel oncology therapies approved by both the FDA and the EMA between January 2003 and December 2024 and found **that 94% were approved by the FDA before the EMA**[1]
- The studies described attribute a portion of the delay in Europe to the period between the CHMP opinion and the EC decision
- Other evidence points towards a **relative underuse of expedited review pathways** in the EU relative to other regulators

Comparison of length of time of market authorisation process[2]



Approval time is calculated from the date of submission to the date of approval by the agency. This time includes agency and company time. EMA approval time includes the EU Commission time. N1 = median approval time for products approved in 2023; (N2) = median time from submission to the end of scientific assessment (see p.20) for products approved in 2023.

Abbreviations: CHMP = Committee for Medicinal Products for Human Use; EMA = European Medicines Agency; FDA = Food and Drug Administration

Sources: [1] Friends of Cancer Research (2025) Available at: https://friendsofcancerresearch.org/blog/20-years-of-fda-leadership-in-novel-cancer-drug-approvals/; [2] CIRS (2025) New drug approvals in six major authorities 2014-2023: Changing regulatory landscape and facilitated regulatory pathways. Available at: https://cirsci.org/wp-content/uploads/dlm_uploads/2024/07/CIRS-RD-Briefing-93-six-agency-briefing-v2.0.pdf

Initiation of the process and length of P&R process

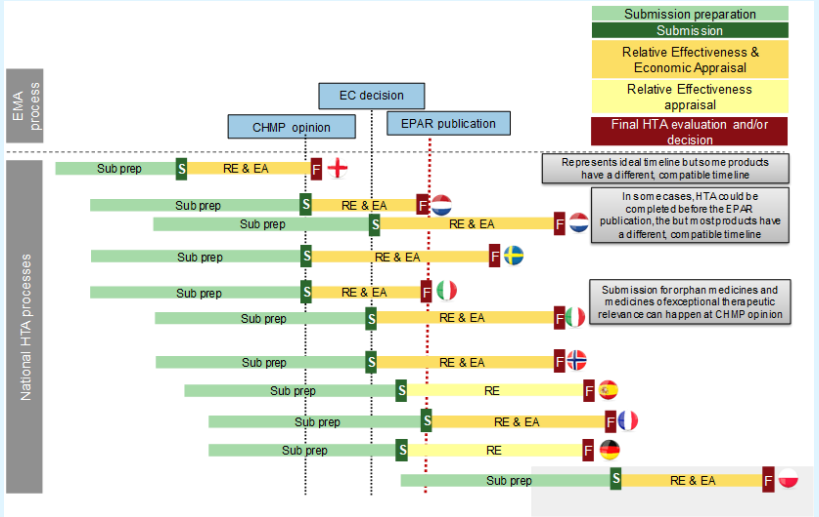
- In a minority of markets, there is immediate access after MA, at least for some products
- However, in many markets **the P&R process does not start automatically**; this requires a submission by the company or decision by those in the assessment process
- Delays in initiating the P&R process occur for various reasons:
  - ➢ **External reference pricing**
  - ➢ The time-consuming nature of the P&R application process including tailor-made dossiers for each country
  - ➢ Rules around the timelines for decision-making, including **reliance on decisions from other countries**

Percentage of products available in EU countries, segmented by company size[1]

Sorted by total availability (%) according to EFPIA W.A.I.T. (2020-2023 cohort)

Country	Top-20 global pharma N =	Other biotech and SME companies N =	Large company delta % above or below the country average reported in W.A.I.T.
Germany	91%	90%	1%
Italy	92%	75%	10%
Austria	91%	75%	9%
Switzerland	88%	61%	15%
Spain	79%	65%	8%
England	65%	66%	0%
Czechia	79%	47%	18%
France	61%	58%	2%
Denmark	73%	49%	13%
Luxemburg	74%	46%	16%
Netherlands	69%	49%	11%
Scotland	65%	50%	8%
Bulgaria	65%	43%	12%
Portugal	65%	46%	11%
Belgium	61%	43%	10%
Sweden	68%	35%	18%
Slovenia	66%	36%	17%
Finland	70%	34%	20%
Greece	73%	20%	29%
Poland	56%	26%	17%
Norway	51%	26%	14%
Cyprus	61%	17%	25%
Iceland	49%	22%	15%
Ireland	35%	27%	4%
Hungary	42%	16%	14%
Slovakia	40%	17%	13%
Croatia	45%	11%	19%
Estonia	35%	16%	11%
Romania	31%	9%	12%
Latvia	31%	7%	13%
Lithuania	19%	14%	3%
Malta	6%	13%	-3%
Serbia	19%	1%	10%
Bosnia and Herzegovina	19%	0%	11%
North Macedonia	17%	0%	9%
Turkey	6%	1%	3%

Time until the reimbursement process can be initiated[2]



Abbreviations: MA = marketing authorization; P&R = pricing and reimbursement
Sources: [1] Patient W.A.I.T. Indicator 2024 Survey, IQVIA analysis of company size, top-20 pharma defined by 2024 Q4 MAT total sales (Rx only) globally; [2] EFPIA; EPAR refers to European public assessment report

Misalignment on evidence requirement

- Once the P&R process is initiated national timelines get extended due to **stop-clocks, request for information or rejections** during the HTA process
- **Misalignment** can be found in all assessment criteria including:
  - Patient population
  - Comparators
  - Trial design
  - End points
  - Statistical analysis
- To illustrate the differences in evidence requirements, we can compare the evidence requirements of EMA and the HTA bodies, and how acceptance of different types of evidence varies between HTA bodies

Evidence requirements vary between agencies, prolonging national discussions and decision-making[1]

Domain	Subdomain	Italy (AIFA)	Netherlands (ZINL)	Poland (AOTMiT)	Portugal (INFARMED)	England and Wales (NICE)	Sweden (TLV)	Degree of alignment across HTA bodies	Degree of acceptance across HTA bodies
		HTA bodies							
Population	Target population as authorized by EMA	Case dependent	Case dependent	Case dependent	Case dependent	Accepted	Case dependent	33%	17%
	Use of biomarkers	Accepted	Accepted	Accepted	Accepted	Accepted	Accepted	100%	100%
	Extrapolation to other populations	Case dependent	Case dependent	Accepted	Case dependent	Case dependent	Case dependent	33%	33%
Comparator	Selected comparator	Accepted	Accepted	Accepted	Accepted	Accepted	Accepted	100%	100%
	Class effects	Not accepted	Case dependent	Accepted	Not accepted	Case dependent	Case dependent	33%	17%
	Indirect comparisons	Accepted	Accepted	Often accepted	Accepted	Often accepted	Often accepted	50%	100%
Endpoints	PFS as endpoint	Case dependent	Often accepted	Often accepted	Case dependent	Accepted	Often accepted	50%	67%
	Other surrogate endpoints	Case dependent	Not accepted	Accepted	Case dependent	Case dependent	Often accepted	0%	33%
	Absence of QoL data	Often accepted	Case dependent	Often accepted	Case dependent	Not accepted	Often accepted	50%	33%

Key: Accepted | Often accepted | Case dependent | Often not accepted | Not accepted

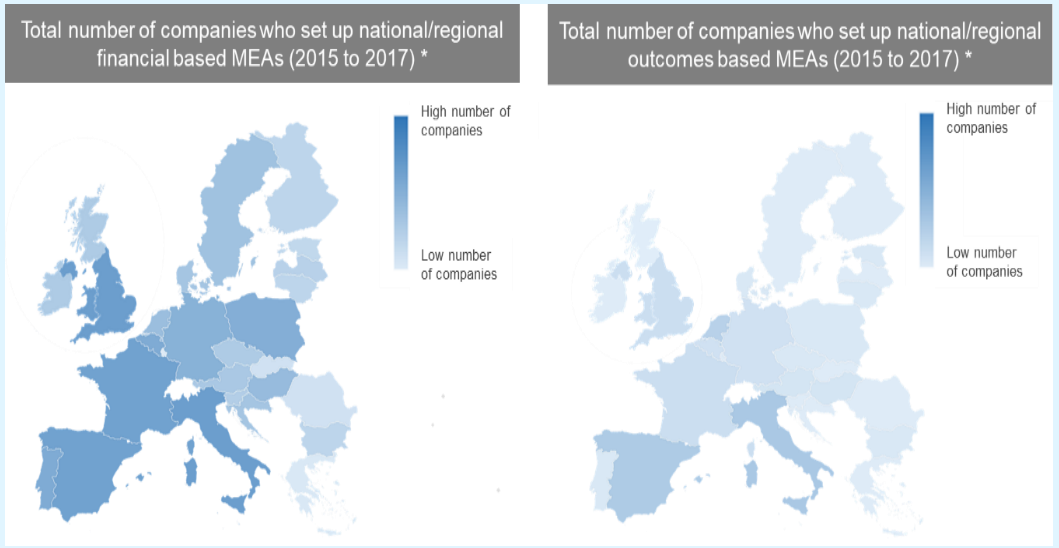
Abbreviations: P&R = pricing and reimbursement; HTA = health technology assessment; EMA = European Medicines Agency

Sources: [1] Wolters et al. (2024) Differences in evidentiary requirements for oncology drug effectiveness assessments among six European health technology assessment bodies — can alignment be improved? Expert Review of Pharmacoeconomics & Outcomes Research. 24(2).

Misalignment of value and price and the value assigned to product differentiation and choice

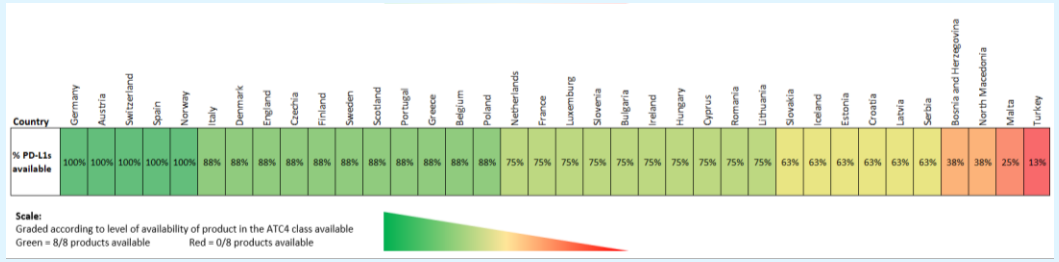
- Even if there is agreement on the evidence regarding the value of a medicine different countries have different level of income and hence ability to pay
- Where prices are higher than the perceived value or affordability, there is an inevitable delay as the price is negotiated
- Where it is possible to use **flexible contracts to align price and value**, this should reduce delays
- The value that countries place on a **particular medicine** also varies due to:
  - Clinical and epidemiological factors
  - Physician choice
  - Value of competing medicines

The use of managed entry agreements across Europe[1]



Number of products available in a therapeutic class (the example of PD-(L)1s)[2]

It is often the case that some products in a class are available, even if the number of products varies between countries. As illustrated by PD-(L)1s (L1G5):



Abbreviations: MEA = managed entry agreement

Sources: [1] EFPIA "MEAs and innovative pricing models: Real world experience" Final Report 2018; [2] Patient W.A.I.T. Indicator 2024 Survey, IQVIA ATC4 class (L1G5, Monoclonal antibodies PD-1/PD-L1, n=8)

Health system readiness

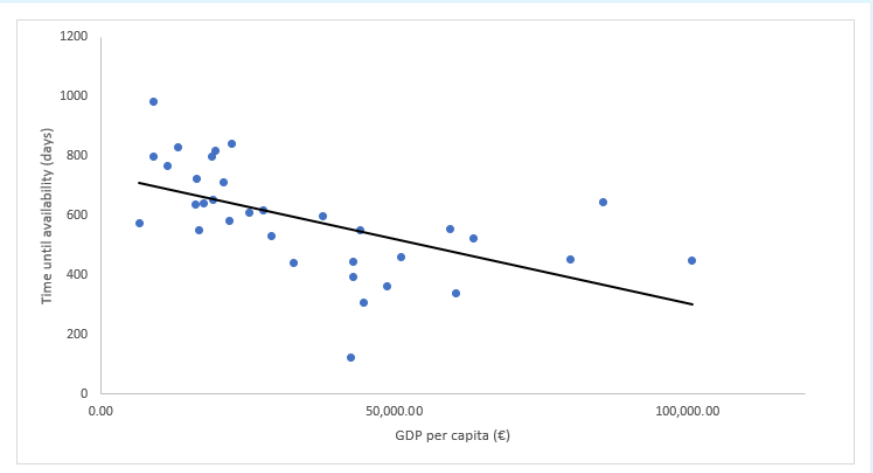
1. Insufficient budget to implement decisions

- Within Europe, we have countries with very different levels of income – with GDP per capita varying from €11,300 to €100,880 per annum – and healthcare investment decisions[1]
- Given the difference in income and spending on healthcare and medicines, it is unsurprising that the market potential varies across European countries

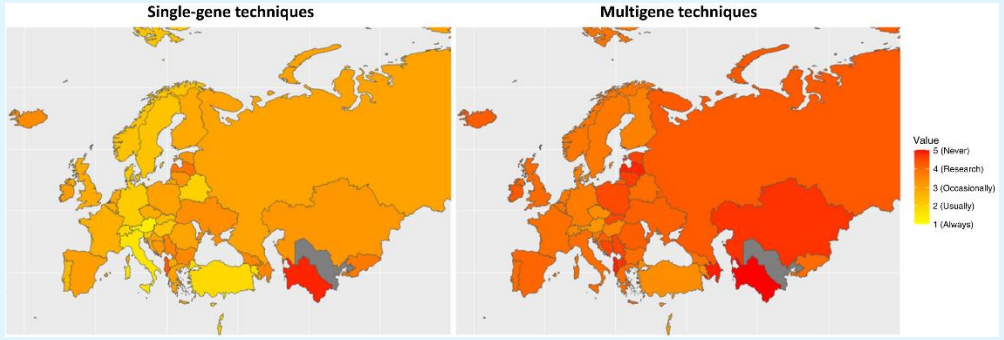
2. Diagnosis, supporting infrastructure and relevance to patients

- Accurate and timely diagnosis is dependent on the availability of accessible screening and diagnosis programs and services
- Even where diagnosis programs exists in a country, access to diagnostic testing can be limited (e.g., uptake of biomarker testing for precision oncology)
- Diagnosis requires investment in reimbursement of diagnostics, appropriate investment in testing facilities but also requires investment in physician education
- Given the small number of patients, Centers of Excellence (CoEs) are key, but these are not evenly developed

Relationship between time to availability (delays) and GDP per capita[2]



Access to precision oncology biomarker testing in Europe (2023)[3]



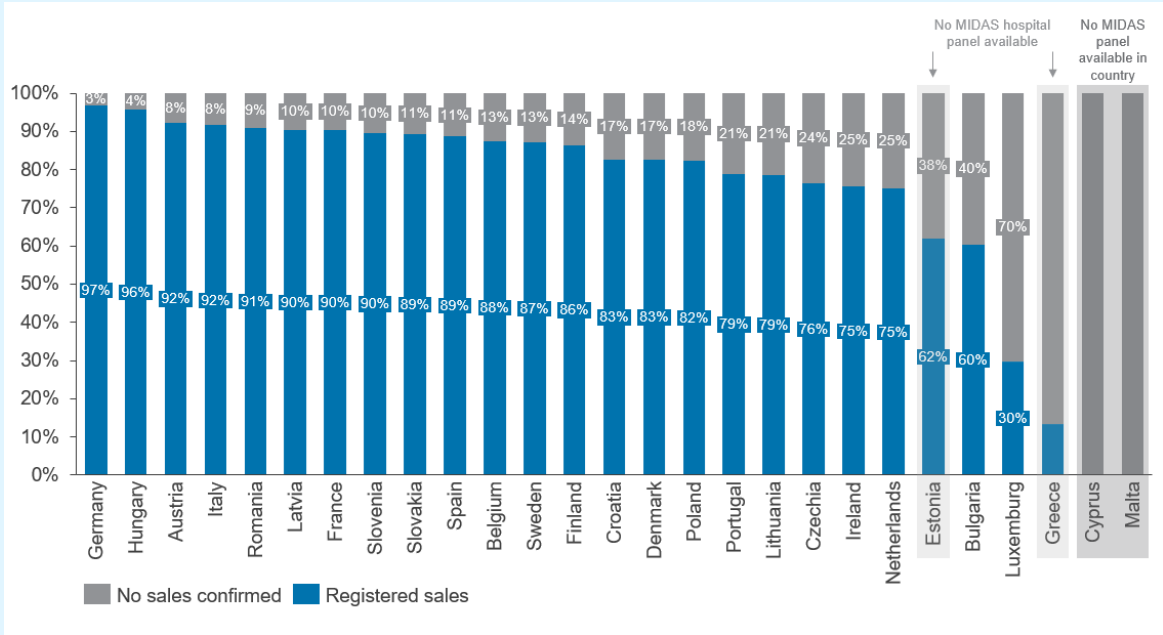
Abbreviations: GDP = gross domestic product

Sources: [1] Eurostat (n.d.). Real GDP per capita. Available at: https://ec.europa.eu/eurostat/databrowser/view/sdg_08_10/default/table?lang=en; [2] The Patient W.A.I.T. Indicator 2024 Survey, OECD 2025; [3] Bayle, A., et al. (2023) ESMO study on the availability and accessibility of biomolecular technologies in oncology in Europe. Annals of Oncology. 34(10):934-945

Availability is not access

- In some countries, reimbursement decisions need to be made at all levels, from **national level to regional level and to then local hospital level**, thus prolonging the time before patients can access treatments
- Even once a medicine is on the public reimbursement list and navigated any regional process, **this does not mean that patients have access to medicines**
- There are many additional barriers that affect usage of medicines including:
  - Publication in the national gazette
  - Clinical guidelines that do not always include the most recent therapeutic innovations
  - Budgets are not allocated for its use, or it is not recommended

Percentage of available products with no recorded sales in the EU[1]



Sources: [1] IQVIA MIDAS sales data 2014–2024. Analysis includes all available products (2020–2023). "Sales" is defined as available in WAIT indicator and showing EU sales in IQVIA MIDAS. "No sales" is defined as available in WAIT indicator and showing no EU sales in IQVIA MIDAS since 2015. Some countries in this analysis are not covered by IQVIA data or do not cover the hospital channel (i.e., coverage is retail only).

Contents

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Policy solutions to improve availability of innovative medicines

		Industry commitment:
1	Proposals to speed up the regulatory process, delivering safe and high-quality diagnostics, vaccines and treatments to patients as fast as possible	*Shared aspiration to reduce regulatory approval times in Europe and bring these in line with international best practice*
2	Proposals that aim to increase transparency of information regarding the placing on the market of centrally approved products	*Industry-launched European Access Hurdles Portal for transparency of P&R applications*
3	Proposals to facilitate a process that allows prices to align with value and ability to pay	*Development of novel pricing and payment models*
4	Proposals to improve the efficiency and quality of value assessment	*An efficient system of European HTA assessments*
5	Proposals to ensure equity of access and solidarity across EU member states	*Conceptual framework for Equity-Based Tiered Pricing (EBTP)*

Abbreviations: P&R = pricing and reimbursement; HTA = health technology assessment