Interview: Agnès Buzyn – Chairwoman of the Board, National Authority for Health (Haute Autorité de Santé – HAS), France



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In an exclusive interview,

Agnès Buzyn, Chairwoman of the Board for the French National Authority for Health (Haute Autorité de Santé – HAS), on her organization's priorities, the particularities of the French healthcare system, and what can be learned from other countries' systems.

Your career includes experiences as a doctor, research scientist and professor of medicine. Your appointment in March 2016 as head of the French National Authority for Health (HAS) was deemed "unusual." What encouraged you to accept this position?

I am indeed a doctor, researcher and professor by background and most of my career was spent as such. I spent a large part of my career as an academic hematologist and clinician at the University Paris Descartes – Necker Hospital. In parallel, in the early 2000s, I was the Director of a research team on tumour immunology at the National Institute of Health and Medical Research (INSERM). It was while I was president of the French National Cancer Institute (INCa) from May 2011 to February 2016 that my interest in public health emerged. During this period at INCa, I gained exposure to public health issues and ever since, my interest in these issues has grown progressively.

Personally, I actually share the same mission as the HAS, which is to improve the quality of healthcare for patients. I have devoted my entire life to improving treatments, and the HAS's

objective is the most beautiful task for a doctor or anyone in the health sector. I think France has a very comprehensive healthcare system, and we must preserve it amid transformations in our sector. It is my life goal to make sure we modernize our system while maintaining its quality.

You were appointed Chairwoman last March – could you please define for our audience what your priorities are?

The HAS has three primary objectives. The first is to evaluate health products, drugs, medical devices and medical procedures. Our evaluation of medical innovation shapes the Social Security's reimbursement system. No medicine can be reimbursed if it has not been evaluated positively by the HAS first.

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Our second mission is a qualitative evaluation of all existing health facilities in the French territory, which we do together with 500 experts and health professionals that are constantly visiting and evaluating French hospitals and healthcare premises. We make sure that health institutions comply with the highest quality standards. We publish reports and rank institutions on their quality procedures, management skills, and accommodation capacities. These reports are made public to ensure transparency with patients.

Third, we define good medical and organizational practices for specialists and general practitioners. This allows for the harmonization of practices at the national level. Our recommendations rest on a scientific analysis of processes and it is important to highlight that financial or ideological considerations do not influence our medical evaluations. Our mission therefore impacts the quality of healthcare in the country. One of our priorities at the moment is for example to expand our capacity to evaluate the quality of care in the ambulatory sector since this sector will play a greater role in the future of healthcare. We must be able to monitor health services in this area to make sure patients are receiving the right treatment. We must also assess the relevance and pertinence of certain practices to ensure they are not outdated.

Another priority is to put patients at the heart of our evaluation system. The time of "paternalistic" medicine is over and HAS is playing a critical role in integrating further patient associations and also patient outcomes in our evaluations. Patient feedback adds great value to our line of work. For the past year, patient have been allowed to rate healthcare facilities themselves, which has been quite a premiere in France. We ask for their feedback when they leave the facility after receiving treatment and this point of view is one of our official indicators to evaluate healthcare facilities. We

have also decided to engage with health and patient associations before we conduct evaluations of health products (medicines and medical devices), as we want to build a better understanding of their needs and expectations. Their perspectives and views on their disease and their expectations are to be shared by our concerned HTA Committees in charge of evaluation of drugs and MD.

As numbers of therapeutic innovations surge, we observe growing discontent and mistrust from society towards medicine and the medical community – the example of vaccinations being just one. How do you explain this trend and what could be the role of an institution such as HAS in curbing this discontent?

We have indeed noticed popular discontent with health services and facilities. Patients are increasingly suspicious of scientists, prescriptions, and innovation. I truly believe that it is due to inappropriate communication and information. We are suffering from a lack of transparency in our sector. Transparency and independent information are paramount in building trust with patients. People are growing warier of lobbies and we must demonstrate our full independence from pressure groups. We must also prove that there are no conflicts of interest in our deliverables. We have a duty of education in ensuring that there is no asymmetry of information between patients and the health industry. I hope that the HAS will be instrumental in restoring trust and public knowledge.

Is there a "model of healthcare" from other countries from which France and the HAS could draw knowledge from?

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Every country has different HTA practices and approaches, and it would not be easy to pinpoint one in particular. No country has a similar organization to France where we have a very particular and unique organization on health products: the Agence Nationale de Sécurité du Médicament et des Produits de Santé (ANSM), our equivalent to the US FDA; the HAS which gives opinions on reimbursement and pricing; the Comité Economique des Produits de Santé (CEPS), the body in charge of pricing; and finally the Social Security, which takes care of reimbursement.

Certain agencies in other countries have already started conducting a medico-economic analysis of public health strategies, and I would say that Canada has a very advanced system when it comes to public health efficiency and patient empowerment from which France can learn from. The UK's NICE is also an interesting model since it is collaborating with academic experts and teams for their evaluations – although inapplicable as such in France essentially because of the political context.

You have declared that the HAS wants to develop medico-economic studies. What has been done so far?

We are working on developing further medical-economic studies. A new procedure called “Forfait Innovation” aimed at helping the medical devices industry get to the French market was introduced recently. . Its goal is to help policy-makers in the health industry gather data to evaluate innovation’s added value to current offerings. Our data collection tools certainly create some forms of delays which are at time misunderstood by the pharmaceutical industry, but it is undeniable to say that patients in France have access to genuine innovation. Furthermore, a major strength of our system is the use of ATUs (Temporary Authorisations for Use) allowing us to successfully provide patients with access to the latest innovative and experimental drugs that they require and which are not yet commercially available (before market authorization).

The HAS’s role is to help public officials with price determination. We analyze each product’s added value, and prices are determined based on our conclusions. Some health products are also subject to a medico-economic evaluation for effectiveness and budgetary impact analysis. We for instance recently produced a guide on the budgetary impact of innovation and new drugs. We also develop medico-economic analysis of strategies and public health recommendations.

In France, once a drug is approved for reimbursement, patients have immediate access to it nationwide which is not always the case in other European countries. In several Eastern European countries for example, you can only have access to certain cancer treatment drugs in very specialized centers.

What would you say are the specific challenges France has to deal with when it comes to its healthcare system and organization?

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Our aging population is one of our greatest challenges. We also have organizational problems and adaptation issues with big data and e-health, as we need to make sure technological breakthroughs benefit patients. For example, one of the next questions is who is qualified to assess algorithms issued from big data? There are also important regional disparities in access to healthcare in France today. Rural areas suffer from a shortage of health professionals, a phenomenon referred to as “medical deserts.”

Also, I believe that French doctors would benefit from more training for including prevention interventions in their practice. They have a great skill-set but should get a better understanding of

common prevention tools for patients. Better prevention could yield significant savings. Only 30 percent of French patients say their doctors have recommended everyday prevention practices and this is unacceptable. Our national health insurance system also focuses more on treatment than prevention, and this has to change. We are starting to promote physical activity as an important component of cancer treatment for instance.

Last October, you participated in the Politico Health Care Summit in Geneva. What do you get from speaking and attending such events?

Attending these events help us understand global trends in drug assessment and price determination. These policies can no longer be introduced at the national level without awareness of international standards, and such summits serve as a platform for exchange among healthcare professionals, businesses, and policy-makers. Cultural differences can positively or negatively impact policy-making. As I mentioned earlier, the definition of threshold for qualitative assessment (QALY) in the UK would be inapplicable in France for instance but there are things we can learn from. We are also working with the European Commission on transnational partnerships and joint-led actions in the field of health technology and drug assessment, as we believe that the pharmaceutical sector would benefit from some form of harmonization of HTA processes at the European level.

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