Assessing European reimbursement friction and private access reliance across therapeutic areas

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Yiannouka, N[1]; Vassoler, H[1]; Grewal, J[1]
[1]Remap Consulting, Cheshire, United Kingdom

INTRODUCTION

- European public healthcare systems are facing increasing budget pressure, driven by post-pandemic fiscal constraints, inflation, multimorbidity and the growing number and cost of innovative therapies[1]
- As payers increasingly rely on cost-containment measures to manage affordability, therapies with high-budget impact, large eligible populations or uncertainty around clinical and economic value may face greater reimbursement friction
- However, the extent and nature of reimbursement friction varies substantially by therapy area and market. Across Europe, this can range from restricted eligibility and negative reimbursement decisions to statutory exclusions
- Obesity medicines illustrate the tension between evidence uncertainty, budget impact and high patient demand. As a result, restricted or phased public access to GLP-1/GIP therapies has coincided with substantial growth in private and self-pay channels[2,3]
- This raises the question of whether similar dynamics exist in other therapy areas: could privately funded care provide an alternative or complementary access route where public reimbursement is particularly challenging?[4]

OBJECTIVES

1. Identify and rank therapy areas experiencing the greatest public reimbursement friction across European markets
2. Assess the role of private-market patient access among high-friction therapy areas as an alternative or complementary access route

CONCLUSIONS

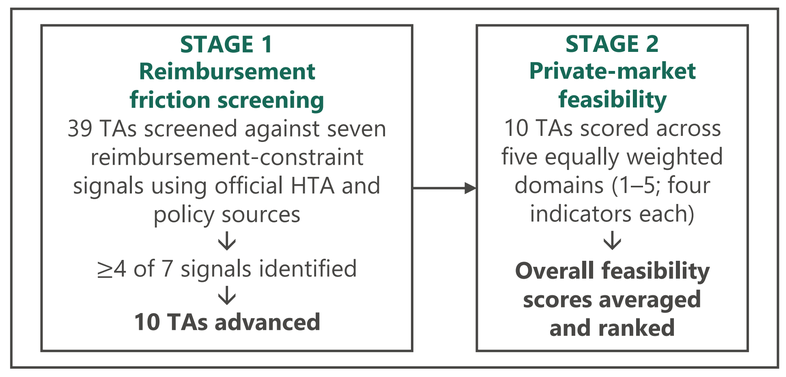
- Public reimbursement friction across Europe was most often characterised by restricted eligibility, leading to heterogeneous levels of access across countries
- Private-market as an alternative access route was strongest for obesity / weight management, erectile dysfunction and fertility / ART, where demand aligned with simpler or service-led delivery
- In contrast, Alzheimer disease-modifying therapies and gene therapies / ATMPs remained poorly suited to broad private access, as high costs, specialist infrastructure and monitoring requirements represent significant barriers for current funding models
- Overall, private funding as an alternative access route appears most feasible in therapy modalities with self-pay channels and non-specialist delivery models

METHODS

Identifying and ranking TAs with the greatest reimbursement friction: A two-stage review searched official HTA and policy sources up to 1 June 2026 (NICE/NHS England, SMC, HAS, G-BA/IQWiG, AIFA, TLV, Zorginstituut Nederland, EMA, ECDC, WHO/Europe, PPRI). Stage 1 screened 39 TAs against seven predefined reimbursement-constraint signals (statutory exclusion, negative HTA, restricted reimbursement, no evaluation, implementation bottleneck, cross-country inconsistency, boundary classification friction); those with four or more signals advanced to Stage 2 (n=10)

Assessing the feasibility of private market access for TAs: Stage 2 scored private-route reliance across five equally weighted domains: patient-funded demand, delivery-channel feasibility, clinical governance burden, commercial viability, and equity/legal risk. Each domain was scored 1–5 (1=most constrained, 5=most favourable) using four indicators (e.g. demand: self-pay precedent, symptom urgency, repeat-use potential and affordability). Domain scores were then averaged to calculate overall feasibility

Figure 1. Methodology of reimbursement friction screening and private-market feasibility assessment



RESULTS

Restricted reimbursement and cross-country variation were the dominant payer barriers: Across 39 TAs, the most common friction signals were: restricted eligibility by line of therapy, subpopulation or prior-treatment requirements (32/39), which fall under the restricted reimbursement constraint signal

Private-market feasibility varied substantially across high-friction TAs: Feasibility scores for the 10 TAs facing the greatest public reimbursement friction varied substantially, ranging from 4.2/5 to 1.2/5. Obesity / weight management and erectile dysfunction scored highest, followed by fertility / ART, reflecting stronger patient-funded demand and more feasible delivery models. Lower-scoring TAs, including Alzheimer DMTs and gene therapies / ATMPs, were constrained by specialist infrastructure, monitoring requirements and high treatment costs (Figure 2)

Figure 2: Overall private-market feasibility score by TA, with domain-level heatmap showing drivers of feasibility across patient-funded demand, delivery-channel feasibility, governance burden, commercial viability and equity / legal risk

Therapeutic area	Overall feasibility	Demand	Delivery	Governance	Commercial	Equity / legal
Obesity / weight management	4.2	5	4	4	5	3
Erectile dysfunction	4.2	5	5	4	3	4
Fertility / ART	4.0	5	4	3	5	3
Severe alopecia areata	3.6	4	4	3	4	3
Smoking cessation	3.4	3	5	4	2	3
Lipid lowering	3.2	2	3	4	3	4
Precision oncology	2.6	3	2	3	3	2
Treatment-resistant depression	2.4	4	2	1	3	2
Alzheimer DMTs	1.6	3	1	1	2	1
Gene therapies / ATMPs	1.2	1	1	1	2	1

Most constrained 1 2 3 4 5 Most favourable

IMPLICATIONS

- If public reimbursement remains restricted, patient demand for alternative funding routes may continue to grow
- The obesity / GLP-1 market illustrates the growth of self-pay channels when supported by innovative outpatient care pathways, e.g. pharmacy services and digital prescribing care pathways
- This recent evolution may lower delivery barriers for other suitable TAs, but is unlikely to overcome constraints where specialist infrastructure, intensive monitoring, high cost or equity / legal risk remain the main barriers

Figure 3: Private-market suitability assessment framework - Key questions and illustrative scoring rationales per domain

	Demand	Delivery	Governance	Commercial	Equity / legal
Key questions	Is there sufficient patient demand and willingness to self-pay for treatment?	Can treatment be delivered through existing private healthcare channels?	Can treatment be safely managed in private settings with appropriate monitoring and clinical oversight?	Is the addressable private market sufficiently large and commercially viable to support treatment provision?	Can private access be provided without significant legal, equity or reputational concerns?
Scoring rationales	**OBESITY** 5/5 Established uptake of self-pay GLP-1 therapies demonstrates that patients are willing to fund treatment when public access is restricted, supporting sustained private demand[4]	**AD DMTS** 1/5 Treatment requires specialist infusions, diagnostic testing and repeated MRI monitoring, making delivery dependent on infrastructure that is difficult to replicate or scale in private settings[6]	**ED** 4/5 Oral therapies can be prescribed with relatively limited monitoring, making private provision simple, although cardiovascular and drug-interaction screening remains necessary[8]	**FERTILITY / ART** 5/5 Oral therapies can be prescribed with relatively limited monitoring, making private provision simple, although cardiovascular and drug-interaction screening remains necessary[5]	**GENE THERAPIES** 1/5 Restricting access to patients able to privately fund exceptionally expensive treatments raises significant equity concerns, particularly where scarce specialist capacity may be diverted[7]

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Abbreviations: AD: Alzheimer's disease; AIFA: Italian Medicines Agency; ART: assisted reproductive technology; ATMP: advanced therapy medicinal product; DMT: disease-modifying therapy; ECDC: European Centre for Disease Prevention and Control; ED: erectile dysfunction; EMA: European Medicines Agency; G-BA: German Federal Joint Committee; GLP-1: glucagon-like peptide-1; HAS: French National Authority for Health; HTA: health technology assessment; IQWiG: Institute for Quality and Efficiency in Health Care; MRI: magnetic resonance imaging; NICE: National Institute for Health and Care Excellence; NHS: National Health Service; PPRI: Pharmaceutical Pricing and Reimbursement Information; SMC: Scottish Medicines Consortium; TA: therapeutic area; TLV: Swedish Dental and Pharmaceutical Benefits Agency; WHO: World Health Organization

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