Joint contribution to the public consultation
Brussels, 30 April 2010

The European Medicines Agency Road Map to 2015: Independence should be the priority

Health Action International (HAI) *Europe*, *International Society of Drug Bulletins* (ISDB) and *Medicines in Europe Forum* (MiEF) are pleased to contribute to the public consultation on the European Medicines Agency (EMA) road map to 2015[1].

We welcome the EMA's commitment to become an authoritative source of information for the public (**a**). This can be achieved by increasing the Agency's transparency and openness, aspects where effort is still needed[2]. We particularly welcome EMA's willingness to make available to the scientific community the data on drugs that have fallen by the wayside (**b**). Better access to information can also be encouraged by improving package leaflets (**c**), promoting independent health information, most notably on health determinants, as well as raising public awareness about existing sources of comparative and unbiased patient information.

We also appreciate EMA's concerns on environmental issues. Nevertheless, it is relevant to include more emphasis on the environmental risks of nanomaterials[3].

The EMA has identified three working priorities at the core of its role: addressing public health needs; facilitating access to medicines; and optimising the safe use of medicines. Unfortunately, the means described to tackle these priorities are, in some cases, somewhat disappointing (**d**), if not counterproductive (read below).

In order to constructively contribute to an improved EMA road map to 2015, we have opted to focus on one particular issue: **the Agency's financial and intellectual independence from pharmaceutical companies**. This issue is further expanded in our joint response (points 2 to 5 below, which correspond to the evaluation process of medicinal products). Concrete proposals for improvement are suggested at the end of this response read on page 6).

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a- Transparency of drug regulatory agencies provide patients with access to relevant information and represent a better alternative to the current EU Commission's proposals on 'patient information' that aim to introduce disguised "direct-to-consumer advertising" in Europe (for more details, read AIM, ESIP, ISDB, HAI Europe, MiEF joint analysis of the legal proposals on "information" to patients by pharmaceutical companies. Available at: www.isdbweb.org/pag/documents/En_LegalProposalsInfoPatient_JointPaper_March2009_000.pdf).

b- Yet, the statement "*it would seem appropriate to explore what incentives could be offered [to the pharmaceutical companies] to make this otherwise lost information available to the scientific community*" requires further clarification. Making this data available to the scientific community would contribute to avoid redundant studies of potential dangerous substances in humans or animals. But is that not within the social responsibility remits of pharmaceutical companies and of health authorities? There should not be any incentive: clinical data belong to the public (ref. "Phase I trials: end the secrecy" *Prescrire Int* 2010; (105) : 46).

c- Useful patient information on therapeutics should be comparative, so that patients can learn about the different treatments available and what to expect from them, in order to make an informed choice (or to participate in the decision-making). To improve the readability, quality, and consistency of the package leaflets a thorough review of the guidelines governing the readability of the labelling and package leaflets is needed to achieve better enforcement of article 59 of Directive 2001/83/EC consolidated. As a start, it is essential to consider the sequence of the information and to conduct thorough consultations/testing with groups of patients/users that are representative of the population that will receive the treatment (the elderly, for instance).

d- For example, the EMA proposes an "*accelerated assessment scheme for medicines for unmet needs*", but does not address the fact that the current R&D paradigm, market-oriented and patent protected, does not consider real health needs and does not encourage real therapeutic advances.

1- Guarantee the Agency's independence. In order to understand how EMA's priorities and functioning have evolved, one should be aware that the Agency is very heavily funded by pharmaceutical companies. Industry funding has progressively increased since 1995 when the EMA was established. In 2010, the collection of pharmaceutical companies' fees will amount to more than 80 percent of the Agency's overall budget (**e**). In contrast, the fees collected by the US Food and Drug Administration (FDA) from drug companies submitting applications for marketing authorisations for human medicines and/or biological products represent less than 20 percent of the FDA's overall budget (**f**).

To guarantee the EMA's independence, and prevent difficulties in sustainability due to fewer applications and subsequent fluctuations in fee revenues, any direct financial relationship between the Agency and industry should be avoided. This could be achieved by channelling industry fees to the European Commission, and by restructuring EMA's budget so that fees would make up but a small proportion of its overall budget.

2- "Earlier and continuous" scientific advice increases risks of conflicts of interest. Providing "scientific advice" is a mission of Drug Regulatory Agencies (article 57 of Regulation (EC) 726/2004). A company developing medicinal products may consult the EMA or a national authority at any time to obtain further guidance on the pharmaceutical, preclinical and clinical development trials and studies that are required within the registration process. For example, so-called "briefing meetings" are used to reinforce scientific advice on the development of new therapies, technologies and so-called "borderline products"[4].

The Drug Regulatory Agency can charge the pharmaceutical company for their advice (for instance, fees charged by the EMA range from 38 100 euros to 76 300 euros for an initial request, and from 19 100 euros to 38 100 euros for follow-up, with reductions available to small and medium enterprises)[5].

The EMA's draft road map states that if regulatory authorities were to engage with companies' in the early stage of development, they would gain timely knowledge of the data, which in turn would facilitate the review process. **The impression given is that companies' requests and payments for scientific advice are mostly a mechanism to reach agreement on how to prepare and submit a successful market authorisation dossier.**

The EMA's draft road map goes even further by proposing that:
- the rapporteurs for each approval dossier should be appointed at an earlier stage;
- health technology assessment (HTA) bodies should be engaging in dialogue with companies at early stages.

If an organisation is responsible for providing advice to the industry about the best way to proceed in drug development while also being responsible for the subsequent marketing authorisation evaluation, that could clearly constitute a conflict of interest. If the pharmaceutical company follows the EMA's advice, the EMA will essentially become "responsible" for the outcomes and be involved as a "co-developer". It will then be increasingly difficult to deny a marketing authorisation, even if trial results are disappointing.

The primary aim of "scientific advice" should be to provide a comprehensive and rigorous assessment of a new medicine (**g**). It should not be encouraged for financial reasons, i.e. for the Agency to "balance its budget" or for the pharmaceutical company to "improve its chances of approval". Rather, scientific advice should be given on the initiative of health authorities on particular occasions, and not become a systematic activity aimed at enhancing the approval rate of new drugs (**h**).

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e- The contribution of pharmaceutical companies is disproportional. The European Medicines Agency's total budget for 2010 will be app. 198 billion euros, compared to about 194 billion euros in 2009. It will include a contribution of 37 billion euros from the European Union (about 19 % of the overall budget), a considerable decrease from 2009, where it amounted to receipt of 47 billion euros (equivalent to 24 % of the overall budget for 2009).

f- The Prescription Drug User Fee Act has authorised the US Food and Drug Administration (FDA) to collect fees from drug companies that submit marketing applications for certain human drug and biological products since 1992. The PDUFA aims to provide "*additional revenues so that FDA could hire more staff, improve systems, and establish a better managed human drug review process to make important therapies available to patients sooner without compromising review quality or approval standards*" (www.fda.gov).

g- For example, scientific advice can be the suggestion to include older participants in a clinical trial for a drug aimed at the elderly; to conduct a clinical trial versus the reference treatment ('gold standard') when available instead of versus placebo (this is in accordance with the ethical requirements of the Helsinki declaration on clinical trials), etc.

h- Moreover, the statement "*it should be explored what kind of incentives to pharmaceutical companies can be provided to facilitate inclusion of the post-authorisation medicine development in the current Agency's scientific advice framework*" needs to be further clarified.

More transparency is needed on the area of scientific advice. The European public assessment reports (EPARs) should include an additional section summarising scientific advice given by the EMA at each stage of the development process. This information would not only facilitate better understanding of the data provided, but also allow for an assessment of the role of scientific advice in the approval of new medicines.

3- The benefit-risk assessment of health products needs to be evidence-based. In the last decade, the paucity of new products that offer even a modest therapeutic advantage stands in stark contrast to the large number of new products that expose patients to unjustified risks. Since 2005, an average of 20 products with little or no therapeutic advantage is approved on an annual basis[6]. Even the EMA recognises that there is a drop in pharmaceutical innovation.

Since 1965, the criteria for marketing authorisation in Europe are the demonstration of a medicine's efficacy, safety and quality. Efficacy is usually demonstrated in clinical trials, in which the effects of the new drug are often compared to those of a placebo rather than to "the best therapeutic option available" for the same indication. Consequently, some drugs constitute a step backwards, unnecessarily exposing patients to adverse effects when other safer treatments exist (**i**).The so-called "non-inferiority studies" should no longer be accepted as these do not preclude new products that can be worse than the comparator drug[7].

In its draft roadmap to 2015, the EMA considers that *"the availability of other therapeutic options taking into account the degree of unmet medical need*" needs to be considered in order to "*decide whether or not to grant a marketing authorisation*". We welcome this measure. Therapeutic advance should be the 4th criterion to be demonstrated when applying for a marketing authorisation[8]. **The therapeutic advance of a new medicine would be appraised in comparison with existing treatments, and demonstrated by relevant clinical data collected from comparative clinical trials.** Clinical trial results would then need to indicate the extent to which the new medicine would be **more effective or safer than the existing standard treatment, specifying the relevant patient population** (For instance, *trastuzumab* (Herceptin°) is an adjuvant to breast cancer treatment with well-defined therapeutic indications; yet its efficacy was only demonstrated in women with a tumour which over-expresses protein HER-2[9]).

The EMA seeks to improve the benefit-risk assessment of new drugs by encouraging "*continuous dialogue during the assessment*" and "*more statistical expertise*", and by "*involving patients' views*".

The experience of Independent Drug Bulletins (ISDB) reveals that **secretive "dialogues" between the regulators and pharmaceutical companies are not required when the data is robust, and clinical trials have been designed to meet health needs.** The evaluation of benefits resulting from treatment needs to be based on clinical endpoints relevant to patients according to the natural course of the disease (i.e. mortality rate in case of myocardial infarction). In some clinical trials, "surrogate" endpoints can be useful (i.e. the prevention of complication such as strokes in hypertensive patients). However, they should always be used with caution. Treatments that are effective on surrogate endpoints (i.e. cholesterol level lowering) may be ineffective or even harmful when assessed as to their impact on patient-relevant outcomes[10]. As for the evaluation of treatment risks, these have to take into account data from clinical trials and adverse drug reactions reports, pharmacology and patients characteristics[11].

In what concerns the involvement of stakeholders in the Agency's work, civil society representatives can provide valuable input and therefore their involvement is encouraged. However, the **EMA should improve and enforce the transparency requirements to prevent any potential abuse by industry-front groups**[12]. According to a recent investigation by Corporate Europe Observatory, EMA currently fails to monitor the declarations of interest made by patient groups. Most notably, the two patients' representatives at the EMA's highest level, the management board, belong to patient groups heavily funded by the industry[13].

As to scientific experts, each stakeholder (the delegates, as well as their respective organisations) should declare any conflict of interest (through an annual declaration that should be updated when any changes occur; additionally experts should verbally declare any conflicts of interest at the beginning of each meeting, and these should be recorded in the minutes). This should apply to all experts and stakeholders participating in any meeting of any committee, or "coordination group", or working party or working group. All these declarations should be made publicly available on EMA's website (**j**).

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i- This was the case for *rofecoxib* (formerly marketed under the brand name Vioxx°), an anti-inflammatory agent that was marketed even though it was no more effective than *ibuprofen* but exposed patients to greater risks. In 2004, having been marketed for several years, it was withdrawn when independent teams of scientists demonstrated tens of thousands of adverse cardiovascular reactions, some of which were fatal (particularly myocardial infarction) (Jüni P *et al.* "Risk of cardiovascular events and rofecoxib: cumulative meta-analysis" *Lancet* 2004; 364: 2021-2029.).

j- Currently Regulation (EC) 726/2004 foresees only that "*all the declared competing interests which could relate to the pharmaceutical industry shall be entered in a register held by the Agency which is accessible to the public on request, at the Agency's*

4- Risk management systems and post-authorisation "efficacy and safety" studies: countless perverse effects. It has been demonstrated that premature licensing is achieved at the expense of proper evaluation, leading to more pharmacovigilance problems further down the line[14]. Years of experience show that in Europe, the US and Canada, pharmaceutical companies generally do not honour their commitments on post-authorisation evaluation of medicinal products[15,16].

'Risk management plans' and other post-authorisation studies could lead to a situation where "conditional" (also called "staggered" or "accelerated") marketing authorisations become the rule rather than the exception, even when no genuine public health need is identified (**k**). Converting current "risk management plans" into "benefit-risk management plans", as proposed by the EMA, is one additional sign that the aim is to "*ultimately lead to an integrated assessment of benefits and risks under real life conditions*", which means, in practice, to expose a larger population to medicines that have not been thoroughly evaluated.

If there are safety uncertainties that have emerged in the pre-approval phase, risk management and safety studies should not be postponed after the marketing authorisation has been granted as in the case of *rimonabant* (Acomplia°) (**l**). Alternatively, the granting of the marketing authorisation should be postponed. Worse still, post-authorisation studies are too often used by marketing authorisation holders as a pretext to keep on the market a drug with an unfavourable risk-benefit balance for a few more years, while awaiting the results of the study required by health authorities (i.e. *rofecoxib* (Vioxx°), *rimonabant* (Acomplia°), *varenicline* (Champix°/Chantix°), etc.).

According to Regulation (EC) 507/2006, a centralised conditional marketing authorisation may be granted only if the risk-benefit balance is positive; if the benefit to public health outweighs the risks inherent to insufficient data; and there are unmet medical needs. These criteria should not be weakened and risk management systems or post-authorisation studies should not be used to circumvent these requirements.

In general, early marketing authorisation for drugs with an unclear safety profile should be avoided. Commercial interests should not deter patient safety and protection. In the instances where there is no unmet medical need (i.e. approval of one more anti-hypertensive drug or of one more anti-inflammatory drug), the trend in earlier approvals is disquieting (**m**).

Moreover, at a time where direct-to-patient communication by pharmaceutical companies is being deregulated (e.g. increase in "disease management" or "compliance support" programmes financed by pharmaceutical companies), **it is essential to ensure that risk management systems and post-authorisation studies are not used to foster patient loyalty to a particular branded medicine, or to drive physicians to prescribe a new medicine** (**n**,**o**).

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offices." (article 63 paragraph 2). It represents a discrimination and inequity in the access to information. Any European citizen should be able to receive a copy of the declarations of interests at least per post or by e-mail.

k- Pharmaceutical companies and drug regulatory agencies use risk management systems and post-authorisation studies to reassure the public when they place inadequately evaluated medicines early into the market. *Rimonabant* (formerly marketed as Acomplia°) was licensed for the treatment of obesity. Yet, one of its effects was to increase suicides. The European agencies' responded by setting up a "risk management system", without publishing any of its details. It took app. two years after marketing authorisation for *rimonabant* to be withdrawn from the market. The US Food and Drug Administration had refused to approve this drug from the outset. Similarly, *varenicline* (Chantix° or Champixº) has an unfavourable risk-benefit balance in smoking cessation (psychiatric disorders including increased suicide risk, etc.), but thus far the only measure has been to set up a risk management system.

l- *Rimonabant* (Acomplia°) was withdrawn from the European market in October 2008, only 2 years after being granted marketing authorisation in obesity, due to an unfavourable risk-benefit balance (increased suicide risk). The US drug regulatory agency (FDA) on the other hand had refused to approve *rimonabant* on the basis that the risks were inadequately elucidated).

m- The EU Pharmaceutical Sector Inquiry shows that the time from patenting to first approval is down to less than six years (ref: European Commission. Pharmaceutical Sector Inquiry Final Report. Brussels 2009. SEC(2009) 952.p 53).

n- The Commission itself noted that non-interventional studies are "*often of poor quality and frequently promotional*" (ref.: Strategy to better protect public health by strengthening and rationalising EU pharmacovigilance: public consultation on legislative proposals, Brussels, 5 December 2007 (point 3.2.5)).

o- The so-called "compliance programmes" and other "disease management" programmes are increasingly used as a marketing strategy to create brand loyalty (ref. Pharm Exec "DTC's New Job: Boosting Compliance" Sep 1, 2003 http://pharmexec.findpharma.com/pharmexec/article/articleDetail.jsp?id=73307).

For example, in France, in 2006, the pharmaceutical company selling Forsteo° (*strontium*) claimed that it had to set up a "compliance programme" in order to abide to an Health Economics Committee's requirement (ref. "Forsteo° compliance programme: just say no" http://english.prescrire.org/bin/m2/?w=compliance&mid=30832&f=3). During the debates on company-sponsored "compliance programs", the health ministry and the Federation of the French pharmaceutical industry curiously claimed that these programmes were an integrant part of the European marketing authorisation. EMA confirmed in written in reply to an ISDB member's request that no drug companies have yet been asked to conduct such programmes as part of a marketing authorisation agreement (ref. "Compliance programmes: not to be confused with risk management plans" http://english.prescrire.org/bin/m2/?w=compliance&mid=30832&f=3).

5- Cost-effectiveness assessment needs to remain independent from the Drug Regulatory Agencies. The EMA wants to be recognised as the "leading authority" in the evaluation and supervision of medicines. It intends to work more closely with health technology assessment (HTA) bodies to make sure that their assessments are not too divergent. Pharmaceutical companies are increasingly challenging health technology bodies' recommendations when these do not serve their commercial interests. They would like HTA bodies to be bound by EMA decisions (**p**).

HTA bodies have expertise in benefit-risk assessment, as well as in cost-effectiveness assessment. HTA bodies play an important national level role in the sustainability of Member States' social insurance systems. They should remain independent from Drug Regulatory Agencies and from any influence of pharmaceutical companies[17].

Rather than trying to "harmonise" the methods of HTA institutions and limit their scope, or to support approaches that would not take into account the varied context of different Members States, EMA' role is to act as a provider of information. It should provide HTA bodies and the scientific community with complete assessment reports, as well as any relevant data corroborating its decisions. Once again, openness and transparency are crucial to enable others to build on EMA's work.

6- Patient safety working area needs to be strengthened. We welcome EMA's willingness to improve patient safety, yet the emphasis on this working area needs to be clearly identified as a priority in the Agency's Road Map to 2015.

The Recommendation on patient safety from the Council of the European Union from June 2009 stresses the importance of improving patient safety in Europe[18]. Patient safety, particularly the prevention of medication errors, is a working area that was specifically endorsed by DG Sanco[19] and that needs to be followed up by the EMA.

Priorities are to:

- improve the quality of packaging to minimise the medication errors in practice. Guidelines on naming, labelling and packaging of medicinal products need to be reviewed to proactively address patient safety concerns. In addition, packaging, labelling and package leaflets should be subject to user testing both in the hospital and ambulatory settings. The comprehensive results of such tests should be assessed by Drug Regulatory Agencies before granting a marketing authorisation;

- encourage the use of the international non-proprietary names (INNs) in daily life. Using the INN rather than the brand name improves medication safety (**q**). The risks involved in using a given proprietary name should be assessed to identify possible sound-alike or look-alike names, which could create confusion in users, when taking into account the brand names of medicines that are already on the market. This assessment should be submitted to the drug regulatory agencies as a component of the application for marketing authorisation. Proposed names should be modified or rejected when the systematic review and user testing identify a higher risk of misunderstanding[20]. The minutes of the meetings of the Drug Names Review Group should be made publicly available.

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p- For example, Servier challenged the National Institute for Clinical Excellence (NICE) because its recommendations on Protelos° (*strontium*) differed from the EMA's conclusions. The appeal court said that NICE was not bound to EMA's decisions, but that NICE should give clear explanations to appellants for decisions against them, particularly when they ran "*contrary to the reasoned decision of an equivalently eminent body*" (ref. "NICE to review guidance on Protelos after challenge" *SCRIP* 16 April 2010 : 23).

q- The INN is the name of the active substance. Its common stem identifies the therapeutic class the substance belongs to. The INN should be visible also on the primary packaging (bottle, blister, vial, etc.) and also on devices included in the packaging (particularly for liquid preparations, mentioning the dose per graduation). It is in fact customary for patients to throw away the box and only keep the blister in their bags or purses.

In short: concrete proposals for improvements of the draft EMA roadmap to 2015

In its draft roadmap to 2015, the EMA details plans to strengthen its fee-for-service relationship with pharmaceutical companies, which represent a threat to its independence. The EMA should seize this opportunity to take stock of the pharmaceutical portfolio change within the European Commission structure to **become more independent and accountable to the public (r)**.

To be able to carry out its public health tasks, the Agency needs to:

- **be weaned off a fee-for-service relationship with pharmaceutical companies through public funding from the European Union** (**s**);
- **reconsider its proposal to give systematic scientific advice** that places the Agency in an untenable position in terms of conflict of interest;
- **concentrate on evidence** (scientific data) from clinical studies that have been designed to meet health needs, and **assess the benefit-risk balance of medicinal products on a comparative basis (therapeutic advance)**;
- improve and **enforce its transparency requirements to effectively prevent conflicts of interest**;
- encourage the **interaction with independent civil society representatives;**
- **prevent "conditional", "accelerated" or "staggered" marketing authorisations from becoming the rule** rather than the exception, if no genuine unmet medical need is at stake, so as to prevent unnecessary exposure to avoidable harm;
- coordinate the activities from its various committees, coordination groups and working parties, while **guaranteeing the separation of powers among committees that approve medicinal products from the pharmacovigilance committee** (currently, pharmacovigilance decisions are often delayed, the most recent example being the case of Avandia° (rosiglitazone): having licensed the medicine in the first place, authorising committees have difficulties in overturning their original decision) (**t**).

Among the working areas in its work plan to 2015, **the EMA should also include a specific chapter on transparency.**

As a public supranational regulatory body in the field of medicines, and bearing in mind the major impact its decisions have on public health, EMA must be accountable to the general public. Its transparency policy needs to be improved and strengthened to demonstrate its political willingness to serve first and foremost citizens' interests and public health[2].

In order to improve EMA's transparency, the EMEA should make the following documents easily accessible online:

- using the **Eudrapharm database**[21]: package leaflets, summary of product characteristics (including details of votes in the approval process[22]), labelling (including the mock-ups of the outer packaging (i.e. the box), of the primary packaging (e.g. blisters) and of any delivery device), public assessment reports, risk management plans together with the detailed conditions to be fulfilled and their deadline, and when completed, the results of the post-authorisation studies/risk management plan measures (in the case of non-completion a clear indication that the deadline was not respected should be included); periodic safety update reports (PSURs) (or at least the assessment reports of these PSURs);

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r- Since early 2010, the EMA is under the supervision of Directorate General Health and Consumer policy (DG SANCO) rather than under DG Enterprise and Industry.

s- The regulations introduced in 2004 increased the independence of and resources allotted to pharmacovigilance by requiring its public funding: "*activities relating to pharmacovigilance* (...) *shall receive adequate public funding commensurate with the tasks conferred*" (article 67(4) of Regulation (EC) 726/2004).

t- The legislative proposals on pharmacovigilance which are being currently discussed by the European Parliament should allow for more authority and autonomy for the future committee on pharmacovigilance. It is important to prevent delayed decision-making and its negative impacts to public health. Examples include:

- the case of *nimesulide:* after several months of hesitation, the CHMP confirmed the hepatic risks of *nimesulide* (Nexen°), but introduced half-baked measures, limiting the treatment duration to 15 days, while leaving European patients exposed to the risk of death. This was unjustified, given the large number of existing anti-inflammatory drugs with similar efficacy and better safety profile;

- the case of *rimonabant* (Acomplia°) (read note k on page 4);

- the arbitration procedure on the combination *paracetamol* + *dextropropoxyphene* (Di-antalvic°): this arbitration went on for a year and a half before the CHMP finally recommended its withdrawal in June 2009, due to its unfavourable risk-benefit balance. By end April 2010, the European Commission had not confirmed the June 2009 CHMP recommendation. This means that, in practice, European citizens in some Member States are still exposed to Di-antalvic°-induced harm.

- using the **EudraCT database**[23]: detailed protocols, a draft consent form model, detailed results (raw data) enabling independent analysis. In fact, clinical trials participants expect trial outcomes to contribute to the advancement of science;
- using the **EudraVigilance database**[24]: access to the full content of the Eudravigilance database, which consists of scientific data of public-interest. In fact, adverse drug reactions (ADRs) are reported by health professionals and patients to facilitate the accumulation of scientific knowledge, and to prevent otherwise avoidable ADRs and drug-induced harm;
- through the **EMA's website**[25]: the detailed agenda of the Committee meetings (CHMP, COMP, HPMC, PDCO, CAT, future pharmacovigilance Committee) and of the Coordination group (CMDh) meetings; the transcripts of each of these meetings including the list of all experts attending and of experts not allowed to participate due to conflicts of interests, as well as a "*description of decisions taken, details of votes and explanations of votes, including minority opinions*" (alignment with article 126b of Directive 2001/83/EC consolidated).

The register held by the Agency with all the declarations of competing interests should be accessible online for any given meeting of committees, "coordination group", working party or working group.

In addition, EMA's committees and the CMDh should meet openly in public, on a similar model to the FDA's expert advisory committee meetings, enabling open submissions and public meeting attendance[26].

The redefinition of commercially confidential information is crucial to the improvement of transparency. The new EMEA transparency policy should be based on the general principle of access to all documents. "Commercially confidential information" should be defined and interpreted very strictly (**u**). An open debate should take place, civil society representatives should be invited to present views, particularly those who have requested information to EMA and to whom access has been denied on the grounds of "commercial confidentiality". This initiative should provide the platform for a comprehensive mapping and analysis of the specific needs in medicines information for various target groups: patients, consumers, health professionals, social protection bodies, independent drug bulletins, HTA institutions, etc.

The EMA should also include another important aspect in its work plan to 2015: medical devices' evaluation.

The **medical devices** market is rapidly expanding[27]. The EMA should structurally adjust to be able to **scientifically assess medical devices being marketed in the European Union**. The US Food and Drug Administration can rely on the expertise of its Center for Devices and Radiological Health (CDRH) which is responsible for regulating companies that manufacture, repackage, re-label, and/or import medical devices sold in the United States[28].

Thank you for taking our comments into account when establishing the final EMA Roadmap to 2015.

Sincerely,

HAI Europe **ISDB** **MiEF**

HAI Europe. Health Action International (HAI) is an independent network of health, consumer and development organisations working to increase access to essential medicines and improve rational use. More info: www.haiweb.org. Contact: teresa@haiweb.org.

ISDB. International Society of Drug Bulletins (ISDB), founded in 1986, is a world wide Network of bulletins and journals on drugs and therapeutics that are financially and intellectually independent of pharmaceutical industry. Currently, it has 80 members in 40 countries around the world. More info: www.isdbweb.org. Contact : js@bukopharma.de.

MiEF. Medicines in Europe Forum (MiEF), launched in March 2002, covers 12 European Member States. It includes more than 70 member organizations representing four key players on the health field, i.e. patients groups, family and consumer bodies, social security systems, and health professionals. Such a grouping is unique in the history of the EU, and it certainly reflects the important stakes and expectations regarding European medicines policy. Admittedly, medicines are no simple consumer goods, and the Union represents an opportunity for European citizens when it comes to guarantees of efficacy, safety and pricing. Contact: pierrechirac@aol.com.

u- All data with a bearing on human health, notably clinical data, should be excluded from the definition of "commercial confidentiality".

Some references

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2- For more details, read our detailed answer to EMA's consultation on its draft transparency policy at: http://prescrire.org/docus/JointAnswerEMEATranspPolicy_Sept2009.pdf: 38 pages

+ Annex A to this answer: Prescrire Editorial Staff "Legal obligations for transparency at the European Medicines Agency: Prescrire's assessment over four years" *Prescrire International* 2009; **18** (103): 228-234. Available at: http://www.prescrire.org/docus/Transparency.pdf.

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