

**A PROPOSAL FOR A TRANS-TASMAN AGENCY TO  
REGULATE THERAPEUTIC PRODUCTS**

**RESEARCHED MEDICINES INDUSTRY ASSOCIATION OF NEW ZEALAND  
SUBMISSION ON THE DISCUSSION PAPER JUNE 2002**

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**PREAMBLE**

The Researched Medicines Industry Association of New Zealand (RMI) is the professional and trade organisation of New Zealand's research-based pharmaceutical industry. Its 24 member companies are engaged in the research, development, manufacture and marketing of prescription medicines and the ongoing improvement of medical and scientific knowledge about their products.

The RMI comprises member companies with a range of specialities and interests. The different nature of the companies (size, commercial focus, reporting lines, research interests, etc.) is reflected in the range of views on the proposed Trans-Tasman Therapeutic Goods Authority (TTTGA) received by RMI from companies. Hence, this submission concentrates on areas where there is broad industry consensus from RMI members. In addition to this submission on behalf of its members, RMI has recommended that each member company make its own written submission to Medsafe on the Discussion Paper.

Since RMI companies are principally involved in prescription medicines, this submission does not cover in any great detail the proposed regulation of over-the-counter (OTC) medicines, complementary healthcare products or medical devices.

For the most part, this submission follows the order of the text in the Discussion Paper. Section headings from the Discussion Paper are included only where comments have been made.

## EXECUTIVE SUMMARY

RMI is broadly in favour of a joint New Zealand/ Australia regulatory authority covering therapeutic products, and concurs with the over-arching principles for the proposed regulatory scheme, as stated under Part C, section 1.4 of the Discussion Paper.

New Zealand and Australian companies could benefit from being part of a larger regional grouping with products controlled under the auspices of a respected regulatory authority with sufficient critical mass to ensure world-class evaluation, control and audit functions. A common regulatory regime would also provide access to a greater pool of scientific expertise. In turn, these factors would provide consumers with rapid access to new and innovative medicines. Increasing the profile of New Zealand as a market for therapeutic products, and a place to conduct research activities, would also help achieve RMI and the New Zealand Government's stated aims of stimulating international investment in the New Zealand knowledge economy.

RMI is keen that any trans-Tasman Therapeutic Goods Authority (TTTGA) should incorporate the best aspects of the current Medsafe and Australian Therapeutic Goods Administration (TGA) regimes and eliminate the least acceptable elements of the current regimes (e.g. unnecessary "local" technical and regulatory requirements). Where possible, the TTTGA should utilise international regulatory best practices (ICH, CPMP, GHTF, etc.). The TTTGA should ideally become a centre of excellence that could in due course expand its influence into the wider SE Asia/Pacific region.

RMI supports the regulation of *all* therapeutic products (i.e. prescription and over-the-counter medicines, complementary healthcare products, and medical devices) by the proposed TTTGA, in order to ensure adequate safety, quality and efficacy of products being marketed in New Zealand and Australia. For each category of product, RMI is in favour of regulatory controls being applied using appropriate "risk assessment" principles.

From an industry perspective, RMI notes that the regulatory controls would facilitate access to appropriate, safe and effective therapeutic products, utilise international regulatory best practices, and make decisions in an acceptable timeframe. However, RMI has significant concerns that the Discussion Paper does not include any specific statement about the costs of compliance with the proposed regulatory controls.

RMI notes that, although Medsafe may not have as robust a regime as the TGA, the current controls in New Zealand have for many years provided essentially the same regulatory outcome as in Australia. Although the TTTGA would

provide a single point of access to a larger trans-Tasman market, New Zealand companies do not see many benefits in moving toward a regulatory authority that would be similar in organisation and culture to the current TGA. The TGA is generally considered to impose excessive control through an unnecessarily bureaucratic and costly regime.

RMI therefore strongly recommends that “impose minimal regulatory controls and compliance costs, consistent with the protection of public safety” be added to the list of guiding principles for any proposed regulatory regime.

Similarly, New Zealand companies do not foresee any benefit in paying a level of fees similar to those currently charged by the TGA. RMI would strongly oppose a cost structure for the TTTGA that exceeded the current running costs of TGA alone.

RMI notes that the cost-containment strategies operated by the Pharmaceutical Management Agency Ltd (PHARMAC) have had a major impact on the regulatory environment for therapeutic products in New Zealand. Although the reimbursement policies of PHARMAC and the Australian Pharmaceutical Benefits Scheme (PBS) lie outside the scope of the TTTGA proposals in the Discussion Paper, they could have a major impact on the success or otherwise of the TTTGA, and in the provision of new and innovative products to consumers. For this reason, RMI strongly recommends that the New Zealand and Australian governments include due consideration of the impact of reimbursement policies on the operating environment for therapeutic products as part of the review of the TTTGA proposals.

RMI notes that the establishment of the TTTGA would not tighten existing arrangements in relation to parallel importation. Since PHARMAC policies have resulted in the price for many New Zealand products being substantially lower than in Australia and elsewhere, the illegal trans-Tasman trade in therapeutic goods is likely to continue. Indeed, unless a sponsor company took additional steps to safeguard its own interests (e.g. by distributing different batches in New Zealand and Australia), it is likely that the source of products labelled with a single trans-Tasman Product Licence (PL) number would be more difficult to trace than at present. In this case, any benefits of having a single PL would be negated and the onus of controlling parallel importation would fall on the industry, rather than on the regulatory authority. Therefore, RMI strongly recommends that the regulatory controls be reviewed, in order to achieve a satisfactory mechanism for preventing parallel importation.

In this submission, RMI has raised a number of concerns about proposals in the Discussion Paper, and has provided a number of recommendations for the TTTGA project team to consider. The main areas of additional concern are as follows:

- **Governance and accountability.**

RMI is concerned about the size and make-up of the Board, and the potential for bias towards the Australian partner. Instead of the proposed Board of five members, RMI recommends that the Board be constituted with seven persons with relevant expertise, and with a minimum of three persons on the Board being New Zealand citizens/residents.
- **Organisation of the Agency.**

RMI notes that there is a high risk that New Zealand would, over time, lose the expertise to evaluate new medicines, particularly if the principal functions of the TTTGA were located in Australia. For this reason, RMI recommends that the TTTGA retain a significant core of expertise within New Zealand, and/or establish a “centre of excellence” in New Zealand for specific regulatory activities.
- **Stakeholder input.**

RMI believes that the valued input of major stakeholders should be an integral part of the management of the TTTGA and recommends that stakeholder representation should be formalised. This could be achieved by the formation of a separate advisory committee, reporting at Board level rather than to the Managing Director.
- **Protection and release of information.**

RMI notes that the New Zealand Official Information Act 1982 (OIA) is generally more permissive than the Australian Freedom of Information Act 1982 (FOI), in terms of the type of data that may be released by the respective regulatory authority. RMI shares the concerns of international companies regarding the release of information that in most countries would be considered commercially sensitive, and which could be used by a competitor for commercial advantage. RMI recommends that the legislation establishing the TTTGA specifically define the extent and limitations of the OIA and FOI, in relation to the release of information held by the authority.
- **Consumer Medicines Information (CMI).**

RMI generally supports the proposal to extend the requirement for CMI to all prescription and pharmacist only medicines. However, this should not be mandatory until the issues relating to delivery of CMI have been resolved.

- **Clinical trials.**

RMI considers that the TTTGA proposals could enhance the potential for clinical research in both New Zealand and Australia. However, the potential benefits depend upon achieving a regulatory regime that is clearly based on international best practices that could provide decisions in an acceptable time frame, and with minimal compliance costs to industry.
- **Generic medicines.**

RMI generally supports the proposed approach to determining bioequivalence of generic medicines. However, RMI notes that any regulatory regime would have to take into account the distortion of the generics market that has resulted from various PHARMAC policies. As a consequence of these policies, the innovator product in New Zealand is often no longer the market leader, and may even have been removed from the market for commercial reasons.
- **Advertising.**

RMI supports regulation of advertising in a way that promotes the appropriate and safe use of therapeutic products. RMI supports the implementation of a principles-based trans-Tasman code for therapeutic advertising, supported by a self-regulatory advertising regime along the lines of the existing systems in New Zealand. Common regulatory outcomes could be delivered across both countries by the establishment of a single trans-Tasman advertising appeals body. RMI will participate fully in the review of advertising arrangements in Australia and New Zealand, through the trans-Tasman Expert Group on Advertising and input into the independent review by Mike Codd.
- **Transitional arrangements.**

RMI supports the proposed principles that would apply to the transitional arrangements for therapeutic products, notably the principle of imposing the lowest possible compliance costs consistent with adequately protecting public health and safety. RMI is already involved with Medsafe in a scoping project to look at transitional arrangements for medicines and is keen to be involved in further developing any regulatory principles by which harmonisation of approvals could be achieved.

Other than indicating that the TTTGA will operate on a full cost-recovery basis, the Discussion Paper contains no information about the financial aspects of the proposal for a joint regulatory agency. RMI notes that the New Zealand Institute of Economic Reform (NZIER) has been commissioned to provide an analysis of the costs and benefits of the proposed scheme, but that the NZIER report is not yet available to stakeholders.

Because of the size and nature of the New Zealand industry, it is clear that the “cost burden” of any TTTGA to the New Zealand industry would be much greater than that to the Australian Industry. Hence, it is more likely that implementation of the proposed TTTGA would result in a movement of industry capacity and skills towards the “centre of gravity” in Australia. This would be accompanied by a corresponding marked reduction in the ability of the New Zealand industry to maintain a critical mass.

Clearly, no definitive assessment of the TTTGA proposals can be made by industry until the proposed fee structure of the authority is available (i.e. evaluation fees, annual licence fees, etc.). Moreover, RMI is unable to indicate support, or otherwise, for the TTTGA proposals until the likely economic impact on the New Zealand industry sector and overall New Zealand economy is known.

## **PART A: DESIGN AND ROLE OF THE AGENCY**

### **2. NAME OF THE AGENCY**

***Question 1: Do you have any suggestions for a suitable name for the agency?***

A number of suggestions have been suggested, including:

- Medsafe Australia New Zealand (MANZ)
- Trans-Tasman Therapeutic Products Authority (TTTPA, or T<sup>3</sup>PA)
- Australia & NZ Therapeutic Products Authority (ANZTPA)
- Trans-Tasman Medicines Control Authority (TTMCA)
- Australia & NZ Medicines Control Authority (ANZMCA)
- Therapeutic Products Risk Management Authority (TPRMA).

In each case, “Agency” could be substituted for “Authority”. Likewise, “Medical Products” could be substituted by “Therapeutic Products” (see also the comments under Question 5 below).

The term “Therapeutic Products” is generally preferable to “Therapeutic Goods”, as this better indicates that the products are healthcare items, rather than goods for commercial sale.

Please note that throughout this submission, the term Trans-Tasman Therapeutic Goods Administration (TTTGA) has been used for the proposed joint New Zealand/Australia regulatory agency.

### **3. GOVERNANCE AND ACCOUNTABILITY**

#### **3.4 Board**

RMI has concerns over the make-up of the Board. Despite both countries having an equal representation at Ministerial Council level, there would be a possibility of an Australian bias at the Board level. Although a minimum number of Australian citizens/residents is stated, there is no equivalent proposal for any Board member to be a New Zealand citizen/resident.

It would not be unrealistic for the Board to be made up of four Australians to one New Zealander. Although the Discussion Paper states that Board members would be appointed on merit rather than citizenship/residency, it is possible that members would primarily represent their own country or individual stakeholder’s interests in any matter.

Moreover, RMI considers that a Board of only five persons could increase the potential for bias towards one of the two partner countries. A Board of only five

persons would also limit the expertise that could be called upon for the benefit of the TTTGA.

For the above reasons, RMI recommends that the Board be constituted with seven persons having relevant expertise, with a minimum of three being New Zealand citizens/residents.

### **3.6 Stakeholder Input**

RMI believes that the valued input of major stakeholders is an integral part of the management of the TTTGA. For this reason, RMI recommends that stakeholder representation be formalised in some way, rather than simply "consultation and input", as stated in the Discussion Paper. This could take the form of a separate advisory committee, reporting at Board level rather than to the Managing Director.

Meetings the stakeholder advisory committee should be held more often than the twice a year stated in the Discussion Paper.

### **3.9 Accountability to Parliaments**

***Question 2:** The governance and accountability arrangements described have been developed by officials and have the in-principle agreement of both Governments. Are there any aspects of the governance and accountability arrangements that you feel could be improved? If so, what alternative(s) would you recommend and why?*

See separate comments under sections 3.4 and 3.6 above.

## **4. INTERNAL ORGANISATION OF THE AGENCY**

***Question 3:** What are the key issues that should influence the internal organisation of the Agency?*

RMI supports an internal organisation of the TTTGA according to type of product (i.e. prescription and OTC medicines, complementary healthcare products, and medical devices), plus other units with responsibility for regulatory activities that apply to more than one type of product. (e.g. compliance and auditing activities, export certification and laboratory testing).

However, RMI favours an organisational structure that is flexible in approach, rather than operating in fixed units with rigid boundaries. In any case, the staffing level of each unit should be sufficient to ensure that assessments are conducted in a timely manner and that performance measures are achieved.

Clearly, the TTTGA should incorporate the best aspects of the current Medsafe and TGA regimes and eliminate the least acceptable elements of the current regimes. In particular, the TTTGA should be free of any “local” technical and regulatory requirements (or local *interpretation* of international guidelines), unless absolutely necessary for ensuring the safety of New Zealand and Australian consumers. Ideally, this should be achieved with the minimum level of regulatory controls and compliance costs.

A TTTGA would include certain elements of the existing administrative systems and much of the current human resources expertise of Medsafe and TGA. There is a high risk, however, that New Zealand would over time lose the expertise to evaluate new medicines, particularly if the principal functions of the TTTGA were located in Australia. The Food Standards Authority Australia New Zealand (formerly ANZFA) is an example where New Zealand has been relegated to the status of an administrative branch office.

RMI recommends that the TTTGA should retain a significant core of expertise within New Zealand. This could involve individual staff members with expertise in particular areas (e.g. pharmaceutical chemistry, or a specific therapeutic area), and/or the establishment of a “centre of excellence” in New Zealand for specific regulatory activities (e.g. evaluation of generic medicines, pharmacovigilance, etc.).

## **PART B: ESTABLISHING THE AGENCY AND THE REGULATORY SCHEME**

### **1. ESTABLISHING THE AGENCY**

***Question 4:*** *Do you have any concerns in relation to the blended approach of the Agency? If so, how might these be addressed?*

RMI believes that the blended approach is a pragmatic way of establishing the TTTGA and allowing the concerns of each country to be addressed. It is likely, however, that this arrangement will be perceived by certain New Zealand stakeholders as an unnecessary ceding of sovereignty to Australia.

## **PART C: REGULATORY SCHEME FOR THERAPEUTIC PRODUCTS**

### **1. OVERVIEW**

#### **1.1 Scope of the Regulatory Scheme**

RMI believes that the proposed definition of “therapeutic product” needs to be revised. The wording “...an ingredient or component in the manufacture of therapeutic products...” should probably read “any *active* ingredient, or component...”, i.e. there is no reason to include all pharmaceutical excipients in this definition. In this respect, RMI notes that “starting materials” would be specifically exempted from the requirement for a PL (see section 2.2.8 of the Discussion Paper).

#### **1.2 Terminology**

***Question 5:** Please indicate your preferred collective term to describe the products to be regulated by the agency.*

RMI recommends the use of “therapeutic product”. This term fully encompasses the concept of therapeutic use and the range of medicines and medical devices that would be regulated by the TTTGA.

The term “medical product” might be better understood by the lay public, but might confer an unnecessarily “clinical” interpretation for lower-risk medicines and complementary healthcare products.

#### **1.3 Types of Therapeutic Products**

***Question 6:** Do you agree with the overall scope of the regulatory framework set out above? If not, in what respect should it be modified, and why?*

RMI considers the overall scope of the proposed regulatory framework to be sound.

RMI notes that the definition of medical products is currently being reviewed by the regulatory authorities in the European Union (EU). Where possible, the definitions for medicines and medical devices under the TTTGA should reflect those used by regulatory authorities in other major overseas markets, notably those involved in the International Conference on Harmonisation (ICH) process.

## 1.4 Principles of the Regulatory Scheme

***Question 7: Are there other principles you think should be applied when developing further detail on the regulatory framework for therapeutic products?***

RMI has significant concerns that the Discussion Paper does not include any statement about the cost of compliance with the proposed regulatory controls. Although Medsafe may not have as robust a regime as the TGA, the current controls in New Zealand have for many years provided essentially the same regulatory outcome as in Australia. Although the TTTGA would provide a single point of access to a larger trans-Tasman market, companies do not see many benefits in moving toward a regulatory authority that would be similar in organisation and culture to the current TGA. The TGA is generally considered to impose excessive control through an unnecessarily bureaucratic and costly regime.

RMI strongly recommends that “impose minimal regulatory controls and compliance costs, consistent with the protection of public safety” be added to the list of guiding principles for any proposed regulatory regime.

RMI recommends that the policy and regulatory framework for therapeutic products should encourage and reward overseas investment in New Zealand and Australia. This could include encouragement of the establishment of manufacturing or research facilities in either country.

***Question 8: Under what circumstances do you think it should be possible to invoke the opt-out mechanism?***

RMI considers that the opt-out mechanism should only be invoked in the case of a *major* government policy difference in one of the jurisdictions (e.g. genetic engineering, cultural issues, etc.), or where a significant safety issue can be identified (e.g. potential for misuse/abuse of a product).

RMI recommends that the opt-out mechanism should not apply to economic or funding issues.

## 1.5 Risk-based Approach to Regulation

***Question 9:*** Do you agree that the Agency should adopt a risk-based approach to the regulation of therapeutic products? If not, what alternative approach would you suggest? Why would this alternative approach be more effective in achieving the overall objective of protecting public health and safety?

RMI supports the regulation of therapeutic products according to the level of the assessed risk.

## 1.7 Protection and Release of Information

***Question 10:*** Are there any other categories of information that would be held by the proposed joint agency and which should be subject to controls on its release, either permanently or for a defined time period? Please identify any such categories and explain why you take this view. Please provide relevant material and comment to justify your view bearing in mind the recognised public interest in maintaining open Government.

Although the purpose of both the New Zealand OIA and Australian FOI is to provide for openness in government, the scope of the legislation in the two countries varies considerably. The OIA is generally more permissive than the Australian FOI Act, with regard to the type of data that can be released. Internationally, companies are concerned that Medsafe can release details about therapeutic products that in most countries would be considered commercially sensitive information, and which could be used by a competitor for commercial advantage. In a joint authority environment, companies may be reluctant to submit applications if the information submitted is subject to both Acts, and if the more “lenient” provisions apply.

RMI recommends that the legislation establishing the TTTGA specifically define the extent and limitations of the OIA and FOI, in relation to information on therapeutic products held by the authority. This would provide clarity to industry and other stakeholders, and preclude adverse consequences arising as a result of future amendments to the principal Acts in each country.

RMI recommends that the following information be considered commercially sensitive information and should not be released by the TTTGA:

- product formulation details
- manufacturing processes for active ingredients and finished product
- manufacturers of active ingredients
- manufacturers of finished products
- product specifications
- assay and test procedures
- unpublished clinical data.

RMI notes that the European Union is currently considering extending the data exclusivity period for therapeutic products from 5 years to 10 years. RMI supports a 10-year exclusivity period and recommends that the data exclusivity period be included in the review by the TTTGA project team.

## 1.9 Fees and Charges

***Question 11:** Are there any other principles you think should be applied to the setting of fees?*

RMI endorses the concerns of New Zealand companies regarding the current disparity in the current fees charged by Medsafe and TGA. For example, an application for approval of a new active substance costs approximately A\$12,500 in New Zealand, compared to A\$200,000+ in Australia. Despite these major differences, Medsafe and TGA controls provide essentially the same regulatory outcome in both countries.

Views have been expressed that the overall costs of the TTTGA would approximately equal the sum of the current running costs of Medsafe and TGA. However, RMI would strongly oppose a cost structure for the TTTGA that exceeded the current running costs of TGA alone.

Most RMI companies operate on an international basis and would likely license products across both New Zealand and Australia. Clearly, there would be major cost impediments to any sponsor company wishing to apply for a PL only in New Zealand. This is likely to negatively impact on the New Zealand industry and economy. Hence, RMI recommends that consideration be given to substantially lower evaluation fees where a sponsor company has indicated that a product will only be marketed in one or other country.

RMI notes that the cost-containment strategies operated by PHARMAC have had a major impact on the regulatory environment for therapeutic products in New Zealand. In particular, PHARMAC contracts for sole-supply of products mean that sponsor companies have to bear the full costs of gaining and maintaining product approvals, yet have no guarantee that they will find a market for their products. Although the reimbursement policies of PHARMAC and the PBS lie outside the scope of the Discussion Paper, they could have a major bearing on the success or otherwise of the TTTGA, and in the provision of new and innovative products to consumers.

RMI recommends that the TTTGA fee structure reflect the current and future impact of PHARMAC/PBS policies. For products that are not fully subsidised, this could include a minimal annual licence fee to cover administrative costs only, lower evaluation fees for changes to keep the product file up to date, etc.

## 2. REGULATORY MECHANISMS

***Question 12: Do you support the concept of product licensing for therapeutic products?***

RMI supports the concept of product licensing for therapeutic products, based upon a risk-assessment of the safety, quality and efficacy of products.

RMI also supports the concept of a provisional PL (for a time-limited period, subject to conditions and further assessment of the product at the end of the authorisation period), but would not favour a system of periodic review and renewals of PLs across all products, akin to the European system.

See also RMI's comments on Export Medicines, under Part D, section 10.

***Question 13: What requirements should be imposed on licence holders through the "standard conditions" on a product licence?***

RMI supports the standard conditions listed in the Discussion Paper. As indicated above, post-marketing requirements for safety reporting, etc. should be in line with those promulgated by international organisations such as ICH. Any standard conditions should appear on the product licence.

***Question 14: Are the criteria for determining what is a separate and distinct product reasonable? If not, what criteria should be used and why would these criteria be more appropriate?***

RMI has no issue with the criteria listed in the Discussion Paper.

### 2.2.9 Parallel importation

RMI notes that the establishment of the TTTGA would not improve existing arrangements in relation to parallel importation. It is true that the current regulatory mechanisms in each country prohibit importation of a product without the consent of the sponsor company and this prohibition would be retained. However, in the case where a product had a joint PL and was labelled with a single PL number, it would be extremely difficult to trace the exact source of the product. In such a case, it would be up to the sponsor to take additional steps to safeguard its interests, for example by distributing different batches of the product in each country. This would unfortunately negate any benefits of having a single PL.

As indicated above, the cost-containment strategies operated by PHARMAC have led to the prices for many New Zealand products being substantially

lower than in Australia and elsewhere. This situation, along with reduced traceability of products, is likely to increase the illegal trans-Tasman trade in therapeutic goods.

RMI strongly recommends that the product licensing scheme be reviewed, in order to achieve a satisfactory mechanism for preventing parallel importation.

### **2.3 Register of Therapeutic Products**

***Question 15: Certain information held in the Register of Therapeutic Products would be available to the public. What information should be publicly available? What additional information should be available to sponsors?***

The information in the Register could reflect the core details on the PL document (see section 2.2.1 of the Discussion Paper), with the exception of commercially sensitive information, such as quantitative formulation details, manufacturers of finished products, etc. (see also comments under Question 10 above). Other information available on the CMI (e.g. storage conditions) could also be included.

Sponsors should ideally be able to access additional details about their own products, e.g. shelf life, approved variations, expiry of provisional consent, licence fee details, etc. Other companies should only be able to access information in addition to that held on the Register via a specific request under the provisions of the OIA or FOI legislation.

### **2.4 Expert Advisory Committees**

***Question 16: Do you think the range of expert advisory committees described above is appropriate? If not, what other expert advisory committees should there be, and what would be the functions of these committees?***

RMI notes that the range of expertise on expert advisory committees listed under point 2.4 of the Discussion Paper does not include any reference to persons with expertise and experience in the pharmaceutical industry. As indicated in the comments on Part A, section 3.6 above, RMI recommends that stakeholder representation be formalised, possibly as a separate advisory committee to the Board. As a general rule, there should be industry representation on committees, where appropriate.

## **PART D: REGULATION OF MEDICINES**

### **1. RISK-BASED APPROACH TO REGULATION**

*Question 17: Do you agree with the risk-based approach to the regulation of medicines described in this section of the paper? If not, what alternative approaches would you like to see applied? Please indicate why you consider the alternative approach would be more appropriate.*

RMI supports the risk-based approach to the regulation of medicines. As stated above, however, this should be implemented at the lowest possible compliance costs and regulatory controls, consistent with the protection of public safety.

### **3. STANDARD TERMINOLOGY FOR MEDICINES**

While RMI generally supports the use of standard terminology for the naming of substances, it recommends that the TTTGA adopt a flexible approach, in order to accept names ratified by major international organisations. This will enable harmonisation of labelling with jurisdictions such as Europe and the USA.

RMI recommends that the recommended International Non-proprietary Name (rINN) replace the Australian Approved Name (AAN) and Australian Biological Name (ABN) in most instances.

### **4. SCHEDULING OF MEDICINES**

In order to reduce unnecessary regulatory controls and compliance costs, and to further harmonise the scheduling between New Zealand and Australia, RMI recommends that the separate State involvement in determining medicine classifications in Australia be removed.

### **5. INFORMATION ABOUT MEDICINES**

#### **5.1 Labelling Requirements**

RMI generally supports the proposed labelling requirements for medicines. However, the mandatory inclusion of the PL number could place an unnecessary fetter on industry, as it would require specific New Zealand/Australian labelling. Hence, therapeutic products imported from major overseas markets would have to be re-labelled. In addition, PL numbers on packs exported from New Zealand/Australia could be confused with PL numbers used in the importing country.

RMI recommends that the list of elements included on labels should also include the relevant classification statement for the product.

## **5.2 Information for Prescribers**

RMI recommends that, rather than “Product Information”, the information for healthcare professionals be named “Prescriber Medicines Information” (PMI), “Health Professionals Medicines Information” (HPMI), or similar. This would clearly distinguish it from the Consumer Medicines Information (CMI) and limit any confusion in the minds of consumers.

## **5.3 Information for Consumers**

***Question 18: Do you agree with the proposal to extend the requirement for CMI to all medicines? What do you see as the advantages and the disadvantages or such a proposal?***

With the exception of certain specialist product (e.g. hospital only medicines), RMI supports the proposal to extend the requirement for CMI to all prescription medicines and pharmacist only medicines. Consumers are becoming more demanding of information about the medicines they take and CMI is a good vehicle for enhancing the advice received from the prescriber or pharmacist.

However, CMI for prescription medicines and pharmacist only medicines should not be a mandatory requirement until the problems of CMI delivery to the consumer have been resolved (see also the response to Question 19 below).

CMI should not be mandatory for pharmacy medicines and general sale medicines. These products have low intrinsic risk and the core consumer information should be provided on the product labelling.

Importantly, CMI should be kept in a concise, easy-to-read format – anything longer than the equivalent of one A4 sheet of text is likely to reduce the communication of relevant information to consumers.

***Question 19: A limitation of CMI is that it often is not readily available to consumers How could this limitation be addressed under a joint agency?***

The issues surrounding delivery of CMI has posed problems both in New Zealand and Australia. RMI considers that companies should be responsible for the preparation of high quality CMI for their products and that companies can be instrumental in the provision of CMI through electronic (e.g. Internet websites) and physical (e.g. package inserts) means.

For prescription medicines and pharmacist only medicines, however, the ideal mode of delivery is a hard copy sheet handed over by (and, where necessary, discussed with) the prescriber and/or pharmacist. Other than provision of the CMI in an original electronic format, it is unreasonable for industry to cover the cost of this form of delivery. Instead, this should ideally be centrally funded by government through professional contracts with prescribers and pharmacists.

***Question 20:*** *Should it be a requirement that CMI be provided as part of the packaging and labelling of a medicine? Should there be any obligation at all on the sponsor to assist consumers in obtaining CMI? Are there other approaches that should be considered?*

RMI does not support CMI being provided as part of the packaging and labelling of a medicine. Although this should remain an option for companies, common packaging lead-times of up to 12 months would mean that this would not be the best way of providing up to date information to consumers. Additional packaging costs would result in higher costs for consumers.

See also the response to Question 19 above.

At a meeting of industry stakeholders in Auckland on 9 July, Susan Martindale indicated that CMI would be the subject of separate TTTGA focus group meetings. RMI is keen to be involved in this process.

## **6. REGULATION OF INGREDIENTS AND INTERMEDIATE PRODUCTS**

### **6.2 Drug Master Files**

RMI recommends that the TTTGA accept European Certificates of Suitability in lieu of Drug Master Files, without the need for additional evaluation of the technical data.

## **8. POST-MARKET SURVEILLANCE OF MEDICINES**

RMI supports the implementation of an appropriately targeted, transparent, and rigorous post-market monitoring system for medicines. Where possible, the TTTGA pharmacovigilance programmes should incorporate the reporting requirements promulgated by international bodies such as ICH.

## 9. ACCESS TO UNLICENSED PRODUCTS

### 9.1 Medicines Used in a Clinical Trial

*Question 21: Should the mechanisms for clinical trial approval be unified in Australia and New Zealand? If so, should there be separate centralised expert scientific approval committees in each country or should there be a joint Australia/New Zealand expert scientific committee?*

RMI considers that the TTTGA proposals could enhance the potential for clinical research in both New Zealand and Australia. International companies could be attracted to perform studies in a regional grouping of countries seen as having a “western” healthcare system and a regulatory authority with sufficient critical mass to ensure world-class evaluation, control and audit functions. A common regulatory regime would facilitate trans-Tasman multicentre studies and allow access to a greater pool of clinical expertise. This would help achieve the RMI and New Zealand Government's stated aims of stimulating international investment in the knowledge economy.

However, these potential benefits depend upon achieving a regulatory regime that is clearly based on international best practices in clinical research, and could provide decisions in an acceptable time frame with minimal compliance costs to industry. The regime should uphold ICH standards & guidelines without imposing unnecessary “local” requirements, maintain a robust technical and ethical review, and follow internationally accepted audit & pharmacovigilance processes.

RMI generally supports the concept of a separate review of the scientific elements of clinical trial protocols, along the lines of the current Health Research Council Standing Committee on Therapeutic Trials (SCOTT). The scientific review should be concurrent with review by local ethics committees and should be confined to products or procedures that do not have an established safety record.

RMI recommends that each country retain a separate expert scientific approval committee. Each committee should recognise the decisions made by the committee in the other country. However, in certain areas where expertise may be difficult to find (e.g. gene therapy/biotechnology), it may be more appropriate to have a single trans-Tasman expert committee. In any case, it is important that the committee is constituted with the relevant expertise to perform the reviews, and have adequate administrative support to enable it to complete reviews in a timely manner.

Although outside the scope of the TTTGA process, RMI would welcome the development of trans-Tasman Code of Good Clinical Research Practice, a trans-

Tasman ethics committee application form, standardised technical/ethics committee review times, etc.

At a meeting of industry stakeholders in Auckland on 9 July, Susan Martindale indicated that clinical trials would be the subject of separate TTTGA focus group meetings. RMI is keen to be involved in this process.

## 9.2 Unlicensed Medicines Supplied to Individuals

***Question 22:*** *What mechanisms should a joint agency put in place to provide an appropriate degree of assurance:*

- *of patient protection;*
- *of informed consent; and*
- *that sponsors do not use the scheme for supply of unlicensed medicines as a means of de facto marketing?*

RMI supports the development of regulatory mechanisms that provide for the limited use of unlicensed medicines to individual patients under controlled conditions.

In line with risk assessment principles, the level of regulatory control should be consistent with the potential for risks to patients. The Australian Category A and Special Access Scheme (SAS) appear to provide an appropriate degree of patient protection for patients suffering from life-threatening and serious medical conditions. However, elements of the New Zealand (effectively “self-certification”) system could be retained for supplies to patients suffering from less serious medical conditions. In any case, controls should be simple, clear, and able to be applied in an expeditious manner.

## 10. MEDICINES FOR EXPORT

RMI supports *limited* regulatory controls on medicines intended solely for export to a country outside New Zealand/Australia. Although products manufactured in New Zealand and Australia should comply with the international requirements of the two countries, RMI considers that the proposed level of regulation for export medicines would stifle export opportunities for the industry.

RMI recommends that the routine requirements for export medicines should be limited to certification that the products have been manufactured in a facility in New Zealand or Australia that is approved by the TTTGA in accordance with the principles of Good Manufacturing Practice (GMP). Where products already have a PL for marketing within New Zealand/Australia, the usual provisions for issuing a certificate of a Pharmaceutical Product would apply. This would enable the importing country to have reasonable assurance of the quality of the

product, without the need for further evaluation and clearance of the product by the TTTGA.

In the case where the sponsor company already has marketing approval in the country to which the product is exported, regulatory control by the TTTGA should be minimal.

***Question 23: Which option for export only licensing do you prefer and why?***

RMI prefers Option 1, as this provides greater flexibility for modification of the export licence, and would involve less administration for the TTTGA and industry. Hence, compliance costs would be lower.

***Question 24: Are the criteria for determining what is a separate and distinct product reasonable? If not, what criteria should be used and why would these criteria be more appropriate?***

RMI considers that the criteria for determining what is a separate and distinct product are reasonable.

## **PART E: REGULATION OF PRESCRIPTION AND OTC MEDICINES**

### **2.4 Sunscreens**

***Question 25: Do you agree with the proposed criteria for categorising sunscreens? If not, what alternative approaches would you propose, and why?***

RMI supports the proposed criteria for categorising sunscreens.

## **3. PRESCRIPTION MEDICINES AND OTHER SPECIFIED CLASS III MEDICINES**

RMI generally supports the proposed criteria for regulating prescription medicines. In particular, RMI supports the use of best international regulatory practice and relevant international guidelines (e.g. CPMP/ICH) in the preparation and evaluation of applications for licensing.

### **3.3 Evaluation Timeframes**

***Question 26: Recognising that imposing statutory timeframes on the evaluation process has the potential to result in increased fees, do you think there should be statutory timeframes? If so, should there be a penalty on the Agency for not meeting the timeframe?***

RMI supports the provision for statutory timeframes on the evaluation process, to ensure timely approval and licensing of new products. RMI also supports financial penalties for the TTTGA if timeframes are not met.

Importantly, however, timeframes must represent “real” deadlines, i.e. timelines that would motivate the TTTGA to work expeditiously but would not allow the authority to artificially manage its workload. Under the present TGA system, a quick evaluation can be made just before a deadline, to ensure penalties are not payable. Instead, RMI would expect to see a “full and complete” evaluation conducted before the deadline, so the company could be fairly certain that it would be unlikely for additional queries to be raised later in the approval process.

### **3.4 Accelerated (or Priority) Evaluation**

***Question 27:** Do you agree that the Agency should have an accelerated (or priority) evaluation system for prescription and other specified Class III medicines? If so, what criteria should be used to determine when priority status should apply to an application? Please give reasons to support your view.*

RMI supports the provision for an accelerated evaluation system for prescription/Class III medicines. Apart from the hastening the supply of medicines in emergency situations, the only basis for an accelerated evaluation should be significant clinical need.

Medsafe currently allows priority assessment based upon “significant potential cost savings” and a similar criterion has been proposed in the Discussion Paper. Although the role of PHARMAC and PBS is otherwise outside the scope of the Discussion Paper, experience has shown that applications from PHARMAC for priority assessment of generic medicines have had a negative effect on the regulation of medicines in New Zealand. The speed of other new medicine applications has been compromised, both for generic and innovative medicines. Often, the potential for cost savings for the prioritised product cannot be adequately defined, and may relate a commercial deal involving a number of different products. For these reasons, RMI strongly recommends that “significant economic benefits” not be included as a criterion for accelerated evaluation.

RMI does not support the provision for accelerated evaluation on payment of a higher fee. As with accelerated evaluation on economic grounds, this could skew the regulatory process. RMI questions whether the TTTGA would be able to ring-fence sufficient evaluation resources just for those applications with accelerated timeframes, without compromising the evaluation of other medicines, and/or significantly increasing compliance costs.

### 3.6 Generic Prescription Medicines

***Question 28: Do you consider the Agency should adopt the approach described above in determining bioequivalence of generic medicines? If not, what alternative approach should be used?***

RMI generally supports the proposed approach to determining bioequivalence of generic medicines. However, it is important to note that the principle of “no lesser accountability” applies here, i.e. evaluation standards for generic medicines should not be lowered in the move to a TTTGA.

Clearly, bioequivalence of the generic product must be established against the local (i.e. the New Zealand and/or Australian) innovator product. In this respect, RMI notes that the introduction of PHARMAC sole supply contracts has resulted in a distortion of the market, and a monopoly situation for just one generic product of a particular active ingredient. As a consequence, the innovator product is often no longer the market leader, and may even have been removed from the market for commercial reasons. The “market leader” product can change with each sole supply contract.

Given an acceptance level of approximately  $\pm 20\%$  for pharmacokinetic parameters, the third generic product in the market could conceivably have 80% of 80% of the clinical activity of the original innovator product. The potential variances within New Zealand would be compounded if the Australian market for generics were included. Any regulatory regime would have to take the above factors into account.

## 4. ORPHAN MEDICINES

***Question 29: How should an orphan products programme work under a joint agency?***

RMI generally supports the proposal for an orphan products programme, along the lines of the current US and European schemes.

RMI notes that since the indicated diseases are rare, not only are the products not commercially viable, but companies are unlikely to invest heavily in the cost of their development. Although it is preferable that these products comply with the same standards as other products, in reality it is unlikely that the safety, quality, and efficacy data available for an orphan product would be as comprehensive as those for non-orphan products. Hence, RMI recommends that “pragmatic” data requirements be established for orphan products. Data deficiencies could be signaled though conditions on the licence, and/or statements in the Prescribing Information document.

***Question 30: What cut-off should apply to the number of affected individuals before orphan designation could be obtained?***

RMI supports the figure of 75 per 100,000 applied under the current US scheme.

***Question 31: Should a period of market exclusivity be offered to orphan products? If so, how should this be achieved?***

RMI supports the ten years exclusivity period applied under the current European scheme.

RMI also supports incentives for sponsors to obtain product licences for orphan products. As indicated above, such incentives could include tax breaks for conducting research into orphan indications within New Zealand or Australia.

## **PART F: REGULATION OF COMPLEMENTARY HEALTHCARE PRODUCTS**

**Question 32: What do you consider to be the appropriate collective term for these products in the legislation and why?**

RMI supports the use of the term “complementary healthcare product” to describe those products currently regulated in Australia as complementary medicines, and products regulated in New Zealand as herbal medicines, homoeopathic medicines and dietary supplements. This term adequately describes the use of these products in the healthcare arena, yet stops short of conferring the status of “medicines” on products that may have limited therapeutic potential.

## **PART G: REGULATION OF MEDICAL DEVICES**

RMI supports the regulation of medical devices by the TTTGA in line with international regulatory best practice, based upon the principles of the Global Harmonisation task Force (GHTF).

***Question 36: Should the mechanisms for approval of clinical trials of devices be unified in Australia and New Zealand? Should there be separate centralised expert scientific approval committees? If so, should there be committees in each country or should there be a joint Australia/New Zealand expert scientific committee?***

See comments under Question 21 above.

**Question 37:** *What mechanisms should a joint agency put in place to provide an appropriate degree of assurance:*

- *of patient protection;*
- *of informed consent; and*
- *that sponsors do not use the scheme for supply of unlicensed medical devices as a means of de facto marketing?*

See comments under Question 22 above.

## **PART H: SURVEILLANCE AND ENFORCEMENT**

RMI generally supports the proposed TTTGA procedures for monitoring compliance with the new regulatory system. In particular, RMI welcomes the proposals to encourage compliance by appropriate self-regulation by the industry.

### **8. Specific Issues**

#### **8.1 Product Tampering**

**Question 38:** *Should tamper-evident packaging be mandatory for products licensed by the Agency for sale in Australia and/or New Zealand? If so, what sort of time period would industry need to introduce tamper evident packaging?*

RMI supports mandatory tamper-evident packaging for therapeutic products openly supplied to the public, i.e. general sales and pharmacy medicines. Clearly, there are cost implications for mandatory tamper-evident packaging and this might limit the availability of otherwise acceptable products from overseas markets.

The supply of pharmacist-only and prescription medicines is channeled through pharmacists. Although manufacturers of pharmacist-only and prescription medicines should be *encouraged* to use tamper-evident packaging, RMI does not support the mandatory requirement of tamper-evident packaging for these types of products.

If tamper-evident packaging were made mandatory, a two-year time period for introduction would probably be appropriate.

**Question 39:** *If tamper-evident packaging was not mandatory, how could the public be adequately protected from the risks associated with undetected tampering?*

Tamper-evident packaging is the preferred method for therapeutic products openly supplied to the public.

## **PART I: REVIEW OF REGULATORY DECISIONS**

### **2. MERITS REVIEW**

***Question 40: Is the proposed two-stage merits review process appropriate? How could it be improved?***

RMI supports the proposed two-stage merits review process.

An improvement could involve an arbitration process between Stage One and Stage Two, using an independent arbitrator agreed by both parties. Alternatively, the complainant could be involved in the selection process for members of the independent expert review panel under Approach 3.

***Question 41: Which option is most appropriate for the external merits review body? Why?***

RMI supports the implementation of either Approach 1 or Approach 3. Approach 1 is likely to achieve consistency in decision making across different reviews of TTTGA decisions. Approach 3 would ensure relevant expertise on the independent expert review panel for a particular case under review.

***Question 42: Are the proposed arrangements for juridical review of the Agency's decisions appropriate? How could they be improved?***

RMI considers the proposed arrangements for juridical review of the TTTGA's decisions to be appropriate.

RMI notes, however, that the judicial review and other relevant legislation in one country may be inconsistent with that in the other country. While legislation may be fairly similar between New Zealand and Australia at the moment, it is possible that future legislation, or amendments to existing legislation (made without the consent of the other country), might adversely affect the TTTGA judicial review process. Hence, consideration should be given to how this issue can be resolved.

## **PART J: ADVERTISING**

RMI supports the regulation of advertising in a way that promotes the appropriate and safe use of therapeutic products.

RMI notes that, as part of the consultation process for the proposed TTTGA, an Expert Group on Advertising has been established, comprising representatives from a wide range of stakeholders from both sides of the Tasman. In addition, Mike Codd has been engaged as a consultant, to review the advertising arrangements in Australia and New Zealand and recommend the best approach to a trans-Tasman advertising regime. Mike Codd's final report is due to be lodged by the end of November 2002.

RMI supports the implementation of a principles-based trans-Tasman code for therapeutic advertising. Existing industry Codes of Practice could continue to operate alongside this code, as long as the industry codes embrace all the principles in the over-arching code.

The trans-Tasman code for therapeutic advertising could be backed up by a self-regulatory advertising regime along the lines of the existing systems in New Zealand. The benefits of the New Zealand advertising regime could be retained via the Therapeutic Advertising Pre-vetting Service (TAPS) and Advertising Standards Authority (ASA) complaints system.

RMI supports the establishment of a single trans-Tasman advertising appeals body, to ensure that common regulatory outcomes can be delivered across both countries.

RMI supports the decision to exclude from the TTTGA proposals and Mike Codd's terms of reference any review of policy differences of the New Zealand and Australian governments with respect to advertising of medicines.

## **PART K: TRANSITIONAL ARRANGEMENTS**

### **1. PRINCIPLES APPLYING TO TRANSITIONAL ARRANGEMENTS**

RMI supports the five proposed principles that would apply to the transitional arrangements for therapeutic products, notably the principle of imposing the lowest possible compliance costs, consistent with adequately protecting public health and safety. RMI is keen to be involved in further developing any regulatory principles by which harmonisation of approvals could be achieved. The recent project to harmonise the classification of medicines could be used as a model for this process.

RMI is already involved with Medsafe in a scoping project to look at transitional arrangements for medicines. RMI companies will compare approved details for products in New Zealand and Australia, in order to determine the current level of similarities/differences between the product ranges in the two countries.

RMI recommends that sponsors of a particular product currently marketed in both New Zealand and Australia be able to “merge” the currently approved details from both countries. In order to ensure satisfactory safety, quality and efficacy of products, this process may have to be restricted to new active substances approved by Medsafe and TGA within a certain period of time (e.g. 5 years) of commencement of the TTTGA. In this case, an appropriate expert advisory committee in both countries would have recently reviewed the new medicine applications. This acknowledges that there has been close collaboration between the MAAC and ADEC advisory committees and that during recent years common regulatory outcomes have been achieved by the two agencies.