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## Foreword

In November 2000 the Therapeutic Goods Administration hosted a Regional Regulators' Forum in association with the World Self-Medication Industry 4th Asia Pacific Regional Conference in Sydney, Australia.

Participants included therapeutic goods regulators from 14 countries in the Asia Pacific region as well as industry and consumer representatives.

The Forum was designed to develop a regional approach or understanding intended to foster closer collaboration in the region between the regulatory authorities. This should lead to harmonised approaches in the regulation of therapeutic goods, particularly in the Asia Pacific region.

The Forum also considered a declaration – titled the 'Sydney 2000 Declaration'. The Declaration was prepared by drawing on the key principles underpinning good regulatory practice and pointed towards future collaboration between regulators in the region.

The Regulators' Forum was a significant first step in addressing issues confronting us all, including the use of Internet technology and the need to enhance and promote reasonable choice of therapeutic goods through truthful and valid advertising of self-medication products.

This record provides a transcript of the presentations given at the Regulators' Forum.

I look forward to the Declaration being progressed and also being a focus for further development at the next Asia Pacific Regional Regulators' Forum to be held in Tokyo during November 2002.

Terry Slater  
National Manager  
Therapeutic Goods Administration  
Australia

Chairman  
Regulators' Forum  
November 2001



## **Record of the Asia Pacific Regional Regulators' Forum**

### **Opening by the chair, Mr Terry Slater, National Manager, Therapeutic Goods Administration, Australia.**

It is my pleasure to open this Regulator's Forum held in association with the WSMI 4th Asia Pacific Regional Conference.

I am delighted to chair proceedings today and I am looking forward to an interesting exchange of views and ideas.

Today's Forum brings together the therapeutic goods regulators from around the Asia Pacific Region. I would like to extend a special welcome to you all. We are very privileged and honoured that you have joined us here today.

We have international guests from as far away as Europe and as close as New Zealand.

In addition to the regulators present at the table, we have a distinguished Australian consumer advocate who will address us shortly from a consumer perspective of regulation.

I have no doubt that you will all share in the discussions and benefit from the exchange of ideas at the table.

I would like to extend a warm welcome to all our observers. I hope that today's Forum, for you as observers, proves to be informative and interesting also.

I plan to lead off today with a number of brief presentations as set out in the agenda we have before us. I would like to consider a draft Declaration that has been circulated to participants. The Declaration touches on issues we will be discussing and sets our sights on future cooperation in the region.

Our agenda and the Declaration highlight the importance of the self-medication industry to us all and to our societies.

The industry itself acknowledges a shift in focus and an accommodation, in certain cases, of consumer preferences for self-medication. We all understand

that empowered responsible individuals have a role to play in our health care arrangements.

There is no doubt that self-medication can result in positive outcomes. Such outcomes should be encouraged particularly in circumstances where demand for health care outstrips overall economic growth.

Adequate consumer information, truthful and evidence based advertising and greater visibility of non-prescription medicines facilitates a responsible approach by informed consumers.

The World Health Organisation supports the self-medication industry as one that can help, prevent and treat symptoms and ailments that do not require consultation.

Responsible self-medication can help reduce the burden on medical services, increase the availability of health care to the most deserving cases, and it can provide greater opportunity for patients to manage their own chronic conditions.

We should endeavour to keep these issues in sight as we develop and implement our respective regulatory schemes in the region. If we can find ways of effectively collaborating and strengthening our commitments in these areas, considerable progress will be made.

As national regulators we all have responsibilities to ensure the timely availability of safe, high quality and effective therapeutic goods. We are all responsible for minimising our community's exposure to potential health hazards and for monitoring and evaluating technologies and processes.

Most of us are responsible for national regulation, market approval and ongoing monitoring of medicines, medical devices, chemicals and drug and blood products. This importantly includes the setting of product standards and ensuring products are fit for their intended purpose and that the therapeutic claims made are valid. While the emphasis may vary between us, such responsibilities remain for all of us.

Much of this work is done in partnership with others. We should encourage strong and lasting links with industry, consumers and governments.

We should encourage strong links with our neighbours. For our part we foster a very close working relationship with a number of countries in the region and

I will be encouraging this work in the future. Some of the lessons learned in our region are most helpful to us all.

We are very fortunate today to have a number of very senior and experienced participants from regulatory authorities throughout the world, and we also have representatives from the World Self-Medication Industry at the table, Dr Jermone Reinstein, and Ms Juliet Seiffert Executive Director of the Australian Self Medication Industry (ASMI). I would like to pay tribute to ASMI and to Juliet in particular for her tireless work and that of her team in organising this very successful conference.

I would like to extend a particular welcome to Janne Graham from the Consumer Health Forum in Australia, who represents Australian consumers.

I would also like to welcome Dr Patrick Deboyser, Head of Food and Law in Biotechnology with the European Commission. I know in particular Dr Deboyser would like an opportunity to comment on our work with New Zealand in the moves to establish a common regulatory framework between our two countries.

Finally , I would like to welcome all the other participants at today's Forum.

I said a moment ago that our timing is tight so I'll leave my opening remarks at that.

I would now like to turn to our first presentation, which is Australia and New Zealand, and the proposed trans-Tasman therapeutic goods agency. Dr Stewart Jessamine presents it from New Zealand and Mr Graham Peachey from Australia.



# **Joint Australia / New Zealand trans-Tasman therapeutic goods agency**

## **Presentation**

### **Dr Stewart Jessamine**

This presentation is a case study incorporating the building of a trans-Tasman regulator. While this project first commenced prior to 1995 it was only after a great deal of discussion over several years that in 1998 Australia and New Zealand agreed to create a project team to explore the viability of establishing a joint trans-Tasman agency to regulate health care and therapeutic goods.

Hang on to your hats because in 15 minutes, with Graham Peachey from the TGA, we are going to present 5 years work and 18 months of very intensive project planning.

## **Why create a joint agency?**

There were several drivers for wanting to consider creating a joint agency; foremost amongst these is a need to maintain regulatory capacity.

The increasing complexity of medicine manufacture and effect is the bane of every small regulatory authority. As things become more complex, small regulatory authorities struggle to attract people with the right skills to assess the safety of the medicine and in some cases even struggle to identify clinicians in the broader community who are qualified or experienced enough to perform evaluations. The problem is most obvious with the assessment of biotechnology products where in New Zealand, there is at best, only one person who is qualified enough to evaluate the manufacturing process of these products. The lack of an appropriate skills base represents a potential health hazard that faces every regulator in this room to various extents.

The creation of a joint trans-Tasman agency was perceived to be one way of ensuring that both countries could manage the regulation of an expanding range of increasingly complex products. It was also perceived that the creation of an Australasian regulator might also enhance the influence of each country in regional and global regulatory activities.

As you know there are only a small number of individual regulators who are actually able to engage at the International Conference on Harmonisation (ICH) process and sit at the ICH table, where the standards that we all must apply are formulated. We think that moving to create regional regulation or a shared

joint regulatory authority will increase the 'voice' of regulators in both countries and may represent a significant step towards increased participation in the ICH and other international regulatory processes.

Last but not means least, Australia and New Zealand have a Closer Economic Cooperation Agreement and joint regulation would be one, we believe, of facilitating trans-Tasman trade.

## **Developing a creative process**

The first steps taken in the project was the establishment of an interdepartmental steering group, comprising of officials from key stake-holding government departments. This steering group in turn derived a series of principles and criteria that would have to be met if a trans-Tasman regulator was to be acceptable to either Government. These criteria include consideration of the cost of the regulatory approaches or philosophy, to be applied by the regulator when considering an application as well as consideration of the ability of the model to meet best international regulatory practice and to position the agency to influence global standards setting and decision making.

For the purposes of model development the different industry policies and funding mechanisms for medicines used by the governments in both countries, which are quite distinct and quite separate, were excluded from consideration in the project. The focus of the modelling process was on technical evaluation and approval.

Early in the model development phase of the project it became clear that while the regulator in each country duplicated some of the work undertaken by the other regulator, a number of the activities undertaken by each regulator were unique to each country. These differences in the range of regulatory activities performed by each regulator represented a major challenge to the project team when it came to the development of potential models of shared regulation.

## **Developing the models**

In developing a regulatory model the project took a 'form follows function' approach to model design. This approach required that we first determine the functions performed by a regulator before designing a potential regulatory model. The following slide (refer slide 3) of a nine piece jigsaw that identifies the key regulatory activities performed by all regulators: performing technical evaluations; setting standards; monitoring compliance, and undertaking regulatory activities such as removing medicines from the market or approving

medicines; providing expert advice; communicating decisions, approving activities such as issuing licenses and performing enforcement activities. For the sake of this presentation you can consider the green jigsaw piece in the middle of this slide to represent the administrative glue that holds a regulator together.

Using this functional approach we then derived a range of potential models and assessed them against these essential principles.

The principles are fairly self-evident namely the new regulator must:

- enhance public health and safety;
- be responsive to the needs of each country;
- deliver common regulatory outcomes whilst taking into account sovereignty issues;
- provide each country with shared input;
- facilitate stake holder input;
- administer evidence risk base approaches to decision making;
- be compliant with the various codes of good regulatory practice of which we've quoted;
- be transparent; and
- be timely and inclusive in the decision making processes.

In addition the agency must meet domestic and international treaty obligations, encourage the development of the therapeutic goods sector in both countries, support the export of therapeutic goods, and be fully funded through fees and charges paid by industry. The requirement for full cost recovery from the sector is current government policy in Australia and is proposed government policy in New Zealand.

## **Potential Regulatory Models**

While a number of models are possible the differences between the models are largely derived from decisions about what activities you want to share in what we have called a 'joint agency'. The slide (refer slide 7) outlines a 'Joint Agency' where all regulatory activities are shared. In this 'Joint Agency' model

applications come in from industry, are assessed by the joint agency's experts who make recommendations, or decision, to a statutory office holder and executive committee who publish and enforce these decisions. The Executive committee (which includes representation from both countries) performs a number of administrative functions including oversight of regulatory policy, and approval of regulatory standards developed in-house by the agency.

The development of broad health, or public health policy, is not a function of the Joint Agency but rather is developed by the governments of both countries and passed on to the Executive of the agency for implementation. The Executive is responsible to the governments of both countries for administration of the agency and meeting the agreed policy goals.

The Joint Agency model is a fairly standard model of regulation. If adapted it would replace both the TGA in Australia and Medsafe in New Zealand. It would perform the full range of regulatory functions for both countries based around a unified set of guidelines. As the model is fully paid for by industry the model may have an inherent bias towards improving levels of service to industry at the level of pre-market assessment, because after all that's where the bills are being paid from. In our opinion a counter-balance to this pro-industry bias needs to be built into this regulatory model. Specific arrangements to ensure adequate funding and operation of the agency's post-market functions should redress the potential imbalance.

The next slide (refer slide 8) is an example of another much simpler model called the 'Joint Technical Advisory Model'. In this model, technical evaluation of a product is the only shared function and all the other regulatory functions take place in a residual regulator in each country.

In our opinion this model contains a number of flaws. In our evaluation of each model a general rule emerged which states that the more interfaces you have the more expensive the model becomes. In addition, as the number of potential interfaces between offices and sections increase, the efficiency of the agency and the ability of the agency to set common standards and deliver a common regulatory outcome decrease.

The final slide (refer slide 9) demonstrates is a very innovative approach to regulation that we've called the 'Virtual Joint Agency' model. In this model each agency agrees to give up doing certain functions and relies on the other agency to perform those functions. This model represents a very complex form of mutual recognition where, for the sake of the argument, New Zealand would stop assessing new chemical entities and would accept reports and the opinion of Australia, and Australia would stop evaluation of OTC medicines and accept

New Zealand's decisions instead. Once again the complexity of this model means that it fails to meet many of the essential principals we have used to assess the acceptability of any given model.

This is a 10-minute guide to "why do we want a joint agency"?

I hope it is clear why the first model described in these slides as 'The Joint Agency' model is the preferred model. In our opinion sharing a single agency, which performs the full range of regulatory activities in each country, this model has the greatest ability to meet all of our essential principles while being the simplest model to administer.

I'll now hand over to Graham.

Thank you.



# **Joint Australia / New Zealand trans-Tasman therapeutic goods agency**

## **Presentation**

### **Graham Peachey**

Thank you Dr Jessamine. I've been given the task of outlining the details of the preferred trans-Tasman therapeutic goods agency.

As Dr Jessamine has said, we have been spending quite some time consulting all relevant interest groups on the various approaches he outlined. We have put out a formal consultation paper and we have been fortunate enough to visit centres in Australia and New Zealand and canvass some of the issues. In doing so, we are very alert to the government, industry and consumer views on the establishment of a trans-Tasman therapeutic goods regulator.

The industry and trade implications of moving towards a combined joint agency between Australia and New Zealand have been raised with us. And there have been discussions, as you would expect, on the possible advantages (and disadvantages) of establishing a single market for some of these products.

There have also been issues associated with the development of broad Australian and New Zealand public health policies. It is worth mentioning here that, from the start we have sought to construct an institutional arrangement that effectively quarantines some of those broad public health and policy issues.

By doing so, we have sought to develop arrangements that reserve the right of both countries to develop broad policy, independently from the other. As an example, we are looking at ways of quarantining issues like pharmaceutical pricing policy, intellectual property and the parallel importation of products from the activities of the joint agency. In the end the trans-Tasman agency and its activities should not have an impact on such policies. This has become part of what we have referred to as our 'not negotiables'.

Costs and what cost should be recovered are obviously something very topical in our consultations in Australia. As some of you will be aware, the Therapeutic Goods Administration in Australia recovers all its costs through user fees and charges. It is our expectation that a similar charging arrangement would apply unless Government changed its policy in this area. It clearly raises issues for the New Zealand industry which currently pays part, but not the full, cost of regulation in that country.

It is of interest, however, that the New Zealand government has already signalled that it would move to full cost recovery, regardless of the outcome of the work on the trans-Tasman agency.

Governance arrangements for the trans-Tasman agency have been canvassed, along with sovereignty issues. During our earlier experience with setting up joint trans-Tasman arrangements, issues associated with governance and sovereignty proved to be quite fertile areas of discussion.

It is something to be expected in an arrangement that potentially offers up some sovereignty over decision making. It is something for both Australia and New Zealand to consider carefully. We are looking at ways of preserving national sovereignty and the right for either jurisdiction to go its own way, while at the same time, building an institutional arrangement that actually takes advantage of 'the best of both worlds'.

Advertising therapeutic goods has been another topical issue raised with us in our consultations with the Australian States and Territories and with the industry and consumer interest groups. We have a different approach in Australia to New Zealand. Australia prohibits the advertising of prescription medicines, while New Zealand does not. Whatever the outcomes we need to look to common standards, single advertising codes (for governments and industry), common institutional arrangements and appeal processes in this area. While ambitious, it is achievable.

So where to from here?

In recent times we have agreed amongst ourselves, but are yet to get formal government endorsement, that the joint agency should rely on the following Governance principles.

- (i) The first is that the joint agency will have a distinct legal identity with a legal personality in both countries, not just one.

As I said earlier, there is very limited experience or precedence in this area. We are trying to devise for therapeutic goods a scheme that creates a joint agency with a legal personality in both Australia and New Zealand. The domestic laws in both countries come together to create the new joint authority.

- (ii) The joint authority will also be set up under the terms of a treaty.

This creates the binding legal obligations between the two countries.

- (iii) The overriding principle is that the joint authority should lead to common regulatory outcomes in both countries.

This has its origins in the Trans Tasman Mutual Recognition Agreement. Our aim is consistent with the object of that Agreement and sets up a scheme that will result in some commonality in regulatory decisions.

- (iv) The joint authority will also have direct accountability to ministers in both countries.

The Australian Minister for Health and the Minister for Health in New Zealand will guide the joint authority. There will also be accountability direct to Parliaments in Australia and New Zealand.

- (v) We have agreed that the decision-making authority will be based on what we have called shared decision-making.

There has been debate whether it should be equal, equitable, shared etc; and we agreed that it should be shared decision-making. The extent of that decision making will rely, at the end of the day, on the extent of participation of both countries. What we have in mind at this stage is that the joint agency will cover all aspects related to the regulation of therapeutic goods in both jurisdictions. It is therefore reasonable that there should be shared decision-making.

- (vi) There will be an "opt out" arrangement for both countries.

As you would expect there would be some circumstances, hopefully only a few, where one country might decide to "opt out" and go it's own way. That of course is linked to the issue of sovereignty we touched on earlier.

- (vii) The governance principles also touch on the delegation of decision making.

I think that is in response to issues that have been raised about how the regulator interacts with interest groups such as industry, consumers and all those effected by it's decisions. We are looking at a system that does not unnecessarily create hierarchy and bureaucracy but actually encourages and facilitates those effected by the regulatory decision-maker to interact closely with the regulator and to ensure the decisions are appropriately delegated.

- (viii) One of the interesting areas for us is the area of administrative review.

In Australia we have the Administrative Appeals Tribunal (AAT), which actually sets up the appeal and review arrangements. It covers a variety of reviewable decisions. However, there is no such body in New Zealand.

We are looking at the possibility of setting up a Medicines Review Appeal Tribunal of some sort. This would accommodate the business of the joint regulator and will be different in what we see in the AAT arrangement at the moment.

- (ix) The governance principles also acknowledge that there will be, as there is at the moment, separation of the broader public health policy.

The broader public health policies of both countries will be developed and managed within the health portfolios of both countries.

The regulatory policy managed within the joint regulatory agency in such a way that the joint regulator will be required to have regard to the broader public health policies of both countries.

- (x) We have also acknowledged that there should be some compatibility in conditions of employment for staff in both countries.

In summary, we are trying to create a trans-Tasman agency that is a genuinely joint Australia, New Zealand therapeutic goods agency. It moves previous experience quite a few steps forward and, in some areas, it breaks new ground for both Australia and New Zealand.

It's quite a leap of faith for both countries.

It will certainly test the boundaries of sovereignty and cooperation between the two countries. But it does fit very neatly under the preferential trade relationship we have between Australia and New Zealand and the Closer Economic Agreement.

Thank you.

**(Terry Slater)**

Thank you Stewart and Graham.

Colleagues I think that has given us a lead for one of the focal points of today's forum which will be cooperation in the Asia Pacific region.

Of course, Australia and New Zealand have been working on Trans-Tasman Mutual Recognition for a number of years. There are other comparable arrangements - but not equivalent. We look with some envy at what has happened in Europe. A large number of countries have managed to get together and form the European Commission and the European Union.

So maybe Patrick Deboyser if I can introduce you to give us some lessons that we all could learn from and take forward in the communique this afternoon.

Patrick, I have great pleasure in giving you the floor to talk to us about how the proposed trans-Tasman therapeutic goods agency model measures up with models in Europe.



# **How the proposed trans-Tasman Therapeutic goods agency model measures up with European models,**

## **Presentation**

**Patrick Deboyser**

**European Commission**

Thank you very much for the invitation to join your Forum here today and comment on your proposal.

Firstly, I'd like to compliment Stewart and Graham and all those that have been involved in this project, it is certainly a very ambitious one and a realistic one.

I left pharmaceutical regulation a year ago now, however I spent ten years helping create the European Medicines Agency and passing legislation. I have undertaken a job, which is regulating food in the European commission.

I am very often in contact with Australia New Zealand Food Authority (ANZFA) and I am very impressed by the work of this body notably in one area, which I am directly responsible for which is biotechnology. Europe, Australia and New Zealand have very similar policies towards genetically modified foods and I must repeat I am very impressed by the work that has been done by ANZFA.

The background of course is quite different, Europe has a long history of political integration, and we have been harmonising the whole legislation for over 40 years. In fact the first directive dates back to 1965.

Since 1965 we have had a joint regulatory framework for the authorisation and the post market monitoring of Pharmaceutical's. I would say that something like 99% of pharmaceutical regulation now originates in Brussels.

The European parliament and the European council administrate everything that deals with marketing authorisation, what we call 'Pharmacovigilance' labelling, advertising, distribution and legal status is harmonised at the EU Level.

The marketing authorisation system interim decisions, on what get to the market, is only a more recent development. It is only since 1995 that we have had single authorisation for some products.

Currently less than 5% of products have EU marketing authorisation, and perhaps I should explain the process.

Reimbursement and pricing is still entirely in the hands of the member states as they control the budget. They control decisions, on what prices will be, prices of products reaching the market, and whether or not they will be covered by the national health service. They do it in quite a different way.

This ranges from strict price control in countries like Spain, Italy and Greece to free pricing in countries like Germany and profit control in the United Kingdom.

In the field of marketing authorisation, the last decade has seen very important developments which are quite similar to those that you are looking towards here.

We created the European Medicines Evaluation Agency (EMA) in 1993 and it started business in 1995 it is what we would describe in old jargon as a Common Agency. It does not however replace the 15 National agencies.

The National agencies still exist but they've seen a reduction in business and turnover due to the creation of the European Medicines Authority, which is based in London.

As you may know the EMA, has retained operation for quite an important share of the market. The division of the responsibility between the EMA, the European agency and the National agency is based on the nature of the products.

Biotechnology products can only be authorised by the community since 1995.

For new and innovative products companies would have the choice of either filing an application with the EMA in London or with individual National agencies. It is quite obvious the different strategies taken by companies who have somewhat systematically tried to file new drugs with the EMA in London, while others prefer the National agencies.

It also depends on what your target is. You may not want to commercialise a product in 15 member states where there is some national niche. It sometimes also depends on how good a company is at implementing in the total market.

The reason why we did not create an agency that would replace all the National agencies and that would deal with all authorisations, is that we

realised we would need to keep the existing system for the foreseeable future. Perhaps even for a couple of generations as we are talking about administering and managing products that are on the market and have been on the market for quite some time.

All in all we have now authorised approximately 250 new products under the new regime and that's in addition to 130 000 products currently on the market. Someone must take care of these products.

This includes 30 000 homoeopathic and plants etc but these are products which require monitoring and renewal of authorisations every 5 years. It was simply impossible to deal with and it was not practical to deal with these products under a single agency system.

The products that qualify for the 'centralised procedure' as we call it require the application to be made directly to the EMEA in London. There's a fee to be paid, quite a substantial one, 200 000 Euro which is something like 180 000 US dollars for an application. That is the flat application fee. If you have combinations of several strengths and presentations it can be several times, some applications go above 1 million US dollars for the application fee.

The EMEA, evaluate the quality, safety and efficiency. Once that opinion is given it's passed to the European Commission, to my former office, where a decision is taken. This decision is valid across the EU.

The product will have a single label in 11 languages admittedly, the same leaflet, and the same presentation in the entire EU. It is a direct decision that companies are obliged to have a single marketing authorisation or a single reference point for Pharmacovigilance.

But we have also maintained the alternative model, which we call the "decentralise procedure" with one important proviso. Since 1998, after a three-year transition period, companies can no longer apply for the same product with a different application in two countries.

Once a country of the EU has granted an authorisation any other member state can only recognise the first authorisation if the second or the third country which is asked to recognise the authorisation has no disagreement from a public health point of view.

Should there be disagreement then there would be a binding arbitration by the EU. The EMEA committee would be asked to deliver an opinion on the

divergence between the two member states and the commission would reach a decision that is binding on the company and on the member states.

If the opinion of the EMEA and the decision of the European Commission is that the second country was right in opposing the approval of a product, which was already on the market, then the first member state would have to withdraw the product from their market.

This system has now been in place for almost 6 years and is due to be reviewed. The results of the review are going to be published at the beginning of next year. I think it's not difficult to predict that the review will find satisfactory results notably for the centralised procedure.

That's not to say that there's nothing to be fixed in the detail, but it is found to be working rather well.

The mutual recognition decentralised procedure has some draw backs, most notable with the fact that companies tend to withdraw applications in the second member state as soon as they realise that there may be a problem rather than risking withdrawal of the product in the entire EU. They would rather withdraw the application from each recognition, which is unfortunate.

I must say from a public health point of view, because there is a public health issue which is not going to be addressed and because the public health's objection by the second member state was unfunded, the product will not get to the market and consumers will not benefit from that product.

Apart from the fact that our backgrounds are so different, we do however have a common legal system. We've a court of justice where decisions by the EMEA or the European Commission can be directly appealed and we have a common system for enforcing decisions across the union.

We have no choice other than to have a single system, as this is what our constitution treaty states.

I believe that there is a lot of merit in the model that you are now proposing for Australia and New Zealand. I do not know whether you have looked at experiences with other parts of the world, including Europe, and drawn lessons both positive and negative from our some times painful experience of over 40 years.

If I may very briefly touch on another issue which is the Regulators' Forum for the Asia Pacific Region.

I would strongly encourage you to develop cooperation at the regional level. I was a member of the International Conference on Harmonisation (ICH) steering committee from 1994 to 1999 and a strong advocate on the ICH steering committee becoming more open to the rest of the world, to develop a "global agenda" as we call it in the ICH.

Dr Tatsuo Kurokawa, one of the founding members of the ICH, along with Roger Williams from the Food and Drug Administration (FDA), have been similarly calling for participation from non-ICH members.

ICH for those who don't know, is a joint project by the regulators and industry of the United States, European Union and Japan. It has observers from Health Canada, Switzerland, but unfortunately there are no observers from the Asia or Pacific region, although we have been discussing that for quite some time.

I was however successful in obtaining observership for WSMI on the ICH steering committee. Dr Derbransko Kransko represents the OTC industry on the ICH committee.

I believe the creation of a Forum within the Asian Pacific region would give a new opportunity to discuss the possibility of having an observer from this region on the steering committee.

Currently there is one from the US, Canada, and Europe, representing the non-EU countries on the ICH steering committee. I think it would only be fair and logical and I believe it would actually contribute to the process if there was one from either Australia or New Zealand or from another regional country.

In fact we have been developing the Pan Europe Regulatory Forum, with a view of preparing ICH meetings, discussing the preparations of ICH and discussing the outcomes of the discussions with the countries.

I was not at the San Diego ICH 5 conference two weeks ago so I don't know of recent developments but I'm quite sure there is still a case to be made for a wider constituency and wider discussion.

So I would very much welcome discussions today on that issue.

Thank you very much for the opportunity to speak here today.

**(Terry Slater)**

Well thank you very much indeed Patrick. We're most fortunate to have you, the first head of the European Medicines Evaluation Agency to present on the many lessons for us to be learnt by your experience.

I'm sure with our observers around the room there must have been a few shivers down the spine when Patrick talked about 1 million dollars as an evaluation fee for an application. And I'm sure there are some regulators around the table who would love that sort of flexibility perhaps to charge.

Patrick there are a number of things that you highlighted, which I think will be invaluable when we come to the open discussion a little later, for us to draw on and a number of important pointers for us in framing our communicate.

So again thank you very much indeed for your contribution and we look forward to you joining in and helping us progress towards that cooperation that you so importantly pointed out, as an important thing for us to try and get in the region.

Having had a look at what Australia and New Zealand are proposing to do and then looked at how 15 regulatory authorities were crunched together, maybe we should turn to the product of self-medication and look at a couple of the models that are very good examples of practice in this area.

I'd like to turn to Dr Robert Peterson from Canada to talk about Over the Counter medicine regulation in Canada.

# Regulation of OTC products in Canada

## Presentation

**Dr Robert Peterson**

**Canada**

Health Canada has certainly looked at the successes of the European Union, and would love to have the opportunity somewhere for a number of small regulators who are able to come together to do something very similar to that.

As it turns out the nearest regulator to Canada happens to be the United States FDA and it is a bit more difficult perhaps to partner with the FDA.

What Health Canada has done recently is recognised that at some point in time Canada will be part of a regulators consortium. Who the partners will be remains to be determined, but we have recently gone through a re-alignment that is engineering for growth, which is nice, as we are no longer down sizing.

In order to attempt to address some of the problems that are facing us with performance, with respect to the time that it's taken to provide approval or authorisations to market, Canada has gone through re-engineering of it's regulators in order to look at an effect for similar functions, and attempted, as much as possible, to begin down the pathway to a somewhat seamless approach to regulation of products.

The Health Products and Food Branch which is shown at the top of this organisational chart (refer slide 2) is one of the new branches that has come into existence in the past 6 months within the Ministry of Health in Canada.

Two other branches were also brought into existence. One branch for environmental health, public safety, tobacco, control measures, and another branch whose principle activities is population, public health surveillance, disease surveillance etc.

The Therapeutic Products Program is at the present time the regulator of medical devices, drugs, biologic's, including blood, blood products, vaccines, genetic therapies as well as for the present time, herbal products, and other natural health products that have a specific claim associated with them.

We will in the process of completion of the re-alignment see a new directorate, when biologic's, and genetics come into existence. At the present time, it is in

the planning phase and exists under the umbrella of the Therapeutic Products Program.

It is clear that as we look at patterned activity that has taken place across the world today, the majority of the patterns that are being filed and approved in biotechnology is going to lead to an enormous growth in biologic's and genetics regulatory activity within the next 5 years. And it's our intention to be prepared by having grown our regulatory capacity over that time frame.

The Natural Health Products Directorate was announced approximately 18 months ago. It is presently engaged in consultation across the country in Canada and in the development of the new regulatory frame work, which we intend to have in place hopefully by the end of this summer, certainly by the end of the next physical year.

The Food Directorate is also a portion of the re-alignment activities. There is going to be, as we recognise from nutraceuticals and other novel foods, the necessity for us to take into account, as much as possible, a common regulatory framework for all of these products.

I would anticipate that the Therapeutics Products Program that at the present time regulates prescription and non-prescription medications in a single bureau pharmaceutical assessment, will divide out once again into prescription medication and non-prescription medications.

We will attempt as much as possible to develop a common regulatory framework for non-prescription medications, natural health products and those products within food that may have some commonality in their requirements for regulation. In order to do that, clearly there will have to be the development of a common framework and perhaps the concept of true self-care products in the process.

Just for some background information on the size of the self-care industry in Canada, total sales now are just under three billion dollars, this is approximately a third of the eight and a half billion dollar pharmaceutical industry in Canada.

We are told that there are ten thousand Canadians employed in this industry and approximately one half of the sales come from 10 multi national corporations. Given the activity and merges with other organisations within industry this may drop down from ten to two or three or who knows where it may be going.

The Natural Health Products areas, as well as prescription to non-prescription switches have stimulated recent growth on self-care products.

We do undertake to share responsibility for regulating self-care products in Canada between Health Canada the Federal Regulator, and other stakeholders within the country.

So again Health Canada, Therapeutic Products Program and Natural Health Products and Food are looking at a common regulatory framework for self-care products in the future. This responsibility is shared at the present time in the following fashion (refer slide 4).

Therapeutic Products Program is responsible for products that have specific therapeutic claims, it regulates drugs that are both imported as well as manufactured domestically, and it determines prescription status at the time of application.

The office of Natural Health Products will assume responsibility for herbals, vitamins, minerals, homoeopathics etc.

It is clear that this regulatory framework will overlap to a large extent with other self-care products.

Therapeutic Products Programs will continue to regulate and once again we would like as much as possible to harmonise a single frame work. Nutraceuticals and novel foods are specific challenges for our food directorate.

Nutraceuticals and novel foods are products without specific therapeutic claims. As a consequence they do not follow under the domain of either the Therapeutics Products Program or the Natural Health Products and yet may have constitute ingredients that far exceed anything that the food directorate can determine as a food supplement or something that belongs there.

Manufacturers have the following responsibilities (refer slide 5) and we meet with members of the association as well as individual manufacturers on a regular basis throughout the course of the year.

We share responsibility with the provinces within Canada as well. The provinces may specify further conditions of sale after the Therapeutic Products Program has granted an authority to market.

The provinces define who a practitioner is, and this is important with respect to prescription medications, since our Food and Drug Act simply specifies that a practitioner is someone authorised under the law of a province to prescribe a medication.

A province therefore can take certain action should they feel it is in the best interest of their local health environment to alter who is authorised to prescribe a prescription product.

Of course the provinces regulate physicians, pharmacist and other health care practitioners with regards to the standard of practice that would be expected.

As I mentioned before the provinces may place more stringent requirements for sale. In other words, a medication or therapeutic product that is approved or authorised as a non-prescription medication in Canada could be required to have a practitioner intervention even when it is not a prescription medicine under the federal regulation.

They can not switch a prescription medication to non-prescription, but as I had mentioned, they can determine who would be appropriate to prescribe.

There is a national association of pharmacy regulatory authorities that have representation from most provinces in Canada. In order to harmonise the types of additional controls that the provinces might wish to place on products coming onto the Canadian market, there has been three schedules agreed to by this group.

Schedule one is prescription only and is established at the time of notice of compliance.

Schedule two would be a pharmacist intervention only. These are products that might be looked upon as behind the counter with a necessity for a pharmacist to intervene but without the necessity for a prescription. Again this is usually looked upon for purposes of need for chronic conditions.

There is a third schedule, which is medications that can be in the self-care or the public area of the pharmacy, but they must be distributed in a pharmacy and they would not be found on the shelves of other retail outlets.

Then there is the fourth category that is unscheduled. These are products that can be found in any retail outlet in the nation.

Health Canada has initiated a number of international efforts in order to begin to look at how we might not only harmonise regulatory activity within Canada but also enter into various agreements seeking a consortium of some nature.

There has been a mutual recognition agreement completed with Switzerland for GMP compliance.

We are in the process of completing and entering into one with the European Union as well.

We are in a confidence building phase at present and we are expecting it to be completed very soon and we'll enter into that.

We have MOU's for drug reviews. We have one with the FDA for joint reviews. We have not at this point in time exercised that MOU.

As was noted earlier by Patrick there is an opportunity for candidates to be present for the ICH deliberations and Canada has adopted virtually all of the ICH guidelines at the present time.

As I had mentioned earlier we are certainly seeking partners for other forms of regulatory activity.

The regulatory framework that I had alluded too earlier, with respect to the re-alignment of the new branch for regulator activity in Health Canada, is seeking a common entry for all non-prescription drugs, natural health products, natural foods and novel foods in order to allow sponsors of applications to have a facilitated entry into the regulatory system.

We would like very much not to have different regulatory requirements for products that have a similar safety profile. Wherever possible we will harmonise these requirements.

We expect there would be common GMP, common reporting and common updates for all of these products whether they are non-prescription, natural health products or novel foods.

While not finalised I anticipate that we will probably use a common compliance enforcement that is geographically located across the nation in order to deal with all of these types of products.

There are several principles that Canada is seeking with the regulatory framework around these products.

We believe that the products clearly should have a high safety margin and are easy to self-administer with respect to calculation of dosage forms.

Equally important and at times perhaps more important is going to be the necessity for these products to be used for conditions which are amenable to self diagnosis and are amenable to self therapy without a great deal of professional supervision.

In other words one might look at the use of certain vitamins as nutritional supplements for preventive means which would clearly fit into the category of self-care without the requirement of supervision.

But if one is going to be treating active rickets with vitamin D or treating active scurvy with vitamin C then those are conditions that are not amenable to self diagnosis or self treatment.

As a consequence we will attempt to develop within the regulatory framework requirements not simply around the product but around the use of the product as it is being employed.

There are many other conditions that are equally obvious with regards to the types of conditions that they might be appropriately used for.

We would also expect that the conditions, for which self-medications are used, should not decline when we progress under self-therapy. So joint destruction for rheumatic disorders being treated with non-steroid or anti-inflammatory agents, which are clearly under many circumstance amenable to self therapy would not be a wise outcome in the case of that type of disease progression.

There could perhaps be debate around products such as beta two, as to whether that represents a self-medication, self care product or not. This depends entirely upon the condition that it's being used for, for example if this is mild, intermediate asthma then that may very well fall into the category of a self-care product.

However if this is moderate to severe asthma then we recognise there is an increase in the mortality rate in young adults who are using beta two agents and are not using any other anti-inflammatory so we would be developing,

hopefully, a framework with respect to those considerations.

If there's any interest in pursuing any of these discussions further we would be more than willing to hear from you and to certainly contemplate any regulatory activity that people would have in mind.

Thank you

**(Terry Slater)**

Thank you very much Robert that was very opportune and it certainly gives us all a lot of thought for how we might look to move ahead in self-medication.

I think Robert you've really posed questions which I'm sure will exercise all our minds about the links between scheduled medicines that are available over the counter, complementary medicines or natural health products and novel foods.

The fact that you've pointed to a need or certainly that your working on a common framework for assessment of these products, standards for them to meet good manufacturing practices in this light, is something for all of us to take away from this forum and to look at very closely.

So Robert thank you very much indeed.

If I could turn to complementary medicines and look at the new model that, in fact, Australia has developed. I have pleasure in introducing Dr Fiona Cumming to talk about Australian Complementary Medicines.



# **Australian Office of Complementary Medicines – Managing the risks**

## **Presentation**

### **Dr Fiona Cumming**

Today I will be talking about the regulation of complementary medicines in Australia and I guess my two fundamental points are that we have a risk-based approach to the regulation and it's an approach that depends on a close collaboration, cooperation, and co-regulatory system between the regulator and industry.

When we talk about complementary medicines in Australia, this is what we mean; herbals, vitamins, minerals, the broad band of nutritional supplements, homoeopathic medicines and aromatherapy oils.

As regulators we are all used to juggling a balancing act between pre-market evaluation and post market vigilance and so what I'm talking about today is how Australia has settled on where the balance should be for complementary medicines.

Registered medicines, those that are formulated from higher risk substances or carry high level claims, are evaluated prior to going to market on a product by product basis for quality, safety and efficacy.

But for listed medicines which are the lower risk medicines carrying lower level claims, most complementary medicines in particular, we've got a different approach.

The quality is still evaluated on a product by product basis, but the safety is evaluated on a substance by substance basis and then the products are individually assessed. I'll talk a bit more about that in a moment.

Efficacy is not evaluated for listed medicines prior to going to market but sponsors of the medicine are responsible for holding appropriate evidence to support all claims that they make, and we'll explore that further.

Listed medicines have a streamlined approach to market entry that's then supported by post-market vigilance.

Our listed medicines get to market in around ten days through an electronic lodgment facility and we are working with industry on developing a new facility that will allow even faster entry.

There is a lot that I could talk about in terms of this regulatory model. I think one of the really important pieces of work we've done since establishing the Office of Complementary Medicines, and looking carefully at the regulation of complementary medicines, has been a review of advertising arrangements.

This was undertaken last year. It was a very big review that involved the regulators and a lot of people who are sitting in this room today including consumers and industry.

What the review gave birth to was a new Advertising Code and Guidelines on evidence requirements for claims made on products as well as a glossary of permitted claims and representations.

The new Advertising Code is principles based. It applies to all therapeutic goods that can be advertised and is overseen by a co-regulatory Therapeutic Good Advertising Code Council.

Advertising is pre-cleared by industry advertising services managers and complaints resolution is undertaken on a co-regulatory basis.

The glossary of permitted claims and representations is another example of how the regulator and industry work together. We are currently developing a database of all the new claims and representations that have been going through the regulatory system and onto the market for the benefit of the industry to see what precedents have been set.

One of the earlier corner stones of this advertising review, was the development of Guidelines on level and kinds of evidence to support claims for listed medicines.

This was undertaken predominantly by the Complementary Medicines Evaluation Committee (CMEC), our expert advisory committee chaired by Professor Dave Roberts who is sitting in our audience, and it was done in consultation with our other expert committees.

What it did was define the evidence standards. If you are going to make one of the claims that are permissible on listed medicines, it defines what kind of evidence you need to hold to support those claims.

The aim being that consumers of the medicines can have confidence in the information that is being supplied about the medicines.

This new system allows for scientific evidence and, as we heard this morning from Ken Cheng and Basil Roufagalis, recognises the importance of evidence based on traditional use.

CMEC looked at the scientific evidence and tried to provide a hierarchy to the strength of that evidence, ie how much trust you can put into that evidence?

They categorise it as high, medium and general, high being randomised control trials and systematical reviews, medium being human trial population studies, epidemiological work that may be non randomised controlled but still work that's been done on humans. And then generally the lowest level, being descriptive studies, reports from expert committees, pharmacopoeias, and monographs reference text.

Then they looked at other references. Out there people were saying how do you use evidence such as in vitro data, animal studies etc.

Basically this type of data is supporting data that you can't base your claims on but it is further data that you could add into the equation.

From there they looked at what kind of claims are used or proposed to be used or likely to be used on these kinds of products.

Again we came up with a hierarchy from the highest degree of promise to consumers to the lower level and here's where the bar was set.

The recommendation from CMEC was that any claim or any product that claims to treat, manage, cure or prevent or to manage a named vitamin deficiency disease should be subject to pre-market evaluation by an expert committee, so that was the bar.

Listed medicines can carry medium or general level claims. So we go from health enhancement and risk reduction down to health maintenance, symptomatic relief and nutritional supplementation chains.

Accordingly if you make a medium level claim you should hold medium level evidence, general level claim, general level evidence. And the sponsors are responsible for holding that evidence at the time of the entry or listing.

The guidelines and the Advisory Code include lists of diseases that are serious diseases and can only be mentioned on registered products.

When we turned to evidence based on traditional use. It was important to get some kind of working definition of traditional use. It was defined as documentary evidence (and it accommodates oral traditions as well as written traditions) that a substance has been used over three or more generations of recorded use for a specific health related medical purpose.

Again we see a hierarchy of claims and a hierarchy of evidence.

The recommendation was if you base a claim on traditional evidence, you should not be able to make the high level claims such as treat, manage, cure or prevent because the evidence is unlikely to be strong enough to support it. But there is always room for applications there.

The main thing is that for medium traditional claims you need two of these four different kinds of evidence.

It could be an approved pharmacopoeia, an approved monograph, three independent written histories of use in the classical or traditional medical literature or availability through any country's government public dispensaries for the indication claimed.

For medium level traditional claims the wording is important so that the consumer understands they're based on traditional evidence rather than full scientific evidence.

The tradition from which the medicine is derived needs to be specified and something to the effect that the claim is based on traditional use.

For the general level, the lower level of traditional claims, one of these kinds of evidence is needed and the tradition from which the medicine has been derived needs to be specified.

These guidelines have been in use since February this year and we have been trialing them under the guidance of an advisory committee that was set up between TGA, CMEC, the Medicines Evaluation Committee and the Advertising Services Managers.

During this time sponsors could either submit applications to go straight to market with claims or they could avail themselves of the advisory group and

get advise on how well the evidence they put forward matched the level of claim that they were wanting to make.

The advisory group has been functioning all year since February and will continue functioning until the end of the year. The actual trial, the formal trial, was between February and August.

Over that time the advisory group looked at more than 400 claims, most of them were based on scientific evidence although a proportion were also based on evidence of traditional use.

I could give you a lot of statistics but I think that probably the most outstanding one is that 230 of those claims would not have been permitted under the old prohibition based advertising regime.

So it demonstrates that this new system has opened up opportunities for industry to give more factual information about their products, and opportunities for consumers to be able to read more about their products as they're making their purchasing decisions.

So in summary, as I said in the beginning we have a risk based approach to the regulation of Complementary Medicines.

We work closely in an industry/government co-regulatory partnership, and as always the ultimate objective is ensuring quality, safety and efficacy in the therapeutic goods that are available to the Australian community so that consumers can have confidence in the medicines available to them.

Here is the address of our web site. [www.health.gov.au/tga](http://www.health.gov.au/tga). So with that web site address I'll close. Thank you.

**(Terry slater)**

Thank you very much Fiona, it really does lead us very nicely into the issue of consumer choice.

It also raises questions about claims and risk and combines with the presentation by Dr Robert Peterson from Canada on what I'll call the continuum from non-prescription medicines that are available through pharmacies down to products that are generally available through supermarkets or grocery stores.

We had this dilemma at the beginning of the Forum as to whether we should have our consumer expectations set out before we started our presentations, or whether we concluded with the consumer view.

Perhaps Janne you'll be able to make up the ground for not having set us some objectives in the first place by your conclusions at the end, after having heard of some of the regulatory issues that we are facing.

So without hesitation can I introduce Janne Graham from our Consumer's Health Forum to give us a consumer perspective to regulation.

# **Regulation of therapeutic goods – A consumer’s perspective**

## **Presentation**

**Janne Graham**

**Consumer Advocate**

I would like to say thank you to Terry and the TGA for this invitation. It is, I think, quite a remarkable occasion, even though it is quite a daunting task.

I’m quite comfortable talking about what Australian consumers know and expect about the regulator. We have an organised health consumer movement that over the last 10 or 12 years has been very active in the area of pharmaceuticals. We have done a lot of work in consulting with interested groups who have a social interest in aging or maternity or young people and those who have come together particularly around chronic illness and diagnostic based disease self help groups.

I am much less comfortable talking about the world consumer or the consumer in the region where I haven’t had that sort of opportunity to consult.

But I do know that whether it’s here or in the developing country or in Europe or in America, consumers in general over the past 20 or so years have been laying claims to certain rights. I’d like to frame these rights in terms of consumer expectations of their governments and of the services that are being delivered to them.

I commented on three of those yesterday, and I think they are still core to the sort of topics that you deal with. These are information, access and choice.

We recognise as we claim all of those, that there’s a balance to be made there, in particular, between issues of access and choice.

Let me comment just very briefly on a couple of others expectations. The overwhelming one of course is the right to safety. In that context we in Australia have an assumption that if something is out in the market place it is safe for us to use.

The minute that you start to have experience with medicines you begin to realise as a consumer that safety, like everything else, is relative.

We depend on the regulator to be sound in the chemical evaluations that are made and to be able to give us information about what those outcomes are, what those relative safety versus risks are.

We talk in the health industry about the right to be heard. Certainly in ordinary health and medical consultations, as you heard this morning there's some dissatisfaction amongst consumers about being listened to, about being attended to.

But in this context it is probably important to recognise the consumers need to report on their adverse experiences when they're using medicines.

It may in fact be somebody else's business to judge whether that adverse experience is an adverse event. The difficulty for consumers is that the report often doesn't get to the place where that decision is soundly made.

In addition to the type of adverse event reporting, which is required of professionals but is voluntary we certainly require that the regulator pay greater attention to the capacity for consumers to report their adverse experiences directly.

As we have a cooperative partnership in Australia our expectation is that we will be able to, over the next few years, develop a system that allows consumers to know that they have been heard. This will set up a way of processing the information that can then be fed into the regulator as part of the safety and quality information needed in monitoring.

Redress is one of the other issues for consumers and in that context perhaps I could use the example of advertising. In Australia we have had some concerns about the pressure of advertising. Now access to the Internet has made that a whole new ball game.

One of the things particularly concerning consumers at the moment is in the area of the lower risk products. Following on from Fiona's talk, the sponsor is now required to hold evidence to support the claims that are being made. Our concern is that when the crunch comes and there's a complaint about the advertising, the information whether held by the sponsor or held by the regulator in the case of high level claims, may not be available to be tested because of commercial-in-confidence. While that's an industry issue, we believe it is also a regulator issue, and we want the regulator to be able to have that information available in a point of contest.

Having started with that generalised consumer expectation statement about what we want in health let me say that I don't think that most consumers expect anything of you as regulators.

I know that most of you give your life's work to this. You are continually confronted with the checks and balances that have to occur, but most of us, go about with our lives occasionally buying medicines, occasionally taking medicines and having not a clue about how or where all of that process happens.

It is only as we become organised in the consumer movement that we start to discover the intricacies and difficulties that you're dealing with. Alternately as individuals when we hit real problems and we have to find a way through those problems. Then we discover for ourselves who is responsible who should be helping us and protecting us and taking some public health responsibility. It is then that we start looking at the systems that are in place and I want to suggest to you as I did in a sense yesterday that there are three requirements of regulators from a systems point of view.

One of those is that the regulator be accountable to the population it serves. That immediately confronts us with a discussion that's already taken place about the issue of sovereignty.

My national organisation during a previous review of the Therapeutic Goods Administration, bid very strongly for sovereignty, accepting however, the more sharing done in terms of information and evaluation across the countries would contribute to time limits.

We argued for sovereignty with the bottom line being that somebody had to be held accountable. Accountability could only happen we thought within a national framework.

We are interested now about the New Zealand Australian harmonisation issue and whether you can actually transfer sovereignty into another entity, that is, sovereignty in neither or sovereignty to both.

Whichever way that is played out it is important to consumers that there is someone, somewhere that is accountable for the activities. If your going to be accountable we've got to find you and we've got to understand your role so you must be visible, be accessible and able to be talked to.

I was thinking, as I was sitting here, how remarkable it was for me to be here today. Ten to twelve years ago the TGA used to live in a part of a building with security buttons inside, in a time where the public service didn't have much security controls. We used to laugh that the security was to keep them in, and so protect us: the reality was that it was actually very hard to get in and talk to the TGA.

If we did there was certain paternalism at the very least, and sometime down right rudeness. On one occasion for instance one of our members went to speak to somebody at the TGA. She's of Chinese birth and had lived in Australia since she was seven. At the end of her statement the member of TGA shook her by the hand and said " but my dear you speak such good English" to which Yuong replied " so do you". Things have changed markedly since then.

We do need the processes and the decision making to be transparent because in a sense that's the other side of accountability.

Because you work in what looks like an expert clinical area there's a sense that what you do is technical, objective and clear. It therefore doesn't need to be opened to scrutiny because the facts are the facts.

The more you consider this you can see how wrong that is. There has been a pervading thought that there's an expertise that's been held by some and therefore there's not a lot of point bringing in outsiders because that makes the decisions political.

However, as you know, everything that you do has some values in it, is driven by the policy or the politics that support the operation.

Clinical evaluations by definition are value laden in some way. For that reason we would argue that wherever there's a decision made there is a role for the consumer to be involved. This may be through some sort of representative or at least consultative process in setting that criteria for that decision making and for being able to review those decisions and comment on them and being able to test and monitor the outcomes.

When you are doing those balancing acts of risk, timeliness, appropriateness and balancing the pressures of industry viabilities versus say an essential drug use, when you're talking about sovereignty there is pressure towards the lowest common denominator to all of those values. You are making decisions instead of the community and we are asking that there be a participatory and consultative process so the community is informing you about the values upon which the decisions must be made.

A few years ago I was invited to attend a conference of Asia and Pacific consumers. The learning for me in that experience was that every consumer of that conference, whether they came from Myanmar, Japan, Taiwan, China, India or Pakistan wanted quality in all aspects of health care.

In a sense the fewer services that were available the more important the quality regulatory framework was, the more important the quality of the products that were out in the marketplace became. (I learned too that it's not only medicines that are risk products but even clean water is a risk product.)

I learnt then that quality of the product, the process, the decision making, the regulation and the partnerships are all valued equally by all of us as users.

The sort of sharing that happens between regulators, assumes already that you have some values in common about what you want to achieve, whether in fact your able to achieve in particular cultures, in particular political environments and particular economic resource limitations. You are all working for quality in medicine regulation.

So there's a real value in the sharing that will go on to establish bench marking to share the modelling and to support each other so that we achieve quality outcomes from your regulations.

It seems to me, that it works two ways. There are some regulatory actions that are perhaps happening in Australia or New Zealand or where ever, that provide models for some other countries. In the new difficult area for us such as traditional medicines, many of you hear today have a history of traditional medicine use in your countries as well as a longer history in coming to grips with regulations of traditional medicines that you can actually share with our regulators.

I address the impossible task of what the consumer wants or expects from regulators.

We want you to have clear policies for your practices and we want to be involved. We want your regulatory framework to fit a broad national medicine policy.

We want from you regulators improved health outcomes through quality decision making and quality services.

Thank you

## **(Terry Slater)**

Look I'm sure there was a point in Janne's presentation where all of us drew the comfort of somebody putting their arm around us and saying we understand your problems as regulators, and we expect you to do, what you have to do. I thought that was wonderful.

Janne then presided to put down for us the heavy burden of responsibility that we carry in meeting our community expectations of us. That is indeed something that weighs on our minds. I can tell you from personal experience, and Janne wonderfully summed up the accountabilities that we have in her summary.

I think in the end what consumers expect from us is improved outcomes, improved quality and improved safety and timeliness. I think all of us would share in that view and those short words describe the heavy burden that we as regulators carry.

I think that that's a wonderful conclusion to the presentations. If I could pick out the six areas that have been touched on by our presenters, the major things are:

- regional cooperation and partnership;
- managing risks by regulators;
- the need for common standards amongst us so that not only are consumers able to trust the quality and safety aspects that regulator's have been regulating too, but industry is able to market their products into different countries with a similar and common standard framework.
- the topical question of advertising and I think all of us recognise the new major avenues of advertising that confronts us, particularly, in regards to the Internet;
- consumer access to self medication and that's certainly a topic we should focus; and
- the public health policies that surround us as a framework in which we regulate.

They are the six key themes that emerged this afternoon.

## **Sydney 2000 Declaration**

### **Regional Regulators' Forum Hosted by the Therapeutic Goods Administration and held in association with the World Self-Medication Industry 4th Asia Pacific Regional Conference 23 November 2000, Sydney, Australia**

During November 2000 the regulators' of therapeutic goods from 14 countries of the Asia Pacific region met at a Regulators' Forum in Sydney Australia.

The Regulators' Forum considered many current issues and shared information and experiences about the regulation of the self-medication industry. In doing so, the Forum recognised that self-medication, for appropriate conditions, is an important first line of health management in the health care community. It was acknowledged that responsible self-medication provides positive health outcomes for individuals, as well as positive consequences for society as a whole.

The Regulators' Forum recognised that the global nature of the therapeutic goods industry has opened the way for greater information exchange between governments, industry, regulators and consumers. It was acknowledged that in a complex and innovative environment, the ability to respond in a positive and farsighted way is an important feature of international information exchange and a measure of success in harmonising approaches.

The Regulators' Forum considered seven themes as key elements in supporting improved and transparent decision making in order to assist in achieving quality health outcomes.

In so doing they recognised the need to:

- foster partnerships and promote potential regional collaboration through the encouragement of both bilateral and multilateral cooperation programs with consideration of existing international mechanisms;
- promote scientific risk/benefit-based approaches to regulation of the self-medication industry;

- encourage communication about, and mutual understanding of, each other's drug evaluation systems throughout the region;
- encourage potential collaboration on the use of Internet technology on therapeutic goods in the region;
- enhance and promote informed consumer access to self-medication and reasonable choice through truthful and valid advertising of self-medication products;
- ensure therapeutic goods policies are directed towards providing people with safe and effective medicines through attainment of a level of regulation appropriate to the assessed risk/benefit, while ensuring the timely availability of safe, high quality and effective therapeutic goods; and
- explore the establishment of a regional regulator's forum as a vehicle for future cooperation.

The participants at the Regulators' Forum agreed to encourage others associated with the advancement of public health to actively work towards successfully achieving positive outcomes in these areas.

In coming to these recommendations the Regulators' Forum carefully considered recent developments and approaches taken in the self-medication industry.

The Regulators' Forum acknowledged the World Self-Medication Industry Guiding Principles which suggests that more and more knowledgeable, responsible and motivated consumers are taking an active interest in their health. It was recognised and agreed that, because of this, governments should have sound policies in place that both allow and encourage responsible self-medication with products designed for such use.

The participants of the Regulators' Forum recognised the necessity and value of partnerships within the region and agreed to exchange more information with all stakeholders to ensure that government policies and directions adequately respond to the needs and desires of their people in the country and the greater community.

The participants at the Regulators' Forum also agreed to review the implementation of the recommendations of the Sydney 2000 Regulators' Forum next time they convene to ensure the longer term benefits from the close and productive work at the Sydney Forum are realised.

Terry Slater  
National Manager  
Therapeutic Goods Administration  
Australia

Chairman  
Regulators' Forum  
23 November 2000



# Appendix A

## Participants

Ms Janne Graham, Australian Consumer Advocate

Dr Robert Peterson, Director General, Therapeutic Products Program, Health Canada,

Dr Patrick Deboyser, Head, Food Law, European Commission

Mr Peter Zinck, Chief Pharmacist, Ministry of Health, Fiji

Dr Sampurno, Ministry of Health, Indonesia

Dr Tatsuo Kurokawa, Director, Safety Division, Ministry Of Health and Welfare, Japan

Dr Pu Young Kim, Food and Drug Administration, Korea

Dr Thiri Tun Myint, Director, Food and Drug Administration, Ministry of Health, Myanmar

Dr Bhupendra Thapa, Chief of Medicine, Drug Control, Department of Drug Administration, Nepal

Dr Stewart Jessamine, Senior Medical Advisor, Medsafe, New Zealand

Mrs Clare Van Der Lem, Manager, Medsafe, New Zealand

Ms Irynne Gonzales, Products Service Division, Bureau of Food and Drugs, Philippines

Dr Clarence Tan, Director, Medical Services, Health Sciences Division, Ministry of Health, Singapore,

Dr Weng Huang, Department of Health, Taiwan

Dr Tharnkamol Chanprapaph, Senior Pharmacist, Control Division, Food and Drug Administration, Thailand

Mr Tran Cong Ky, Vice General-Director, Drug Administration, Vietnam

Ms Juliet Seifert, Executive Director, Australian Self Medication Industry,  
Australia

Dr Jerome Reinstein, Director-General, World Self-Medication Industry

Mr Graham Peachey, Director, Chemicals and Non-Prescription Medicines  
Branch, Therapeutic Goods Administration, Department of Health and Aged  
Care, Australia

Dr Fiona Cumming, Director of the Office of Complementary Medicines,  
Therapeutic Goods Administration, Department of Health and Aged Care,  
Australia,

Mr Terry Slater, National Manager, Therapeutic Goods Administration, Australia


## Appendix B Presentation Slides

Dr Stewart Jessamine and  
Mr Graham Peachey

**Asia Pacific Regional Regulators Forum  
November 2000**

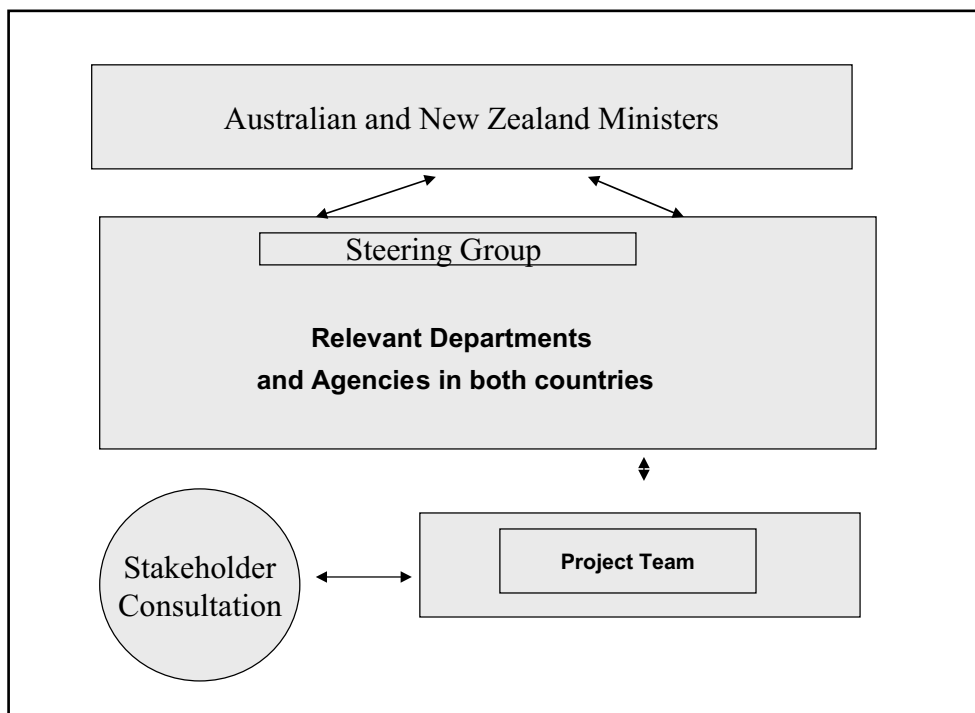
**Australia and New Zealand**

**"A Case Study in Cooperation"**

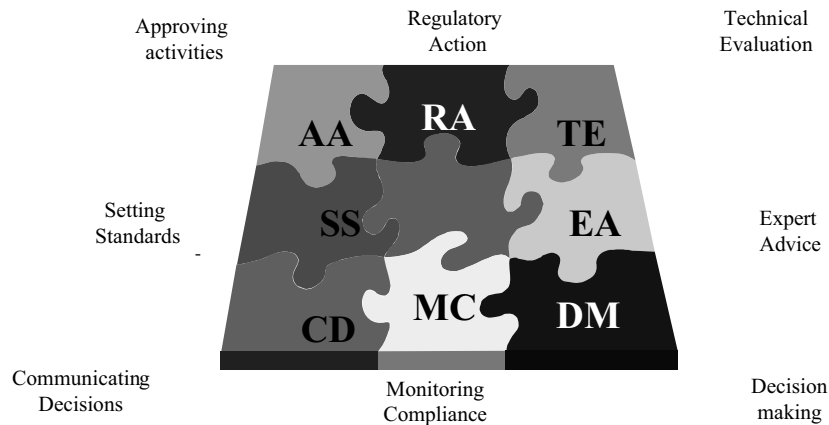


Dr Stewart Jessamine - New Zealand  
&  
Mr Graham Peachey - Australia

1



## Regulatory Functions



3

## Essential Principles

- enhance public health and safety;
- be responsive to the public health and safety needs of each country;
- deliver common regulatory outcomes while taking into account sovereignty issues;
- provide each country with a shared input to decision-making; and
- be directly accountable to both governments.

4

## Essential Principles

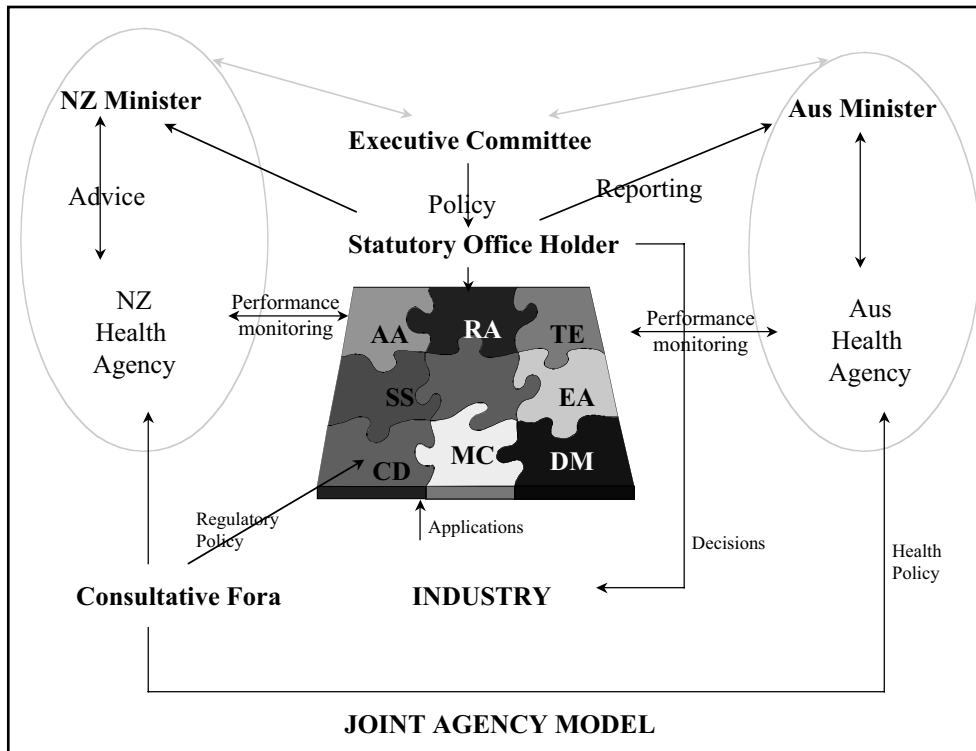
- facilitate stakeholder input to the development of regulatory policy;
- administer an evidence and risk-based approach to regulation and decision-making;
- consistent with the Council of Australian Governments and the New Zealand Code of Good Regulatory Practice principles;
- based on international best practice and principles of natural justice;
- transparent, timely and inclusive;

5

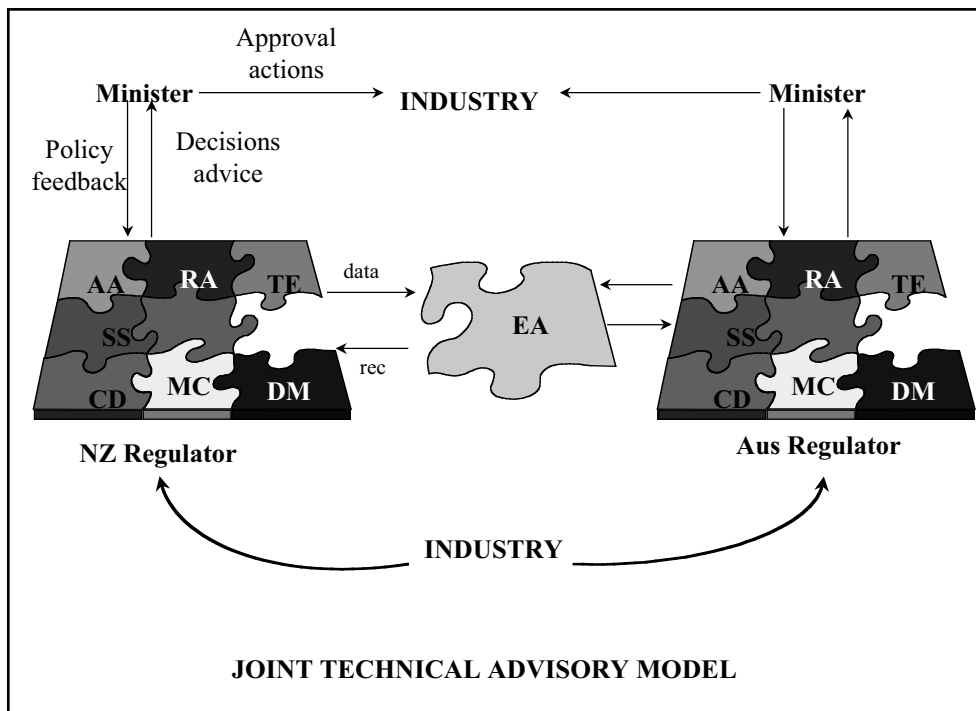
## Essential Principals

- be influential in global harmonisation decision-making;
- meet domestic and international treaty obligations;
- encourage the development of the therapeutic goods sector in Australia and New Zealand;
- support the export of therapeutic goods;
- facilitate trans-Tasman trade subject to the industry and health policies of both countries; and
- be fully funded through fees and charges paid by industry.

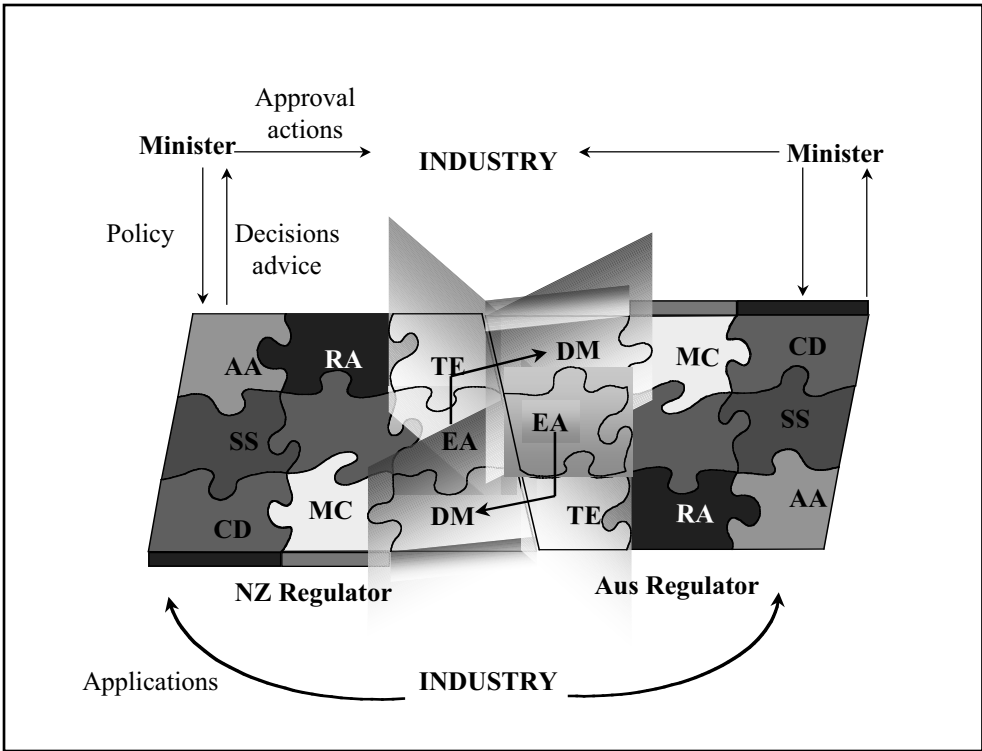
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7



8



**PREFERRED MODEL**  
  
**JOINT AGENCY**

## Stakeholder Issues

- industry/trade implications;
- pricing implications in a joint market;
- costs/what should be cost recovered;
- governance/sovereignty "best of both worlds";
- advertising; and
- separation of complementary medicines.

11

## Governance Principles

- a distinct legal identity with a legal personality in both countries, not just one;
- establishment under terms set out in a treaty;
- common regulatory outcomes, based on parallel legislation, with the authority to implement and enforce laws in both countries;
- direct accountability to both Ministers and both Parliaments;
- provision for shared decision making;

12

## Governance Principles

- an opt-out provision from a common regulatory decision, by either country, in extraordinary circumstances, under agreed criteria and within agreed timeframes that includes a process for the future resolution of issues that have led to a separate decision;
- agreed delegation of decision making;
- common regulatory review and appeal mechanisms which are suitable for therapeutic goods and provide access to industry in both countries;

13

## Governance Principles

- separation of public health policy (which would remain the responsibility of the Australian Department of Health and Aged Care and the New Zealand Ministry of Health) from regulatory health policy (which would be developed in the single joint agency); and
- comparable employment terms and conditions for staff in both countries.

14



## Appendix C Presentation Slides

Dr Robert Peterson

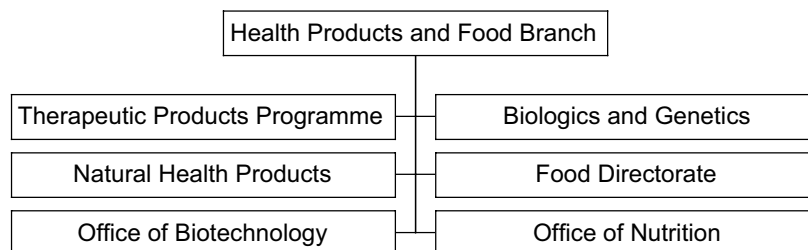
# Regulation of OTC Products

Therapeutic Products Programme  
Health Canada

WSMI 4th Asia Pacific Regional Conference  
Sydney, Australia

1

# Health Canada Realignment



2

## Self-Care Products in Canada

...source NDMAC

- Total annual sales ~ \$2.9 billion
  - 33% total pharmaceutical sales
  - 10,000 employees in Canada
  - one-half of sales from approximately 10 multinational corporations
- Recent growth stimulated by...
  - natural health products
  - prescription to non-prescription switches

3

## Shared Responsibility for Regulating Self-Care Products in Canada

- Health Canada -- TPP, NHP, Food
- TPP
  - responsible for drug safety, efficacy, quality
  - regulates drugs imported and manufactured
  - determines prescription status
- NHP
  - herbals, vitamins, minerals, homeopathics, etc.
- Food
  - nutraceuticals, novel foods

4

## Shared Responsibility for Regulating Self-Care Products in Canada

- **Manufacturers**
  - meet standards
  - assure quality
  - report problems
  - recommend switches
- **Provinces**
  - specify further conditions for sale
  - define ‘practitioner’
  - regulate practice of healthcare providers

5

## Provinces Control Drug Distribution

- **May place more stringent requirements on sale**
  - may require practitioner intervention even when not Schedule F to Regis
- **National Association of Pharmacy Regulatory Authorities**
  - representation from most provinces
  - 3 Schedules to harmonize point of sale requirements in Canada

6

## National Drug Schedules

- Schedule I
  - Prescription only
  - established by TPP Notice of Compliance
- Schedule II
  - Pharmacist only
  - Examples: Insulin, Nitroglycerin
- Schedule III
  - Self-selection area of Pharmacy
- Unscheduled
  - ñ Any retail outlet

7

## International Efforts by Health Canada

- MRAs for GMP compliance
  - Switzerland -- completed, active
  - European Union -- confidence building
  - final stages
- MOUs for Drug Review
- ICH Official Observer
  - adoption of many ICH Guidelines
- Seeking partners for Regulatory Activities

8

## Future Regulatory Framework for Self-Medication

- Common entry for non-prescription drugs, natural health products, and novel foods
- Harmonization of requirements wherever feasible
- Common GMP, reporting, updates, etc.
- Single Compliance/Enforcement group

9

## Important Principles for Self-Medications in Canada

- Should be products which have a high safety margin, and are easy to self-administerÖe.g, few dosage considerations
- Should be for conditions which are amenable to:
  - self-diagnosis
  - self-treatment with little supervision
- Conditions should not silently progress while under self-Rx

10

## Contacting Health Canada

- Therapeutic Products Programme
  - <http://www.hc-sc.gc.ca/hpb-dgps/therapeut/>
- Federal Acts and Regulations
  - <http://canada.justice.gc.ca>
- National Association of Pharmacy Regulatory Authorities
  - <http://www.napra.org>

## Appendix D Presentation Slides

Dr Fiona Cumming

# **"MANAGING THE RISKS"**

Dr Fiona Cumming

Director

Office of Complementary Medicines

Therapeutic Goods Administration

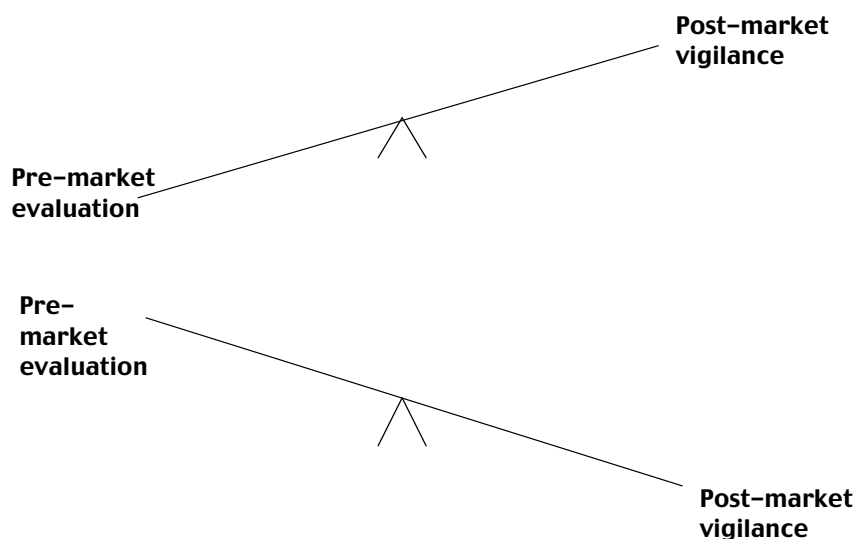
1

## **Complementary Medicines**

- **Herbal Medicines**
- **Vitamins**
- **Minerals**
- **Nutritional supplements**
- **Homoeopathic medicines**
- **Aromatherapy oils**

2

## Managing the risks



3

## Registered medicines – Higher Risk

- **Quality – Good Manufacturing Practice**
- **Safety – Product-by-product evaluation**
- **Efficacy – Product-by-product evaluation**

4

## **Listed medicines – Lower Risk**

- **Quality – Good Manufacturing Practice**
- **Safety – Substance-by-substance evaluation**
  - **Product-by-product assessment**
- **Efficacy – Sponsors must hold evidence to support claims/indications.**

5

## **Review of advertising arrangements – 1999**

- New principles-based advertising code
- Guidelines on evidence requirements
- Glossary of permitted claims and representations

6

## Evidence to support claims for Listed Medicines

- **Scientific evidence**
- **Evidence based on traditional use**

7

### Levels of Scientific Evidence - Primary Evidence

Level	Type of Evidence
High	<b>Evidence obtained from a systematic review of all relevant randomised controlled trials, for example a Cochrane review.</b> <b>OR</b> <b>Evidence obtained from at least one properly designed randomised controlled (preferably multi-centre) double blind trial. It is preferable to have data from at least two independent trials, but in some cases, one large well-conducted trial may suffice. (Advice should be sought from the TGA in such cases).</b>

8

## Levels of Scientific Evidence - Primary Evidence

<b>Medium</b>	<p>Evidence obtained from well designed controlled trials without randomisation. In the case of a homoeopathic preparation, evidence from well-designed, controlled homoeopathic proving.</p> <p><b>OR</b></p> <p>Evidence obtained from well designed analytical studies preferably from more than one centre or research group, including epidemiological cohort and case-control studies.</p> <p><b>OR</b></p> <p>Evidence obtained from multiple time series with or without intervention, including population and ecological studies. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.</p> <p>NOTE: In practice the sources of most medium level evidence will be peer-reviewed published papers and evidence-based reference texts. However, other evidence that meets the requirements may be acceptable. Websites evaluating peer-reviewed published evidence may be a source of suitable evidence.</p>
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## Levels of Scientific Evidence - Primary Evidence

<b>General</b>	<p>Descriptive studies or reports of relevant expert committees. Texts, such as TGA-approved Pharmacopoeias or monographs, or other evidence based reference texts, may be included in this Level.</p>
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## Levels of Scientific Evidence - Non-primary Evidence

<b>Supporting evidence</b>	Non-human data, such as <i>in vitro</i> studies and animal studies, and non-clinical studies such as biochemical, nutritional and microbiological studies. This evidence does not stand alone and may only be used in conjunction with primary evidence.
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11

## Levels and Types of Evidence - Scientific

Level of claim	Type of claim	Evidence required to support claim
<b>HIGH</b>	<ul style="list-style-type: none"> <li>⊗ Treats/cures/manages any disease/disorder/condition.</li> <li>⊗ Prevention of any disease, disorder or condition.</li> <li>⊗ Treatment of specific named vitamin or mineral deficiency diseases.</li> </ul>	High level. Registration only ñ evaluated by the CMEC, MEC or ADEC.
<b>MEDIUM</b>	<ul style="list-style-type: none"> <li>⊗ Health enhancement.</li> <li>⊗ Reduction of risk of a disease/disorder/condition.</li> <li>⊗ Reduction in frequency of a discrete event.</li> <li>⊗ Aids/assists in the management of a named symptom/disease/disorder/ condition.</li> <li>⊗ Relief of symptoms of a named disease, disorder or condition.</li> </ul>	Medium level. Sponsor must hold the evidence for Listable goods.
<b>GENERAL</b>	<ul style="list-style-type: none"> <li>⊗ Health maintenance, including nutritional support.</li> <li>⊗ Vitamin or mineral supplementation.</li> <li>⊗ Relief of symptoms (not related to a named disease, disorder or condition).</li> </ul>	General level. Sponsor must hold the evidence for Listable goods.

12

## Registrable Diseases List - Medicines

<b>Disease/disorder/condition/action ñ serious manifestation of</b>	
Abortifacient action.	Infectious diseases, including sexually transmitted diseases.
Cardiovascular diseases.	Insomnia, persistent.
Dental and periodontal disease.	Mental diseases, ailments or defects, including substance abuse.
Diseases of joint, bone, collagen, and rheumatic disease.	Metabolic disorders.
Diseases of the eye or ear likely to lead to severe impairment, blindness or deafness.	Musculoskeletal diseases.
Diseases of the liver, biliary system or pancreas.	Neoplastic disease (all cancers).
Endocrine diseases and conditions, including diabetes and prostatic disease.	Nervous system diseases.
Gastrointestinal diseases.	Renal diseases, diseases of the genito-urinary tract.
Haematological disorders and diseases.	Respiratory diseases.
Immune disorders and diseases.	Skin diseases.
<b>Other</b>	
Immunisation	Poisoning, venomous bites and stings ñ treatment of.

13

## Traditional Use

- Documentary evidence that a substance has been used over 3 or more generations of recorded use for a specific health related or medical purpose.

14

## Levels and Types of Evidence - Traditional

<b>MEDIUM</b>	<ul style="list-style-type: none"> <li>⊙ Health enhancement</li> <li>⊙ Reduction of risk of a disease/disorder/condition.</li> <li>⊙ Reduction in frequency of a discrete event.</li> <li>⊙ Aids/assists in the management of a named symptom/disease/disorder/condition.</li> <li>⊙ Relief of symptoms of a named disease/disorder/condition.</li> </ul>	This (tradition) medicine has been used for (indication). This claim is based on traditional use.	<p><b>Primary evidence:</b> Two of the following four sources that demonstrate adequate support for the indications claimed:</p> <ol style="list-style-type: none"> <li>1. TGA-approved Pharmacopoeia.</li> <li>2. TGA-approved Monograph.</li> <li>3. Three independent written histories of use in the classical or traditional medical literature.</li> <li>4. Availability through any country's government public dispensaries for the indication claimed.</li> </ol>
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15

## Levels and Types of Evidence - Traditional

<b>GENERAL</b>	<ul style="list-style-type: none"> <li>⊙ Health maintenance, including for example claims relating to nutritional support.</li> <li>⊙ Relief of symptoms (not referring to a named disease, disorder or condition)<sup>2</sup>.</li> <li>⊙ Claims for traditional syndromes and actions.</li> </ul>	This (tradition) medicine has been traditionally used for (indication).	<p><b>Primary evidence:</b> One of the following four sources that demonstrates adequate support for the indications claimed:</p> <ol style="list-style-type: none"> <li>1. TGA-approved Pharmacopoeia.</li> <li>2. TGA-approved Monograph.</li> <li>3. Three independent written histories of use in the classical or traditional medical literature.</li> <li>4. Availability through any country's government public dispensaries for the indication claimed.</li> </ol>
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## **Trial of the Levels of Evidence Guidelines**

- February - July 2000
- more than 400 claims assessed
  - 230 new claims that would have been prohibited under old advertising arrangements.

17

