Obstacles to transparency over pharmacovigilance data within the EMA

Abstract

- In July and August 2014, the European Medicines Agency (EMA) organised two public consultations concerning European pharmacovigilance. These two consultations reveal a number of EMA proposals that are counterproductive to the objective of improving transparency over pharmacovigilance data.

- The EMA’s proposals offer pharmaceutical companies an opportunity to participate in public hearings held by the European Pharmacovigilance Risk Assessment Committee (PRAC), in order to defend their drug. They also provide for the possibility of holding non-public hearings to discuss public data. There is a great risk that the drug industry might use these provisions to influence the debate.

- The strings attached to the access that the EMA proposes to grant researchers to data contained in the centralised European pharmacovigilance database would allow the EMA to censor the publication of their findings. The EMA seems to regard pharmacovigilance data as commercially confidential information.

- Responding to these consultations provided an opportunity to remind the EMA that data about adverse effects are a public good, in the common interest, and that it is unacceptable to keep this information confidential.

The joint response to which Prescrire contributed urged the EMA to systematically broadcast live videos of public hearings on its website. And to prevent hearings from being monopolised by European patient groups that are heavily funded by the pharmaceutical industry, the EMA was also encouraged to ensure that representatives of independent patient groups (victims of adverse effects, consumers, patients and their relatives) are heard, and allowed to testify in their own language.

Access to pharmacovigilance data: too limited. Since 2012, the public has been able to access some quantitative data extracted from the centralised European pharmacovigilance database, EudraVigilance, through the unfortunately rather unwieldy ADRreports interface (www.adrreports.eu). For example, the public can find out how many spontaneous reports were recorded in EudraVigilance in which a specified adverse effect was associated with a given drug.

Pharmacovigilance hearings: industry influence and uncertain transparency. Several of the provisions proposed by the EMA concerning the organisation of public hearings are counterproductive.

- In its draft document, the EMA proposed giving pharmaceutical companies “the opportunity to present its/their view(s) to the participants of the public hearing”. The EMA would thus offer drug companies an ideal platform from which to downplay concerns over the adverse effect profiles of their drugs, despite the risk of influencing the debate.

- The EMA also proposed holding non-public hearings when a company or another person “intending to submit information has confidential data relevant to the subject matter of the procedure”. This provision would undermine the transparency of the debates and the independence of the EMA’s decision-making process. Non-public hearings are only acceptable for protection of the identity of a whistle-blower.

The final versions of the documents released for consultation were still not available as of late June 2015.

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good, in the common interest, state-
ments about the need to protect intel-
lectual property have appeared, such
as the responsibility to apply “appropri-
ate technical and organisational measures
to protect information and personal data (…) against unauthorised or unlawful access, disclosure, dissemination, alteration, or destruction or accidental loss” (4).

This wording, which resembles the
title of the proposal for a European
directive on “trade secrets” currently
under review by the European Parlia-
ment, reveals that the EMA now
seems to regard pharmacovigilance
data as commercially confidential
information or even “trade secrets”,
and has taken on board the pharma-
caceutical industry’s willingness to con-
trol these data and their dissemina-
tion (6,8,9).

In summary: erosion of transpar-
ency. These two consultations reveal
that the EMA’s approach to transparen-
cy over pharmacovigilance data is even
more timid than its approach to clinical
cy over pharmacovigilance data is even
that the EMA’s approach to transparen-
cy.

Selected references from Prescrire’s literature
search.
1- Prescrire Editorial Staff “European pharma-
covigilance: increasingly outsourced to drug com-
2- Prescrire Editorial Staff “The reorganisation of
European pharmacovigilance. Part 2: from spon-
sorous reports to agency reviews and decisions” Prescrire Int 2015; 24 (157): 50-54.
3- European Medicines Agency “Draft rules of
procedures on the organisation and conduct of
public hearings at the Pharmacovigilance Risk
Assessment Committee (PRAC) (EMA/624809/
2013) – draft for consultation” 24 July 2014: 9
pages.
4- European Medicines Agency “Revision of Eu-
EdraVigilance access policy for medicines for
human use (EMA/759287/2009 Revision 1)” 4
5- Medicines in Europe Forum, HAI Europe, ISDB,
Nordic Cochrane Centre “EU Pharmacovigilance
public hearings should be as transparent and inde-
pendent as in the US” Brussels, 14 October 2014:
11 pages. www.prescrire.org
6- Cochrane AEM Group “Information in Europe Forum,
HAI Europe, ISDB “Transparency of adverse drug
reactions in Europe: Proactive public access to
qualitative data is needed, pharmacovigilance data
are not trade secrets” Paris, 15 September 2014:
17 pages. english.prescrire.org
7- AIM, Medicines in Europe Forum, HAI Europe,
ISDB, Nordic Cochrane Centre “EMA’s final policy
on access to clinical data: proactive access to some
data, but strings attached” 16 October 2014:
4 pages.

Pay for performance: financial rewards
without improving quality of care

"Pay-for-performance" systems offer healthcare professionals financial incentives intended to
support public health initiatives, to reduce health care spending, or to apply “best practices” (1). Yet ac-
cording to various analyses, pay-for-
performance programmes yield mixed and often disappointing results (2,3). The effects of one such programme involving benzodiazepine prescribing in France show that the reality can be complex.

Reduced benzodiazepine use? In 2009, one of the objectives of the French National Health Insurance Fund’s pay-for-performance pro-
gramme “CAPI” (Contracts for Improved Individual Practice) was to reduce the proportion of persons aged over 65 years taking long half-life benzodiazepines to less than 5%. However, a reduction in the duration of benzodi-
azepine treatment would have been a more
relevant measure for patients, however (4). In 2011, the “ROSP” programme (Payment for Public
Health Objectives), which addressed the CAPI programme, addressed this issue by encouraging prescribers to limit benzodiazepine treatment to less than 12 weeks (5,6).

In a report on the ROSP programme published in 2015, the National Health Insurance Fund congratulated itself on a re-
duction in the proportion of persons aged over 65 years taking long half-life benzodiazepines from 13.7% in late 2010 to 10.8% in late 2014 (5). How-
ever, the programme failed to reduce the proportion of patients newly treat-
ed with benzodiazepines who contin-
ued treatment for more than 12 weeks; this proportion remained unchanged in 2014, at about 15%.

Counterproductive. The results of a study conducted in the Pays de la Loire region of France may explain this
phenomenon. The reduction in the proportion of prescriptions for long half-life benzodiazepines between
2011 and 2012 was associated with an increase in prescriptions for short half-life benzodiazepines (7). And a greater proportion of patients over the age of 65 years who were prescribed short half-life benzodiazepines continued
 treatment for more than 12 weeks compared with those who were pres-
cribed long half-life benzodiazepines. This seems “counterproductive”.

This pay-for-performance pro-
gramme therefore altered benzodiaz-
epine prescribing patterns without
leading to any real improvement in the
quality of health care. Protecting patients from adverse effects requires
more than payments for meeting mea-
surable performance targets.

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