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Bringing medicines to *life*
Scotland

Lewis Macdonald MSP
Convener
Health and Sport Committee
T3.40
Scottish Parliament
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4th March 2020,

Dear Mr Macdonald,

Many thanks for your letter dated the 28th of February and the opportunity to provide additional context to our discussion during the oral evidence session.

Monitoring patient adherence

In your letter you correctly state that feedback on how a medicine is taken is incredibly important to the pharmaceutical industry. However, I would go one step further and assert that it is not only important to our members but also to patients, clinicians and the wider NHS. Understanding patient compliance is critical if we are to maximise value from the medicines budget.

Currently, the methods for understanding patient adherence, from a manufacturer's perspective, are limited. Novel pricing schemes where HTA bodies, such as SMC, approve a medicine in lieu of evidence on its real-world performance can provide a degree of understanding, but these schemes are the exception rather than the rule.

Currently, there is no formal mechanism for manufacturers to understand how patients comply with their medicine. There are of course informal means, through surveys and intelligence from clinicians, but there is little in the way of a formalised approach to outcomes monitoring.

Our members spend billions of dollars annually researching and developing the latest medicines and want them to be taken correctly in order to achieve the desired outcomes. As a result, some manufacturers have taken it upon themselves to understand where non-compliance exists in order to design potential new treatments that remove the opportunity for poor adherence.

However, a systematic approach to outcomes and adherence monitoring would help streamline this process and the collection of evidence, through patient reported experience or outcome measures (PREMS and PROMS), could improve the current drug development process.

However, as mentioned during the committee evidence session, when it comes to patient safety, there are a number of structures in place to ensure patient and clinician feedback is reported to manufacturers.

The MHRA's Black Triangle system is part of an EU-wide scheme known as additional monitoring, where new medicines are subject to additional scrutiny. The inverted black triangle appears on a medicine's packaging and actively encourages clinicians and patients to report any possible adverse reactions. Typically, new medicines are assigned a Black Triangle for a period of five years following first authorisation in the EU. During this period, if new side effects are recorded, a manufacturer will be able to alter their patient safety information leaflet to reflect this new understanding.

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In addition to the Black Triangle system the MHRA also runs a "yellow card" system where adverse reactions associated with older medicines can be recorded. All serious suspected adverse reactions should be reported, even if the effect is well recognised, and reports can be submitted via the MHRA or directly to the marketing authorisation holder. Patients are able to submit a "yellow card" for a number of reasons and, for medicines, these include:

- a medicine causes side effects
- a medicine doesn't work properly
- a medicine is of a poor quality
- you think a medicine is fake or counterfeit

Depending on the severity of the "yellow card" report, the MHRA, manufacturer or a medical specialist will be invited to investigate. Even if this is not investigated, the side effect will be recorded.

The safety of medicines is continuously reviewed by both manufacturer and the regulatory bodies after marketing approval is given. The manufacturer is obliged to provide periodic reports on all safety information gathered to the MHRA, and corrective actions agreed. In this way, over the lifetime of a medicine, there will be several changes to patient information leaflets, prescribing information and sometimes letters direct to healthcare providers (commonly known as Dear Dr letters). Further research or new data from patients and processes also allow for the identification of new dosage regimes, new formulations or even extending licenses to new indications (but only after robust review of all available data and regulatory approval). A full list of scenarios under which a manufacturer must collect information, and the process to follow, can be found here.

Storage of Medicines and recycling

As explained during the oral evidence session, when a medicine leaves a controlled environment, we have no means of guaranteeing its safety or efficacy. The World Health Organisation specifically advises that patient-returned medicines should not be donated or used again and the MHRA have previously advised that medicines should not be re-used after dispensing to a patient.

During the licensing process the regulator details specific conditions under which a medicine must be stored to ensure its safety. Therefore, regardless of whether these instructions dictate cold storage or a dry environment, if there is uncertainty as to how a medicine's been stored, it cannot be reused. The current regulations for product quality and stability at temperature and humidity can be found here, CPMP/QWP/609/96/Rev 2 (2007).

From a manufacturer's perspective our members are liable for ensuring the safety and efficacy of a product up until it is signed over to the NHS or a pharmacy. During transport, temperature monitors are placed inside each shipment and cold storage facilities are regularly validated to identify cold or hot spots. There are also additional fail-safe mechanisms that will remove or recall a pack if there are any doubts as to its environment during transit. These regulations are necessary to protect patients and the ABPI does not believe that it would be practical to replicate these safeguards in a patient's home environment for the purpose of re-using an unused medicine.

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Furthermore, a 2012 UK Government steering group reporting on the potential to reduce medicines wastage concluded that reusing medicines was not practical, the full report can be read here, but this extract explains why this conclusion was reached:

"We have not considered the "recycling" of medicines supplied in primary care and returned by patients… we decided for practical, technical and ethical reasons… we should exclude this aspect at this time".

Finally, given that a significant proportion of medicine dispensed to patients are generic with a low unit cost, it would not be cost-effective to introduce a complex system for re-using dispensed medicine.

As an industry, we believe that the approach to reducing medicines wastage should focus on prevention rather than cure. This means, ensuring medicines are prescribed appropriately, patients are empowered to understand their treatment and working to improve patient adherence is treated as a public health priority for all involved.

Packaging solutions

Medicines are packaged in containers that are designed to ensure their safety and efficacy. Whether this is a blister pack or a bottle, the materials have been rigorously tested to maintain a particular product's quality.

To my knowledge, no packaging exists that can insulate a medicine from extreme exterior conditions which would enable a medicine to re-enter the supply chain.

And finally, the recently introduced Falsified Medicines Directive, which provides a system to protect patients from counterfeit medicine, should be considered. The use of 2D barcodes and tamper evident seals has been rolled out across the EU to ensure a medicine's authenticity. If a medicine was to re-enter the supply chain, then safeguards would be required to ensure its quality in light of these regulations. Any system that increases the likelihood of counterfeit medicine re-entering the supply chain should be carefully considered.

I trust this information is helpful for the Committee and we would be happy to provide any additional information if required.

Yours sincerely,

Sheuli Porkess

Executive Director of Research, Medical and Innovation, ABPI