# The European Medicine Agency (EMA) and Primary Health Care: an ambiguous relation?

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# What does primary health care (PHC) expect from EMA?

- IN GENERAL
  - Trustworthy/ Reliable
  - Transparent/ Independent
  - Scientific
  - Not (too) bureaucratic
- CONCERNING PHC
  - **Considering risks and not only effect/benefit**
  - **Considering PHC epidemiology**
  - **Considering costs**

# Considering risks and not only effect/benefit,

considering PHC epidemiology and costs.

- Some examples of decisions about risk, unclear for PHC :
  - Risk evaluation glitazones, domperidon, cyproteron
    ➔ after EMA evaluation 'still positive benefit/risk' for broadly used products with existing safer alternatives
- EMA asks only placebo comparisons and not comparative trials with (older) drugs ➔ impossible to have an evaluation of the true added-value of a new drug, essential for PHC.

  ➔ Proposition for all drugs but certainly those used in general practice: Requirement of comparative trials within 5 years after commercialisation?

# Considering risks and not only effect/benefit, considering PHC epidemiology and costs.

- PHC epidemiology is highly relevant in *selection of populations* in the trials:

- ➔even for typical PHC pathology, trials including only/mostly hospital patients result in *unscientific* conclusions for PHC because of selected population:
  these patients have often no effect on first line treatments, are more ill and need more aggressive treatments,
  hence they are *not representative for PHC patients*

# Examples of biased populations

- How representative are clinical study patients with **allergic rhinitis** in primary care?

  David J. Costa et all *J Allergy Clin Immunol. 2011;127:920-6.*

**“Only 7.4%** (95% CI, 4.5% to 10.3%) of the patients seen in primary health care would have been enrolled in the RCTs…”

- Most studies on **diabetes type 2** (typical PHC problem) done in hospital patients

➔ recent new antidiabetic drugs gliflozines (SGLT2-inhibitors) - again - the same population selection

# Considering risks and not only effect/benefit, PHC epidemiology and considering costs

- In PHC we feel implicated in the discussion on affordable health care

(WONCA definition of GP ”makes efficient use of health care resources ”)

- New drugs have very high prices but mostly for rare diseases (cancer, metabolic diseases)

- It becomes more troublesome when it concerns common problems like hypertension, diabetes, arthrosis or .. hypercholesterolemia

# Hypercholesterolemia: the PCSK9 inhibitors

- Hypercholesterolemia in *about 50-70% of adult Europeans*, >>> PHC problem

- New lipid medication **PCSK9 inhibitors**: (monoclonal LDL-receptor antibodies) Evolocumab and Alirocumab
- Used on top of statins in the studies, *only surrogate endpoints* (↓LDLcholesterol)

- Accepted **indications**:
  familiar hypercholesterolemia ( **OK, real potential improvement in very high risk**)

➔<u>but</u> also hypercholesterolemia "in people not tolerating statins" **(➔ ???)**

- Price: >5000€/year ( >< simvastatin 40mg ~100€/year)
  ➔ potential (extra) threat for social security systems in Europe

➔ EMA not critical enough in *acceptance of indications* (and the consequences)

➔Requirement of studies with hard endpoints (morbi-mortality) within 5-10 years?

# Conclusion

- Europeans need EMA and certainly PHC does.
- From the start (endpoints, comparators) to the end (cost, safety) EMA decisions are crucial for PHC and the whole European population
- To do a better job, EMA needs more input from critical PHC clinicians
- Drug policy and rational use of medication is too important to leave to the lobby groups, bureaucracy and hyperspecialised experts seeing only atypical patients.