**Proposal COM(2023) 193** of 26 April 2023 for a **Regulation** of the European Parliament and the Council **laying down Union procedures for the authorisation and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency**

**Proposal COM(2023) 192** of 26 April 2023 for a **Directive** of the European Parliament and the Council **on the Union code relating to medicinal products for human use**

# PHARMACEUTICAL LEGISLATION REFORM

## cep**PolicyBrief** No. 2/2024

## LONG VERSION



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# A. Key elements of the EU proposal

## 1 Background, Extent and Objectives

### 1.1 General Background

- Essentially, the current EU general pharmaceutical legislation is 20 years old and in need of reform.
- Worldwide competition, vulnerabilities of supply chains, industrial policy issues and insufficient digitalisation or the very fragmented progress of digitalisation in the EU, show that a good regulatory basis is needed in order to achieve the aims of health policy in Europe in the next two decades and beyond.
- One aim of the Commission under von der Leyen has therefore been to reform the pharmaceutical legislation in order to ensure "supply … [of] affordable medicines … [and to] support the European pharmaceutical industry to ensure that it remains an innovator and world leader" [Mission Letter to Commissioner Kyriakides 2019, p. 4; see also cep**Adhoc** A Healthy Europe: Von der Leyen's tasks for the new EU Commission].
- More concretely, the so called Pharmaceutical Strategy of the Commission published in 2020 [COM(2020) 761; see also cep**PolicyBrief**] included the political aim of new and reformed health legislation.
- The political umbrella term is the creation of the "European Health Union" [See among others cep**Input** 4/2021 and cep**PolicyBrief** 12/2021].
- The EU Pharmaceutical Legislation has grown significantly over the years and includes various regulations and directives. At its core [hereinafter "Core Pharmaceutical Legislation"], it includes
  - the Community code relating to medicinal products for human use [(EC) 2001/83];
  - the Regulation on Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency [(EC) 726/2004];
  - the Regulation on orphan medicinal products [(EC) 141/2000]; as well as
  - the Regulation on medicinal products for paediatric use [(EC) 1901/2006].
- An authorisation procedure is a mandatory prerequisite, nationally or at EU level, in which the efficacy, safety and quality of a medicine to be placed on the market is examined. In this regard, any medicine will need a so-called marketing authorisation.
- Generally, there are authorisation procedures both at Member State level, as well as EU level. The required procedure depends on the type of medicine.

### 1.2 Extent of the Pharmaceutical Legislation Reform

- The Pharmaceutical Legislation Reform [hereinafter "the Reform"] aims to repeal the current Core Pharmaceutical Legislation, adapt and update its provisions and merge them into two new comprehensive laws:
  - a "Regulation Proposal": Regulation laying down Union procedures for the authorisation and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency (EMA) – COM(2023) 193.
  - a "Directive Proposal": Directive on the Union code relating to medicinal products for human use – COM(2023) 192.
- These two new laws will then cover those health policy issues which are currently regulated in various different pieces of legislation. The Regulation Proposal and the Directive Proposal cover, inter alia, the following health policy issues:
  - general rules on marketing authorisation for all medicines for human use;
  - specific rules on antimicrobials, such as antibiotics;
  - specific rules on orphan medicines, i.e. medicines addressing rare diseases;
  - specific rules on medicines for children (and teenagers).
- Additionally, the following laws will be amended by the Reform:
  - Regulation on advanced therapy medicinal products [(EC) 1394/2007];
  - Regulation on clinical trials on medicinal products for human use [(EU) 536/2014];

  - Regulation on a reinforced role for the European Medicines Agency in crisis preparedness and management for medicinal products and medical devices [(EU) 2022/123, see cep**PolicyBrief** 12/2021].

- Generally, neither the Regulation Proposal nor the Directive Proposal aim to affect the rights of Member States to set prices for medicines or to decide on their inclusion on the scope of the national health system or social security scheme on the basis of health, economic and social conditions [Art. 1 No. 9 Directive Proposal and Art. 1 (2) Regulation Proposal].
- The Member States remain in control of certain particular sensitive health policy decisions, e.g., prohibiting or restricting the sale, supply or use of medicines as contraceptives or abortifacients [Art. 1 No. 10 (a) Directive Proposal].
- It is to be noted, that beyond the Reform, the EU is working on revising directly and indirectly related policy and regulatory areas, such as
  - the legislation on blood, tissues and cells [see cep**PolicyBrief** 15/2022],
  - general intellectual property rights legislation [see Commission Press Release],
  - the legislation on Supplementary Protection Certificates (SPCs), i.e. nationally awarded certificates that provide additional protection of the intellectual property of patent holders, with the Commission aiming to introduce a unitary SPC and/or a single ("unified") procedure for granting national SPCs [see generally cep**PolicyBrief** 35/2018];
  - digitalisation issues, including a European Health Data Space [see cep**PolicyBrief** 13/2022],
  - the legislation on fees payable to the European Medicines Agency (EMA), as well as
  - voluntary measures by the Member States to combat antimicrobial resistance [see Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach].
- Additionally, to complement the reform, 19 Member States agreed to a "Non-paper" on improving the security of medicines supply in Europe aimed at exploring a "Critical Medicines Act" and reducing dependencies for critical medicines and ingredients, particularly with regard to products where there are only a few supplying manufacturers or countries [see cep**Input** How to Prevent Future Medicine Shortages].

### 1.3 Issues Raised and Objectives of the Reform

- Equal and timely access to medicines and shortages of medicines remains a problem. Patients do not always have access to innovative medicines and access varies across the EU [Regulation Proposal, p. 1 and Recital 4 Regulation Proposal].
- The development of growing antimicrobial resistance is a concern, research and development has stalled and the pipeline of effective antibiotics has run dry [see cep**Input** 2/2023].
- Member States have asked for a revision of mechanisms and incentives for the development of medicines addressing unmet medical need [Recital 3 Regulation Proposal].
- Pricing and reimbursement decisions are the competence of the Member States. However, according to the Commission, pharmaceutical legislation could contribute to affordability and access through measures which enable competition from generic and biosimilar products [Recital 46 Directive Proposal].
- The Commission wants patients to have timely and equal access to medicines EU-wide; it also wants to improve security of supply, address shortages of medicines and improve the sustainability of medicines [Regulation Proposal, p. 1].
- The general objectives of the Reform are to ensure a high level of public health through quality, safety and efficacy of medicines, and to harmonise the internal market for supervision and control of medicines [Regulation Proposal, p. 2].
- These objectives are often summarised by umbrella terms such as "access and affordability", "availability" and "innovation". Specifically, [Regulation Proposal, p. 2]
  - "access" and "affordability" refers to the Reform's aim to ensure "timely and equitable access to safe, effective, and affordable medicines";
  - "availability" refers to the Reform's aim to "enhance security of supply and ensure medicines are always available" EU-wide;

  - "innovation" refers to the Reform's aim to "offer an attractive innovation and competitiveness friendly environment for research, development, and production of medicines in Europe".

- These objectives translate most notably into incentives and mechanisms aimed at combatting shortages and securing the supply of medicines, in general, and that of antibiotics, orphan medicines and medicines for children, in particular.

# 2 General Aspects, Definitions and Scope

## 2.1 General Aspects and Definitions

- For historical reasons resulting from the evolution of EU health competencies over the years, the current centerpiece of EU pharmaceutical law is contained in two pieces of legislation, i.e. a regulation and a directive:
  - the Community code relating to medicinal products for human use [(EC) 2001/83], and
  - the Regulation on Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency [(EC) 726/2004].
- These two laws look at the authorisation of medicines from the angle of national authorisations (directive), on the one hand, and EU authorisations (regulation), on the other. The Commission proposes to keep this formal separation and presents two legislative proposals: a "Directive Proposal" and a "Regulation Proposal" [see also above, 1.2].
- The Commission does not suggest merging the provisions into one regulation it saw a directive as the best way "to avoid fragmentation of national legislation". Additionally, there was no support "among the Member States to turn the directive into a regulation" [Recital 10 Directive Proposal].
- Yet, the Directive Proposal is to work in synergy with the Regulation Proposal, meaning that the general standards regarding quality, safety and efficacy of medicines laid down in the Directive Proposal are applicable both to medicines covered by national marketing authorisations and to those covered by EU marketing authorisations [Recital 11 and 13 Directive Proposal].
- The Directive Proposal contains definitions for a wide range of terms [Art. 4 (1) Directive Proposal]. The Commission can amend certain definitions through delegated acts without extending the scope [Art. 4 (2) Directive Proposal].
- The definitions of the Directive Proposal are applicable to the Regulation Proposal. Beyond that, the Regulation Proposal includes further definitions applicable to its provisions [Art. 2 Regulation Proposal].
- Additionally, the synergy of the two legislative proposals is apparent, inter alia, because
  - the rules of the Directive Proposal on prescription, product information, regulatory protection, manufacturing, supply, advertising and supervision are also applicable to medicines covered by the Regulation Proposal [Recital 13 Directive Proposal, e.g. see Art. 29 Regulation Proposal on regulatory protection periods];
  - an EU marketing authorisation confers the same rights and obligations (in all Member States) as one granted in a Member State in the national context [Art. 16 (1) Regulation Proposal];
  - the rules on the periods of regulatory protection set out in the Directive Proposal are applicable to medicines authorised at EU level [Art. 29 Regulation Proposal].

## 2.2 Scope of the Directive Proposal

- The scope of the Directive Proposal covers all medicines for human use intended to be placed on the market [Art. 1 (2) Directive Proposal]. It includes rules for
  - the placing on the market, manufacturing, import, export, supply, distribution, pharmacovigilance, control and use of medicines [Art. 1 (1) Directive Proposal]; and
  - starting materials, active substances, excipients and intermediate products [Art. 1 (3) Directive Proposal].
- The Directive does not apply to [Art. 1 (5) Directive Proposal)
  - medicines prepared in a pharmacy based on a prescription for an individual patient (a so-called magistral formula);
  - medicines prepared in a pharmacy in accordance with a pharmacopoeia which will be supplied directly to a patient by the respective pharmacy (a so-called officinal formula); and

- so-called investigational medicines being tested or used as a reference, including as a placebo, in a clinical trial, see Art. 2 (5) Regulation on clinical trials [(EU) 536/2014].

### 2.3 Scope of the Regulation Proposal

- The scope of the Regulation Proposal is three-fold as it contains the [Art. 1 Regulation Proposal]
  - procedures for the authorisation, supervision and pharmacovigilance of human medicines at EU level;
  - rules and procedures at EU and Member State level on the security of supply of medicines; and
  - governance provisions of the European Medicines Agency [hereinafter "EMA"].
- Certain medicines – included in Annex I – must obtain a marketing authorisation at EU level, such as [Art. 3 (1) Regulation Proposal and Annex I to the Regulation Proposal]
  - orphan medicines; and
  - certain "priority" antimicrobials.
- The Commission may change Annex I to adapt to technical and scientific progress [Art. 3 (5)]. It can therefore decide which medicines have to obtain a marketing authorisation at EU level.
- Other medicines – not included in Annex I – may seek a marketing authorisation at EU level, if that medicine meets at least one of the set requirements, inter alia, that [Art. 3 (2) Regulation Proposal]
  - the applicant shows that the medicine constitutes a "significant" therapeutic, scientific or technical innovation;
  - the applicant shows that this is in the interest of patients' health at EU level; or
  - it is a medicine solely for children.

## 3 Marketing Authorisations of Medicines

### 3.1 General Aspects

- Before they can be put on the market, all medicines must have received a national marketing authorisation from a Member State or a "centralised marketing authorisation" from the EU [Art. 5 (1) Directive Proposal].
- The authorisation decision is based on quality, safety and efficacy criteria and any application must demonstrate that the therapeutic efficacy of a medicine outweighs the risks ("benefit-risk assessment") [Recital 21 and 22 Directive Proposal].
- A marketing authorisation will be refused if, inter alia, the benefit-risk balance is not favourable or the quality, safety and efficacy of the medicine is not sufficiently demonstrated [Art. 15 (1) (a) and (b) Regulation Proposal and Art. 47 (1) (a) and (b) Directive Proposal].]
- The Reform introduces new grounds for refusal of a marketing authorisation based on the environmental risk assessment (ERA), under which an authorisation must be refused if an ERA is "incomplete" or "insufficiently substantiated" or if the risks identified in the ERA have not been "sufficiently" addressed [Art. 15 (1) (d) Regulation Proposal and Art. 47 (1) (d) Directive Proposal; see below, Section 5].
- Generally, national authorities or – in case of medicines authorised at EU level – the Commission can suspend and revoke a marketing authorisation or vary its terms if, inter alia, a medicine is deemed harmful or if a serious risk to the environment or public health is identified [Art. 195 Directive Proposal].
- For certain medicines, special regulations are needed in order to cover their specificities. The proposals include special regulations for
  - orphan medicines, i.e., medicines for rare diseases,
  - paediatric medicines, i.e., medicines for children and teenagers, and
  - antimicrobials, such as antibiotics.

### 3.2 National Authorisation and EU Authorisation: Which is Applicable?

- The two-level authorisation ecosystem – Member State level and EU level – is long-standing practice.

- Generally, some medicines must (see Annex I to the Regulation Proposal) and some medicines can be authorised at EU level [Art. 3 (1) and (2) Regulation Proposal].
- The EU level authorisation is obligatory, inter alia, for high-tech medicines, particularly those resulting from biotechnological processes, so-called priority antimicrobials, orphan medicines and paediatric medicines [Recital 10 Regulation Proposal, Art. (3) (1) and Annex I Regulation Proposal].
- The EU level authorisation is optional, inter alia, for medicines with a significant therapeutic innovation; medicines considered beneficial for EU patients as a whole, e.g., medicines addressing antimicrobial resistance (AMR) and those for public health emergencies, as well as medicines intended solely for paediatric use, i.e., for children and teenagers [Recitals 9 and 11 Regulation Proposal, Art. 3 (2) Regulation Proposal].
- An EU level authorisation is granted by the Commission and is valid in all Member States as well as the European Economic Area (EEA) [Art. 3 Regulation Proposal; see also EMA, Authorisation of medicines].
- Besides this, the following national procedures exist [Art. 32, 33 and 35 Directive Proposal]:
  - purely national marketing authorisation procedure in one Member State [Art. 32 Directive Proposal];
  - decentralised procedure for a marketing authorisation in more than one Member State [Art. 33 Directive Proposal]; and
  - mutual recognition procedure of an existing national marketing authorisation to validate it in another Member State or several other Member States [Art. 35 Directive Proposal].

## 3.3 Specificities Regarding Certain Medicines

### 3.3.1 Orphan Medicines: Medicines Addressing Rare Diseases

- Generally, a life-threatening or chronically debilitating condition is considered a "rare" disease if it affects not more than 5 in 10,000 people [Art. 63 (1) Regulation Proposal].
- For each rare disease, the patient group size is therefore relatively small and the cost of development cannot be recovered by expected market sales. Consequently, the Commission sees a necessity to support research and development with specific incentives [Recital 87 Regulation Proposal, see Section 4.2].
- Medicines intended for the diagnosis, prevention, or treatment of a life-threatening or chronically debilitating condition are granted the designation "orphan medicinal product" (orphan designation) by the EMA during the development stage of that medicine and before the marketing authorisation request is submitted [Art. 63 (1); Art. 64 (1) and (4) Regulation Proposal].
- An orphan designation must be granted if [Art. 63 (1) Regulation Proposal]:
  - the condition does not affect more than 5 in 10,000 people in the EU by the time of applying; and
  - there is no other satisfactory method for dealing with the condition authorised in the EU or, where such a method exists, the new medicine would be a "significant benefit" to the patient group.
- In context of the aforementioned requirements,
  - a "significant benefit" is defined as a clinically relevant advantage or a major contribution to patient care of an orphan medicine if such an advantage or contribution benefits a substantial part of the target population [Art. 2 (7) Regulation Proposal], and
  - a medicine is regarded as "authorised in the EU" if it is authorised in at least one Member State [Recital 93 Regulation Proposal].
- The Commission is, inter alia, empowered to adopt specific criteria for certain conditions via delegated acts if the requirement of 5 in 10,000 people affected is "not appropriate" due to the specific characteristics of certain conditions or "any other scientific reasons" [Recital 91 et seq. and Art. 63 (2) Regulation Proposal].
- The decision to grant or refuse an orphan designation must be made public [Art. 64 (5) Regulation Proposal].
- All medicines designated as orphan medicines must be listed in a public register set up and managed by the EMA [Art. 67 (1) Regulation Proposal].
- The orphan designation is a requirement for an orphan marketing authorisation [Art. 69 (2) Regulation proposal].

- The Reform introduces a new classification of orphan medicines addressing a "high unmet medical need" (HUMN) which are eligible for further incentives [Art. 70 Regulation Proposal, see Section 4.2].
- An orphan medicine is categorized as addressing a HUMN if [Art. 70 Regulation Proposal]
  - no other medicine is authorised in the EU for that disease, or
  - where another medicine is authorised, the applicant demonstrates that its orphan medicine will bring a significant benefit as well as exceptional therapeutic advancement, and
  - the use of a medicine will result in a meaningful reduction in disease morbidity or mortality for the particular patient population.

### 3.3.2 Paediatric Medicines: Medicines for Children and Teenagers

- Children differ biologically and physiologically from adults and may therefore require a different or adapted treatment compared to adults, e.g. with regard to formulation, pharmaceutical form, strength, dosage, route of administration and administration device [Recital 106, Art. 74 (1) Regulation Proposal].
- Pharmaceutical legislation defines the age cohorts between birth and 18 years as "paediatric population" and the relevant medicines as "paediatric" medicines [see Art. 4 (38) Directive Proposal; Art. 74 et seq. Regulation Proposal; for simplification, these medicines will be referred to as "medicines for children"].
- According to the Commission, the development of medicines that could potentially be used in the paediatric population should become part of the development of medicines in general. Therefore, a paediatric investigation plan (PIP) should be submitted at an early stage of the development of a medicine [Recitals 106 et seq., Art. 74 (1) Regulation Proposal].
- A PIP should include all measures to assess the quality, safety and efficacy of a medicine in the paediatric population and measures to adapt the medicine for use in this population [Recitals 106 et seq., Art. 74 (1) Regulation Proposal].
- In certain situations, the requirement to conduct a PIP can be waived, e.g., if a disease for which the medicine is intended does not occur in children. The list of waivers is made public by EMA [Regulation Proposal, p. 16, Art. 75 (1) (b) and Art. 79 Regulation Proposal].
- If a paediatric marketing authorisation has been granted, the medicine is eligible for further incentives [Art. 92 and Art. 93 Regulation Proposal; see Section 4.3].
- If a medicine, that has already been marketed, receives a paediatric indication, the paediatric medicine must be placed on the same markets within two years after authorisation of the paediatric indication to, as the Commission states, "ensure access" for all children in the EU [Recital 76 and Art. 59 Directive Proposal].

### 3.3.3 Antimicrobials: Including Antibiotics, Antivirals and Antifungals

- An "antimicrobial" is a medicine which has direct action on micro-organisms and is used for the treatment and prevention of infections and infectious diseases, including antibiotics, antivirals and antifungals [Art. 4 (22) Directive Proposal].
- "Antimicrobial resistance" (AMR) is the ability of a micro-organism to survive or to grow in the presence of a concentration of an antimicrobial agent that would usually kill or at least inhibit that micro-organism [Art. 4 (34) Directive Proposal].
- The introduction of antimicrobials has made many modern medical procedures possible. However, the rapid rise of AMR has rendered some infections untreatable [see cep**Input** 2/2023].
- As the prudent use of antimicrobials is essential to address AMR, an applicant for a marketing authorisation for an antimicrobial has to submit
  - an antimicrobial stewardship plan, which is to include [Art. 17 (1) (a) in conjunction with Annex I Directive Proposal]
    - information about risk mitigation measures to limit the development of AMR related to the use, prescription and administration of the medicine, and

- information on how the marketing authorisation holder intends to monitor and report resistance to the antimicrobial medicine;

– educational material to inform healthcare professionals, including information on the use of diagnostic tools, testing and other diagnostic approaches [Art. 17 1 (b) in conjunction with Art. 69 (1) Directive Proposal]; and
– an "awareness card" with patient information on AMR and the appropriate use and disposal of antimicrobials [Art. 17 (1) (b) in conjunction with Art. 69 (2) Directive Proposal].

► Obligations can be imposed on the marketing authorisation holder if risk mitigation measures contained in the antimicrobial stewardship plan are not satisfactory [Art. 17 (2) Directive Proposal].

# 4 Incentives

► Any pharmaceutical ecosystem needs to strike a balance between intellectual property protection – of an innovation, e.g. a new medicine – and ensuring competition. Incentives in the form of intellectual property protections provide a foundation for innovation; in the pharmaceutical sector, it primarily revolves around

– patents, i.e. an exclusive right of the patent holder, allowing him to prevent others from manufacturing, using, or selling their invention for a specified period;
– Supplementary protection certificates (SPCs), i.e. an additional protection that extends the exclusivity period for patented pharmaceutical products, to compensate for the time taken to obtain regulatory approvals, by extending patent rights beyond their initial expiration [generally see cep**PolicyBrief** 35/2018];
– regulatory data protection, i.e. a period of exclusivity, during which (generally generic or biosimilar) competitors cannot rely on the originator company's data to seek marketing authorisation for their variant versions of the same medicine;
– market protection, i.e. a period of exclusivity, during which a subsequent marketing authorisation for a competitor's variant version of a medicine (generally a generic or biosimilar) may be sought and granted (in order to enable "day-1" market entry) but the competitors version of the medicine may not be placed on the market until the end of the period;
– market exclusivity, i.e. a period of exclusivity, during which (generally generic or biosimilar) competitors cannot as a rule be granted a marketing authorisation for a variant version of a medicine.

► The Reform includes a system of incentives to reward innovation but also access across the EU, especially regarding orphan medicines addressing rare diseases, paediatric medicines, and antimicrobials, including antibiotics [Regulation Proposal, p. 15 et seq.].

## 4.1 Innovative Medicines in General: Regulatory Data and Market Protection

► A marketing authorisation is granted based on an extensive set of pre-clinical and clinical data that demonstrate the quality, safety and efficacy of a medicine.

► Data which is submitted to obtain a marketing authorisation for an innovative medicine can be used by another applicant for a subsequent marketing authorisation for a variant version of a medicine, usually a generic or biosimilar. To protect the investment of the originator of that data, "regulatory data protection" prevents this use by others for a certain period called the "regulatory data protection period" [Art. 80 (1) Directive Proposal].

► The standard regulatory data protection period in the Reform is 6 years after the issuing of the marketing authorisation. This is a reduction of 2 years compared to the current applicable period of 8 years [Directive Proposal, p. 16 and Art. 81 (1) Directive Proposal].

► Additional time can be granted – totalling up to 4 additional years – if [Directive Proposal, p. 16 and Art. 81 (1) Directive Proposal]

– the medicine is launched in all Member States where the product is authorised within two years of the marketing authorisation: 2 additional years [Art. 81 (2) (a) Directive Proposal]; provided that [Art. 82 (1) Directive Proposal]

- a "sufficient quantity" is "released" and "continuously supplied" to meet patient needs in the Member States where the marketing authorisation is valid, and
- the marketing authorisation was granted at the EU level or via national marketing authorisations through the so-called decentralised procedure;

– unmet medical needs are addressed: 6 additional months [Art. 81 (2) (b) Directive Proposal], and this is deemed to be so if:

- the medicine has an orphan designation and is listed in the public registry [Art. 83 (2) Directive Proposal, see Section 3.3.1];
- its therapeutic indication relates to a life threatening or severely debilitating disease for which either no other medicine is authorised in the EU or, despite other medicines being authorised, morbidity or mortality remains high, and
- the use of a medicine will result in a meaningful reduction in disease morbidity or mortality for the particular patient population [Art. 83 (1) Directive Proposal];

– comparative clinical trials are conducted: 6 additional months [Art. 81 (2) (c) Directive Proposal];
– an additional therapeutic indication is obtained during the regulatory data protection period: 1 additional year [Art. 81 (2) (d) Directive Proposal].

► Additionally, the Reform envisages a two-year market protection period after the expiry of the regulatory data protection period, during which it is not allowed to place a variant version of that medicine, usually a generic or biosimilar, on the market [Art. 80 (2) Directive Proposal].

► Hence, the entire protection period can last up to twelve years if the aforementioned conditions for additional regulatory data protection are fulfilled [Directive Proposal, p. 16].

## 4.2 Orphan Medicines

► The EMA decides on the designation of a medicine as an orphan medicine. That is done during the development stage of that medicine and before the marketing authorisation request is submitted [Art. 63 (1); Art. 64 (1) and (4) Regulation Proposal].

► This designation is valid for 7 years during which incentives, inter alia, to (financially) support the research and development may be provided by the EU and the Member States via framework programmes, such as "Horizon Europe" [Art. 66 (1) and Art. 68 (2) Regulation Proposal].

► Orphan medicines are granted a period of market exclusivity [Art. 71 and Art. 72 Regulation Proposal]. The duration of the market exclusivity varies and, in case of general orphan medicines, is generally reduced under the Reform by 1 year compared to the current situation. Duration periods include for example [Art. 71 (2) Regulation Proposal]:

– nine years for general orphan medicines;
– ten years for orphan medicines which address a "high unmet medical need" [HUMN, see Section 3.3.1].

► The duration of market exclusivity can be prolonged if

– the orphan medicine is launched in all Member States where the product is authorised within 2 years of the marketing authorisation, subject to a requirement to "release" and "continuously supply" a "sufficient quantity": 1 additional year [Recital 103 and Art. 72 (1) in connection with Art. 81 (2) (a) and Art. 82 (1) Regulation Proposal];
– another marketing authorisation is granted for that medicine regarding a new therapeutic indication for a different orphan condition– with a maximum of two prolongations: 1 additional year [Recital 104 and Art. 72 (2) Regulation Proposal].

► Additionally, orphan medicines benefit from total or partial reduction of the fees payable to the EMA [Art. 73 Regulation Proposal].

► A currently available incentive for orphan medicines, i.e., 2-year market exclusivity for completing a Paediatric Investigation Plan, is no longer envisaged in the Reform.

## 4.3 Paediatric Medicines

- A paediatric investigation plan (PIP) covers the measures proposed to assess the quality, safety and efficacy of a medicine in all subsets of the relevant paedatric population, i.e., all children and teenage cohorts up to 18 years of age [Art. 74 (1) Regulation Proposal].
- Prior to the submission of a PIP and during its implementation, the EMA will provide advice free of charge on the design and conduct of the various tests and studies necessary [Art. 89 Regulation Proposal].
- Where an application for a marketing authorisation includes compliance with a PIP, the holder of the patent or SPC is entitled to a 6-month extension of the SPC [Art. 86 (1) Directive Proposal in connection Art. 13 Regulation concerning the supplementary protection certificate for medicinal products [(EC) 469/2009]].
- If the application has been authorised by way of certain national marketing authorisation procedures, the aforementioned extension can only be granted if the medicine is authorised in all Member States [Art. 86 (3) Directive Proposal].
- The aforementioned extension does not apply to medicines which obtain a 1-year extension of their regulatory data protection based on a new paediatric indication bringing a significant clinical benefit [Art. 86 (4) in conjunction with Art. 81 (2) (1) (d) Directive Proposal].
- When a paediatric use marketing authorisation is granted, the paediatric medicine is eligible for independent regulatory data and market protection [Art. 93 Regulation Proposal].
- The EU and the Member States may provide (financial) support for research, development and availability of such medicines [Art. 96 Regulation Proposal].
- Additionally, paediatric medicines benefit from total or partial reduction from fees payable to the EMA [Art. 97 Regulation Proposal].

## 4.4 Antimicrobials

- A “transferable data exclusivity voucher” (hereinafter: “voucher”) is introduced to reward the development of new antimicrobials such as antibiotics [Recital 77-84 Regulation Proposal].
- The Commission may – by means of implementing acts – grant such a voucher to the developer of a “priority” antimicrobial [Regulation Proposal, p. 16 and Art. 40 (1) Regulation Proposal].
- A “priority antimicrobial” is an antimicrobial which has a significant clinical benefit with respect to AMR and has at least one of the following characteristics: [Art. 40 (3) Regulation Proposal]
  - it represents a new class of antimicrobials;
  - its mechanism of action is distinctly different from that of any authorised antimicrobial in the EU; or
  - it contains an active substance not previously authorised in a medicine in the EU that addresses a multi-drug resistant organism and serious or life-threatening infection.
- The EMA conducts the scientific assessment if an antimicrobial is to be considered “priority” [Art. 40 (1) and (3) Regulation Proposal].
- An applicant for a voucher must demonstrate capacity to supply the priority antimicrobial in “sufficient quantities for the expected needs” in the EU and provide information on all forms of direct financial support received for research [Art. 40 (4) Regulation Proposal].
- Once granted, a voucher gives the holder a right to an additional 12 months of regulatory data protection for one medicine – therefore its use is not limited to the new antimicrobial [Art. 40 (2) Regulation Proposal].
- The voucher can be used for any (single) medicine authorised at EU level within the first four years of the respective regulatory data protection period by the holder [Art. 41 (1) Regulation Proposal].
- The voucher can be transferred just once from the original holder to another marketing authorisation holder [Art. 41 (3) Regulation Proposal].
- The marketing authorisation holder to whom a voucher has been transferred must notify the EMA of the price paid for the voucher and the EMA will make that information publicly available [Art. 41 (4) Regulation Proposal].

- The Commission may grant a maximum of 10 vouchers over a period of 15 years [Art. 43 Regulation Proposal].

# 5 Environmental Issues and Environmental Risk Assessment (ERA)

## 5.1 Environmental Issues: General Aspects

- The Commission already made clear in its 2020 "Strategic Approach to Pharmaceuticals in the Environment" that it plans to improve the environmental risk assessment of pharmaceuticals and its review [see cep**PolicyBrief** 2/2020].
- The Commission wants to reduce the impact and risks of pharmaceuticals for the environment and public health because the manufacture, use and disposal of medicines causes pollution with pharmaceutical residues [Recital 69 Directive Proposal].
- Corresponding measures in pharmaceutical law complement the ones that can be found in water law, e.g., the Drinking Water Directive [generally see cep**PolicyBrief** 8/2018], industrial emissions law, e.g., the Industrial Emissions Directive [generally see cep**PolicyBrief** 18/2022] as well as chemical law [Recitals 69 et seq. Directive Proposal].
- A key tool of pharmaceutical law in this respect is the so-called Environmental Risk Assessment (ERA) which is to include risk mitigation measures [Recital 70 Directive Proposal].
- An ERA is the evaluation of the risks to the environment or to public health posed by the release of the medicine in the environment as a result of its use and disposal, and needs to include risk prevention, limitation and mitigation measures [Art. 4 (1) (33) Directive Proposal].
- If an antimicrobial, such as an antibiotic, is concerned, the ERA must also include an evaluation of the risk for AMR due to use, disposal and manufacturing [Art. 4 (33) Directive Proposal].
- The Reform also includes the possibility for a post-marketing authorisation measure in this regard, inter alia, to oblige the marketing authorisation holder to conduct a post-authorisation environmental risk-assessment study if there are concerns about risks to the environment or public health, including AMR [Art. 87 (1) (c) Directive Proposal].
- Furthermore, national authorities and – in the case of a medicine authorised at EU level – the Commission may suspend, revoke or vary a marketing authorisation if a serious risk concerning the environment is identified and has not been resolved [Art. 195 (2) Directive Proposal].
- The supply of a medicine can be prohibited, and the medicine withdrawn from the market if, inter alia, a serious risk to the environment or to public health via the environment has been identified and not sufficiently addressed by the marketing authorisation holder [Art. 196 (1) (f) Directive Proposal].

## 5.2 ERA

- The ERA is an essential part of the specific requirements of an authorisation procedure both nationally and at EU level [Art. 22 Directive Proposal, Art. 7 et seq. Regulation Proposal].
- Any application for a marketing authorisation must include an ERA [Recital 70 Directive Proposal, Art. 6 (2) Directive Proposal in connection with Annex I and Art. 22 Directive Proposal].
- A marketing authorisation must be refused if the applicant does not propose risk mitigation measures that sufficiently address the risks or if the ERA is incomplete or not sufficiently substantiated [Recital 70 Directive Proposal, Art. 15 (1) (d) Regulation Proposal and Art. 47 (1) (d) Directive Proposal].
- An ERA needs to be updated after the marketing authorisation if new relevant information becomes available and could lead to a change of the conclusions [Art. 22 (6) Directive Proposal].
- The Commission can change the ERA requirements set out in the legal text of Art. 22 Directive Proposal by way of delegated acts [Art. 213 Directive Proposal].

### 5.3 ERA: Specific Aspects for Antimicrobials and Medicines Authorised Before 30 October 2005

- The scope of the ERA for an antimicrobial must cover the entire lifecycle of the product [Recital 72 Directive Proposal, Art. 22 (4) Directive Proposal].
- The ERA for antimicrobials must especially include an evaluation of the risk for AMR considering the entire manufacturing supply chain inside and outside the EU [Art. 22 (4) Directive Proposal].
- Medicines authorised before 30 October 2005 which have not been subject to an ERA, and which have been identified by the EMA as potentially harmful to the environment, are required to submit an ERA [Art. 23 (1) and (3) Directive Proposal].
- The EMA will set up a risk-based prioritisation programme in this regard, as well as criteria for identification as potentially harmful to the environment [Recital 74 Directive Proposal, and Art. 23 (2) Directive Proposal].

## 6 Shortages and Critical Shortages

- Recently, an increased number of shortages of medicines have occurred. These were caused by a variety of factors ranging from supply chain disruptions to vulnerabilities endangering the supply of key ingredients and components which put public health at risk [Recital 136 Regulation Proposal].
- "Shortage" refers to a situation in which the supply of a medicine does not meet the demand, a "critical shortage" being considered a situation that can only be resolved at EU level [Art. 2 (14) and (16) Regulation Proposal].
- As a reaction to the COVID-19-pandemic and the shortage situations it has created, the EU has already given corresponding new competences to the EMA, and different working group constellations established within it, via special regulations (hereinafter: "crisis mode legislation") [see cep**PolicyBrief** 12/2021, cep**PolicyBrief** 19/2021 and generally also cep**Input** 8/2022].
- With this Reform, the Commission aims to further mitigate the risk of shortages by establishing structures and mechanisms outside of a "crisis mode" as a sort of permanent precautionary mechanism, especially by introducing new obligations on marketing authorisation holders, inter alia, to notify shortages and marketing withdrawals [Regulation Proposal, p. 1 et seq.].
- In the event of certain (cross-border) health threats, i.e., a "major event" or a "public health emergency at Union level" – in other words, during a "crisis" – the aforementioned special regulations enacted as crisis mode legislation will prevail over the provisions of this Reform [Art. 122 (5) Regulation Proposal].
- Yet, the Reform Proposals are interlinked because different working group constellations within the EMA, established under the crisis mode legislation, are also endowed with rights and duties here [e.g., see Recital 138 Regulation Proposal as well as the corresponding references throughout Chapter X, i.e., "Availability and Security of Supply of Medicinal Products", of the Regulation Proposal].

### 6.1 Notification Obligations

- A marketing authorisation holder must inform the national authorities of the Member States in which the medicine has been placed on the market and – in case of an EU level authorisation – the EMA of the following [Art. 116 (1) Regulation Proposal]:
  - if marketing of a medicine is to be ceased permanently in a Member State: 12 months before the last supply [lit. a];
  - if it has requested to permanently withdraw the marketing authorisation in a Member State: 12 months before the last supply [lit. b];
  - if a medicine is temporarily suspended in a Member State: 6 months before the suspension [lit. c];
  - if a temporary disruption in supply of a medicine occurs in a Member State which is expected to be longer than two weeks [lit. d]:
    - based on the demand forecast of the marketing authorisation holder: not later than 6 months prior to such a disruption, or

- if it is not possible to make a forecast: as soon as the marketing authorisation holder becomes aware of such a temporary disruption.

## 6.2 Shortage Prevention Plans and Further Obligations

- A marketing authorisation holder must have a shortage prevention plan for any medicine placed on the market and provide it upon request [Recital 136, Art. 117 (1), Art. 118 (2) and Art. 119 (1) (a) Regulation Proposal].
- Such a plan must include the minimum set of information provided for in the Annex to the Regulation Proposal such as [Art. 117 (1) in conjunction with Part V of Annex IV Regulation Proposal]
  - product details, e.g., product name, active substance(s) and active substance manufacturer(s), therapeutic indication(s) or pack size(s);
  - shortage prevention measures and supply chain risk management, e.g., alternative marketed medicines or a supply chain map that identifies and analyses risks and vulnerabilities along the supply chain;
  - marketing authorization holder's contact details.
- Furthermore, a marketing authorisation holder is obliged to provide a "shortage mitigation plan" and a "risk assessment regarding the impact of a suspension, cessation or withdrawal" of a medicine upon request [Art. 118 (2) and 119 (1) (a) Regulation Proposal].
- A shortage mitigation plan must include the minimum set of information provided for in the Annex to the Regulation Proposal such as [Art. 119 (2) in conjunction with Part IV of Annex IV; and Art. 122 (4) (c) Regulation Proposal]
  - potential alternative medicines;
  - manufacturing capacities globally per manufacturing site;
  - forecast of demand and supply per month and per Member State during the shortage.
- A risk assessment regarding the impact of a suspension, cessation or withdrawal must include the minimum set of information provided for in the Annex to the Regulation Proposal such as [Art. 119 (3) in conjunction with Part II of Annex IV; and Art. 122 (4) (c) Regulation Proposal]
  - potential alternative medicines;
  - estimated market share per Member State in previous 12 months;
  - impact on the supply of other medicines from the same marketing authorisation holder.
- Generally, when providing information in this regard, a marketing authorisation holder must indicate whether any of it is commercially confidential, identify the relevant parts, and explain why these parts are of a commercially confidential nature [Art. 119 (1) (e) Regulation Proposal].
- Member States must assess whether claims of confidentiality regarding information provided by marketing authorisation holders are justified and protect such information against unjustified disclosure [Art. 121 (1) (a) Regulation Proposal].
- Wholesale distributors and others authorised to supply medicines to the public, e.g., pharmacies, can report shortages to national authorities [Art. 120 (1) Regulation Proposal].
- Importers and manufacturers of medicines, wholesale distributors, stakeholder representative associations, and others must provide any information requested by national authorities or the EMA for the purpose of monitoring shortages [Art. 120 (2) Regulation Proposal].
- Member States must publish information regarding identified shortages on a publicly accessible website [Art. 121 (1) (b) Regulation Proposal].

### 6.3 Critical Shortages

- In order to manage "critical shortages", the Reform introduces a list of shortages for which coordinated EU level action is necessary – the "list of critical shortages of medicinal products" (hereinafter: list of critical shortages) [Art. 123 (1)].
- Member States report to the EMA any shortage of a medicine for which no appropriate alternative medicine is available on the market of that Member State, and which cannot be resolved nationally [Art. 2 (14), Art. 121 (1) (c) Regulation Proposal].
- The EMA must – in collaboration with national authorities – identify medicines for which a shortage can only be resolved at EU level [Art. 122 (2) Regulation Proposal].
- The list of critical shortages is then adopted by a working group constellation of the EMA and both the list itself and the products on the list are continuously monitored [Art. 123 (1) and (2), Art. 124 (1) Regulation Proposal].
- The EMA sets the criteria to adopt and review the list of critical shortages and provides information on actual shortages on a publicly available website [Art. 122 (4) (a), Art. 124 (3) Regulation Proposal].
- Recommendations, on how to resolve or mitigate critical shortages, can be provided by certain working groups established within the EMA, to marketing authorisation holders, the Member States, the Commission, representatives of healthcare professionals as well as other entities [Art. 123 (4) Regulation Proposal].
- The EMA can request information in order to continuously monitor critical shortages from, inter alia, Member States, marketing authorisation holders, importers and manufacturers of medicines, wholesale distributors and stakeholder representative associations [Art. 124 (2) Regulation Proposal].
- If a medicine is on the list of critical shortages, the marketing authorisation holder must, for instance, provide additional information requested by the EMA and give notification as soon as the critical shortage is over [Art. 125 (1) Regulation Proposal].
- If the Commission considers it appropriate and necessary, it must implement respective measures, based on recommendations provided by certain working groups established within the EMA, on how to resolve or mitigate critical shortages [Art. 126 Regulation Proposal].

## 7 Security of Supply of Critical Medicines

- According to the Commission it is important to ensure continued supply of medicines in the internal market, especially the most critical ones [Recital 137 Regulation Proposal].
- A medicine is considered "critical" if insufficient supply of it results in serious harm or the risk of serious harm to patients and has been identified as such at EU level [Art. 2 (13) Regulation Proposal, Art. 127 Regulation proposal].
- Identification and management of critical medicines at EU level are handled by the Member States, the EMA and its working group constellations as well as the Commission [Art. 127, Art. 130-132, Art. 134 Regulation Proposal].
- The EMA must develop a common methodology to identify critical medicines including the evaluation of vulnerabilities with respect to the relevant supply chains [Art. 130 (1) (a) Regulation Proposal; with regard to the evaluation of vulnerabilities of supply chains also see cep**Input** How to Prevent Future Medicine Shortages].
- The Member States must – based on the yet to be created common methodology – identify critical medicines in their country and report these to the EMA [Art. 127 (1) and (2) Regulation Proposal].
- In this regard, Member States may ask
  - the marketing authorisation holder to provide relevant information, including the shortage prevention plan [Art. 127 (3), Art. 128 (1) (a) Regulation Proposal, see also Section 6.2], as well as
  - importers and manufacturers of medicines, wholesale distributors, stakeholder representative associations, and others to provide any relevant information [Art. 127 (4), Art. 129 Regulation Proposal].

- Generally, when providing information in this regard, a marketing authorisation holder must show if it contains any commercially confidential information, identify the relevant parts, and explain why these parts are of a commercially confidential nature [Art. 128 (1) (e) Regulation Proposal].
- Member States must assess whether claims of confidentiality regarding information provided by marketing authorisation holders are justified, and protect such information against unjustified disclosure [Art. 127 (5) Regulation Proposal].
- A "Union list of critical medicinal products" (hereinafter: EU list of critical medicines) is prepared and proposed by the EMA and its working group constellations and adopted by the Commission via an implementing act [Art. 130 (1) (b), Art. 131 (1) and (3) Regulation Proposal].
- Once a medicine is on the EU list for critical medicines, a working group constellation within the EMA can provide recommendations on security and supply measures to, inter alia, the marketing authorisation holder, Member States and the Commission and may propose updates to the list to the Commission [Art. 132 (1) and (2) Regulation Proposal].
- Member States as well as the Commission may implement relevant measures regarding the recommendations on security and supply measures [Art. 127 (7), Art. 134 (1) (a) Regulation Proposal].
- A marketing authorisation holder of a medicine on the EU list of critical medicines is subject to further obligations, including to provide information and comply with any measures taken by the Member States or the Commission in this regard [Art. 133 (d) Regulation Proposal].
- Such measures may include contingency stock requirements for active pharmaceutical ingredients [Recital 138, Art. 133 (d), Art. 134 (2) Regulation Proposal].

## 8 Simplification of Regulatory Framework and Reduction of Regulatory Burden

- The Commission has identified the need to simplify the current regulatory framework and reduce regulatory burden [Regulation Proposal, p. 13].
- Part of this is to simplify the decision-making processes within the EMA, as certain committees must give an opinion on a medicine before it can be authorised.
- The Commission states that the current EMA committee structure creates complexity, duplication of work and does not optimise resources and expertise as, in certain cases, up to 5 EMA scientific committees are involved in the assessment of one medicine [Recital 32 Regulation Proposal, Regulation Proposal, p. 19].
- There will be a reduction and simplification in this regard with the Committee for Medicinal Products for Human Use (CHMP) and the Pharmacovigilance Risk Assessment Committee (PRAC) remaining as the 2 main committees [Regulation Proposal, p. 19 and Recital 33 Regulation Proposal].
- This simplification will allow for a reduction in the scientific evaluation period from 210 days to 180 days [Recital 34 Regulation Proposal].
- To reduce the overall approval time for medicines, the time between the necessary CHMP opinion and the final decision on the application for a marketing authorisation should be no more than 46 days compared to 67 days currently [Recital 49 Regulation Proposal; see also EMA, From lab to patient].
- Patient representatives, among others, will be part of the CHMP and PRAC [Regulation Proposal, p. 19 and Art. 148 (3) (c) and 149 (2) (d) Regulation Proposal].
- Additionally, digitalisation measures, such as electronic submission of applications for marketing authorisation and electronic product information aim to reduce regulatory burden [Regulation Proposal, p. 20 and Recital 72 Regulation Proposal]
- Furthermore, Member States can decide if the mandatory package leaflet for a medicine is provided electronically, in paper format, or both, whereas patients can request a printed copy free of charge [Art. 63 (3) Directive Proposal].
- However, the Commission can – about 6 years after the Reform enters into force – make the electronic-only version of the packaging leaflet compulsory while guaranteeing the right to get a printed copy free of charge via a delegated act [Art. 63 (5) Directive Proposal].

# 9 Regulatory Sandboxes

## 9.1 General Aspects

- The Reform introduces a so-called regulatory sandbox [hereinafter: "sandbox"] to EU general pharmaceutical legislation for the first time [Art. 113-115 Regulation Proposal].
- The concept of a sandbox and its application elsewhere is not new however. The general aim of it is to promote innovation by creating a certain amount of legal freedom: Innovations can be temporarily tested by means of sandboxes under real conditions in a legally secure and delimited area, without having to fulfil all regulatory requirements right from the start.
- Sandboxes provide a structure for experimentation, especially in the context of using digitalisation, artificial intelligence and machine learning for the discovery, development and administration of new medicines [Recital 133 Regulation Proposal].
- A sandbox can also be beneficial for regulators as it enables advancing regulation through proactive regulatory learning with the possibility of finding the best means to regulate innovations and prepare new policies [Recital 133 Regulation Proposal].
- Many such projects can be found in the highly regulated financial sector [generally on this see cep**PolicyBrief** 2/2019] as market entry can only take place if a large number of complex regulations are complied with.
- Since it is almost impossible for start-ups (in the financial sector "FinTechs") to overcome these high legal hurdles in the initial phase, innovative ideas may not be realised, so sandboxes offer support in these cases.

## 9.2 Medicines Under Development Eligible for a Regulatory Sandbox, Conditions and Decision

- Generally, all modalities and conditions of the operation of sandboxes must be set out by the Commission in implementing acts which must include [Art. 115 (3) Regulation Proposal]
  - the eligibility criteria, the procedure for application and the conditions for selection, participation and exiting from the sandbox, as well as
  - the participant's rights and obligations.
- A sandbox for a specific medicine under development can be set up if [Art. 113 (1) Regulation Proposal]
  - it is impossible to develop a medicine or a category of products because of scientific or regulatory challenges which result from characteristics or methods related to the product; and
  - the characteristics and methods contribute positively and distinctively to the quality, safety or efficacy of the medicine or category of product or to patient access to treatment.
- The EMA is responsible for monitoring "emerging medicines" for which it may request information and data from, e.g., marketing authorisation holders, developers, independent experts or researchers, and may initiate preliminary discussions [Art. 113 (3) Regulation Proposal].
- Generally, a sandbox can be set up for those medicines which are likely to fall under the scope of the Regulation Proposal. However, they cannot be set up for medicines which are already advanced in their development programme [Art. 113 (4) Regulation Proposal].
- Where the EMA finds it appropriate, it must provide the Commission with a recommendation to set up a sandbox, including a sandbox plan [Art. 113 (4) Regulation Proposal].
- The EMA is responsible for developing a sandbox plan based on data of developers and following consultations [Art. 113 (5) Regulation Proposal].
- A sandbox plan sets out the clinical, scientific and regulatory justification for a sandbox and identifies which requirements of the following pharmaceutical legislation cannot be complied with and which mitigation measures should be taken: [Art. 113 (5) Regulation Proposal]
  - the Regulation Proposal,
  - the Directive Proposal,
  - Regulation on advanced therapy medicinal products [(EC) 1394/2007].

- The sandbox plan must include a timeline for its duration as well as measures to mitigate possible market distortions due to the sandbox [Art. 113 (5) Regulation Proposal].
- The Commission decides on the setting up of a sandbox by means of implementing acts [Art. 113 (1) and (6) Regulation Proposal].
- A decision to set up a sandbox must be limited in time and must include detailed conditions for its implementation. Furthermore, it must include mitigating measures to address potential risks to public health and the environment [Art. 113 (7) Regulation Proposal].
- The Commission may suspend or revoke a sandbox at any time if [Art. 113 (8) Regulation Proposal]
  - the requirements and conditions are no longer met, or
  - it is considered to be appropriate in order to protect public health.
- If risks to health have been identified after the initial decision to set up a sandbox, the Commission can amend its decision if those newly identified risks can be fully mitigated by supplementary conditions [Art. 113 (9) Regulation Proposal].
- The Commission may extend the duration of a sandbox [Art. 113 (9) Regulation Proposal].

### 9.3 Marketing Authorisation Under a Regulatory Sandbox, Conditions and Decision

- The sandbox is supervised by the competent authorities of the concerned Member States [Art. 113 (2) Regulation Proposal].
- A medicine which was developed under a sandbox may be placed on the market if it was authorised in accordance with the Regulation Proposal whereas the marketing authorisation may include derogations from the requirements set out in the Regulation Proposal and the Directive Proposal [Art. 114 (1) and (2) Regulation Proposal].
- Such derogations may entail adapted, enhanced, waived, or deferred requirements, with each derogation being limited to what is “apt and strictly necessary”, “duly justified” and specified in the conditions to the marketing authorization [Art. 114 (3) Regulation Proposal].
- Initially, the marketing authorisation’s validity cannot exceed the duration of the sandbox whereas this can be extended at the marketing authorisation holder’s request [Art. 114 (2) Regulation Proposal].
- The summary of product characteristics and the package leaflet must indicate if a product has been developed under a sandbox [Art. 114 (4) Regulation Proposal].
- A sandbox and a subsequent marketing authorisation granted under it are interlinked in such a way that if the sandbox is suspended or revoked, the Commission has to suspend the corresponding marketing authorisation [Art. 114 (5) Regulation Proposal].

### 9.4 Supervision by National Authorities and Liability of Marketing Authorisation Holders

- The sandbox does not affect the supervisory and corrective powers of national competent authorities: In case of risks to public health or safety concerns, they can (and must) take immediate and adequate temporary measures to mitigate the risks and inform the Commission [Art. 115 (1) Regulation Proposal].
- If mitigation of risks is not possible or proves to be ineffective, the development and testing process must be suspended without delay [Art. 115 (1) Regulation Proposal].
- Participants in the sandbox remain liable for any harm inflicted on third parties as a result of the testing in the sandbox [Art. 115 (2) Regulation Proposal].

# B. Legal and Political Context

## 1 Status of legislative procedure

| | |
|---|---|
| 26.04.2023 | Adoption by the Commission |
| Open | Adoption by the European Parliament and the Council, publication in the Official Journal of the European Union, entry into force |

## 2 Options for exerting political influence

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|---|---|
| Directorates General: | DG SANTE |
| Committees of the European Parliament: | Environment, Public Health and Food Safety (ENVI), Rapporteur ENVI for Regulation Tiemo Wölken (S&D Group, DE), Rapporteur ENVI for Directive Pernille Weiss (EPP group, DEN) |
| Federal Ministries: | Health |
| Committees of the German Bundestag: | Health |
| Decision-making mode in the Council: | Qualified majority (acceptance by 55% of Member States which make up 65% of the EU population) |

## 3 Formalities

| | |
|---|---|
| Basis for legislative competence: | Art. 114 TFEU (Internal Market) and Art. 168 (4) (c) TFEU |
| Form of legislative competence: | Shared competence (Art. 4 (2) TFEU) |
| Procedure: | Art. 294 TFEU (ordinary legislative procedure) |

# C. Assessment

## 1 Economic Impact Assessment

The Reform aims to re-new the ageing provisions of an extremely important health policy domain in order to set standards of quality and safety for medicines. The Commission is trying to achieve several goals at once, ranging from ensuring “affordability”, “access” and “availability” of medicines, while at the same time fostering innovation in Europe. These goals are difficult to achieve simultaneously and economic, environmental and scientific factors, as well as technological, political and demographic developments, must be taken into account when regulating this health policy field.

Alongside these “usual” challenges of EU Health Policy, however, as well as the fact that Public Health, together with decisive decision-making powers on aspects such as pricing and reimbursement, remain the sole competence of the Member States, the European pharmaceutical system is facing other major challenges. These include geopolitics, industrial policy decisions, vulnerable dependencies on certain raw materials and an ageing society with an increased demand for medicines.

The Commission proposals try to introduce mechanisms for all these aspects. In the following, the main mechanisms are examined, evaluated and, where appropriate, a concrete alternative regulatory approach is proposed.

### 1.1 Incentives: Cumulative Approach to Regulatory Data Protection

In the long term, many factors will influence the EU's success in achieving its goal of being an attractive location for innovation in global competition. Part of it is intellectual property protection as it is the basis for supporting the development of new medicines and bringing them to the European market. The interplay between patents, SPCs, regulatory data protection (“RDP”) and market protection build its foundation. Due to unmet needs, an

ageing European population and health-related challenges and risks such as antimicrobial resistance (AMR) or further health crises, Europe needs innovative medicines. RDP is a key factor in this regard as it rewards innovative performance.

The Commission proposal foresees a reduction of the RDP period from 8 to 6 years combined with a cumulative approach for earning additional years if certain conditions are met. If all the conditions are met, RDP could be extended by 4 additional years.

The Commission uses the cumulative approach with the aim of achieving various – partly conflicting – goals simultaneously. At its core, the Commission Proposal tries to balance out incentivising innovation, on the one hand, and supporting better availability and affordability of medicines across the EU, on the other  The Commission intends to have a significant impact on prices and to reduce unequal access to innovative medicines.

Prima facia, the cumulative approach which allows for up to 10 years of RDP seems to be well-balanced as, compared with other major countries,[1] it could still be regarded competitive. However, even though the idea of this cumulative approach is well-intentioned, it has its practical weaknesses. It tries to address innovation, access, affordability and availability of medicines simultaneously but is unable to eliminate the trade-offs.

**Launching a medicine in all Member States: Uncertainty for everyone involved**

Generally, incentivising the launch of a medicine in all Member States is in line with the aim of achieving a high level of health protection in the EU [Article 35 of the Charter of Fundamental Rights of the EU]. However, the two additional years of RDP can only be earned if a medicine is (1) launched in all Member States where it was previously authorised within two years of marketing authorisation and (2) a "continuous supply" is ensured. In practice, these requirements will generally be difficult to fulfill as any application for this extension needs documentation from all the Member States involved verifying that all requirements are met. This alone is a major undertaking. Furthermore, it remains unclear how the requirement of ensuring "continuous supply" is to be interpreted and how it can be reasonably aligned with obligations to prevent shortages. Overall, it is likely that many medicines will not benefit from this incentive. Additionally, this uncertainty also impacts competition because, at the same time, it puts a burden on producers of generics and biosimilars. This is due to the fact that the latter do not know the point at which they can start using the innovative company's regulatory data to support the authorisation of their version of a medicine.  It is crucial that the cumulative approach enables access and does not exacerbate the situation.[2]

**RDP period to practically decrease**

Moreover, reaping the fruits of the other incentives is also quite challenging. For example, the narrow definition of "unmet medical needs" means that only a few medicines will fulfill this condition. The same applies to the incentive to conduct comparative clinical trials which are highly complex to conduct and result in substantial costs for the pharmaceutical firms. Such comparative clinical trials will only be carried out when the turnover which can be generated outweighs the additional costs. Therefore, it would make sense to increase the proposed additional RDP period for conducting clinical trials. In fact, the proposed cumulative approach implies that in most cases the RDP will decrease, on average, so that an innovative medicine will then probably be protected by RDP for around 7 years, and outliers for longer.

**Impact on internal and external competition and consequent regulatory proposal**

A decrease in RDP will generally favor generics and biosimilar producers as this allows them to start using regulatory data earlier. This generally supports necessary competition. Consequently, prices for medicines could generally decrease as the market entry of competition is facilitated, which may support the aim of lower prices for medicines. From a patient's affordability point of view and the burden on a national healthcare system, this is to be regarded as positive. However, the fact that pricing and reimbursement are decisions taken solely by the Member States needs to be taken into account, as a result of which the actual impact on affordability and access

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1 Such as Canada, USA, Israel, Japan, or Switzerland, see European Commission (2023), Impact Assessment Report, part 1, p. 37 et seq. All sources last accessed: 23.01.2024.

2 If the objective is correct but the approach is not the right one, this may lead to problems. A prominent example where such a situation occurred is the deadline extension of medical devices that led to shortages of medical devices. See for instance, Rothe, C. / Stockebrandt, P. (2019), Deadline extension for medical devices, cepA**dhoc**.

remains in the national domain. On the other hand, RDP represents a decisive incentive for investments in innovation in Europe. Moreover, the pharmaceutical sector is of major importance for the EU. In 2022, 865,000 jobs were associated with the pharmaceutical sector. Since 1990, more than 360,000 new jobs were created with continuous upward development.[3] A general reduction of RDP could lead to less or at least delayed access to innovative medicines and hamper investment in Europe.

Therefore, the cumulative approach to RDP is generally well-intentioned and not per se a wrong approach. However, the requirements, particularly for placing a medicine on the market of all Member States where it was previously authorised – including the indeterminate term "continuous supply" – must be clarified right away. Only then will a cumulative approach be workable and provide the necessary predictability for all stakeholders. RDP rewards innovative performance and Europe needs to stay globally competitive. It is crucial to ensure investment, and to secure and create (new) jobs. Hence, the cumulative approach should generally be amended with the basic RDP period set to 7 years. This means that the average RDP will be a little over 8 years, and will thus at least uphold today's basic 8-year RDP protection period to remain globally competitive.

### 1.2 Vouchers for Antimicrobials

The provision of effective antimicrobials is a key challenge for European and national health policy. The increase in antimicrobial resistance (AMR) to currently available antimicrobials will at some point render them ineffective and, at the same time, too few new antimicrobials are being developed. Those affected as well as society at large are thus facing a dire situation.[4] A clear and present danger exists as we are facing a "silent tsunami".[5]

The issue which needs to be addressed is that the market for antimicrobials, such as antibiotics, is comparably small, sales are low, research and development (R&D) is costly and risky. Any incentive scheme needs to take the expected relatively low volume of sales of novel antimicrobials, and the high R&D costs, into account, including the high value they have for society, to enable treatments, prevent infections and save lives. At the same time, competition must be ensured.

The Commission is therefore proposing a voucher system to incentivize the development of new antimicrobials. Generally, the voucher rewards successful development of a "priority antimicrobial". This means that a new antimicrobial must either represent a new class of antimicrobials,[6] its mechanisms be distinctively unique from existing antimicrobials, or include an active substance not previously authorized in the EU [Art. 40 (3) Regulation Proposal].

**The EU and the Member States and Other Incentives**

The situation to be faced is that health policy is and remains the domain of the Member States.[7] In the aftermath of the COVID-19-pandemic, work to combat certain health threats now takes place at EU level. For example, the new Health Emergency Preparedness and Response Authority (HERA) also tries to incentivise the development of antibiotics by directly financing individual research projects. Yet, all these tools focus on selective, individual projects, rather than a system for long-term continuous innovation and development.[8] There is a need to create an incentive system which fosters the continued innovation and development of new antimicrobials and alternatives. The current system does not achieve this.

In comparison, all previously publicly debated incentive mechanisms have their advantages and disadvantages. Generally, one can distinguish between push and pull incentives. While so-called push incentives aim at the

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3 Statista (2023), Total pharmaceutical employment in EFPIA countries from 1990 to 2022.

4 Nolen, N. / Stockebrandt, P./ Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023, p. 22.

5 Nolen, N. / Stockebrandt, P./ Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023, p. 3. Since 2010, 18 new antibiotics have been approved in Europe, US, Japan and Canada. See: Anderson, M. / Wouters, O. J./Mossialos, E. (2023), Transferable exclusivity extensions to stimulate antibiotic research and development: what is at stake?, in: The Lancet Microbe, 4(3), E127-E128. More importantly, the last time a novel class of antibiotics was discovered was in 1984. See Pew Charitable Trusts (2021), Researcher Explains Challenges in Finding Novel Antibiotics.

6 The last time a novel class of antibiotics was discovered was in 1984. See Pew Charitable Trusts (2021), Researcher Explains Challenges in Finding Novel Antibiotics.

7 Instead of many, see Stockebrandt, P. (2021), Three Steps Towards a European Health Union, cep**Input** 4/2021.

8 Nolen, N. / Stockebrandt, P. / Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023, p. 20.

reduction of R&D costs, pull incentives aim at an increase in revenue.[9] Even prior to the Commission proposal, various incentive schemes were being discussed.[10] Most prominently, the introduction of a "subscription model" whereby the state would undertake to pay (annual) fees – decoupled from sales volumes – to a company for a certain period of time in return for the guaranteed supply of an antimicrobial. The aim is to ease concerns about the return on investment as this would serve as a form of guaranteed revenue for that company.[11] The practical issue here: this is something that can really only be pursued at Member State level.[12]

**The Decisive Elements of the Voucher**

The holder of the voucher will be granted 1 year of additional regulatory data protection (RDP). This mechanism in itself is not criticized as it directly rewards the innovative work.

The reasons why the proposed voucher system is being widely discussed are: (1) the additional RDP protection can also be used for another medicine in the portfolio of the holder and, even more decisively, (2) the voucher can be sold to another company which is then able to use the additional RDP on one of its medicines.

Generally, unlike other incentives, the voucher does not require taxpayer's money as it is self-financing in a first stage. The price for the transferable voucher is negotiable. Evidence has shown that mostly small and medium-sized enterprises (SME) conduct R&D for antimicrobials.[13] The issue here is that other pharmaceutical companies will most likely purchase a voucher from an SME competitor and use it for a profitable "blockbuster" medicine in their portfolio. It is argued that therefore this could be seen as a "loosening" of the relationship between innovation and reward or as "overcompensation" of the buyer of a voucher.

The very likely scenario described above will place a burden on national healthcare systems and patients because, giving these blockbuster medicines one more year of RDP protection will delay competition through generics and biosimilars . The costs to be faced will therefore be increased monopoly prices for these profitable medicines. The price will decrease due to competition but only at a later stage.

**Why the voucher is proportionate**

Firstly, any assessment of the proposed voucher system must consider the precondition that any voucher can only be granted if the new antimicrobial is a "priority antimicrobial". This means that it must, by law, e.g., represent a new class of antimicrobials – which has not been the case for roughly 40 years with regard to antibiotics.[14] Additionally, the requirements for granting a voucher are restrictive and provide an incentive to bring novel antimicrobials to the markets, which is appropriate and the right approach to tackle AMR.

Secondly, the additional RDP can only be used for a limited group of existing medicines, specifically those which are still within the first 4 years of an RDP.

Thirdly, the proposal foresees a limitation to one single transfer ("one voucher, one transfer") and includes the necessity for transparency, as the selling price must be notified to the European Medicines Agency ("EMA") which must make this information publicly available.

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9 Renwick, M. / Mosssialos, E. (2020), Fostering clinical development and commercialisation of novel antibiotics, in: Eurohealth Observer, 26(1), p. 10.

10 See altogether Nolen, N. / Stockebrandt, P. / Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023, p. 20 et seq.

11 Nolen, N. / Stockebrandt, P. / Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023, p. 21.

12 Sweden is currently testing this incentive; Nolen, N. / Stockebrandt, P./Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023, p. 21, see footnote 125.

13 European Commission (2023), Study in support of the evaluation and impact assessment of the EU general pharmaceutical legislation: impact assessment report, p. 84.

14 The last time a novel class of antibiotics was discovered was in 1984. See Pew Charitable Trusts (2021), Researcher Explains Challenges in Finding Novel Antibiotics.

Fourthly, the proposed voucher system is restricted with regard to volume as only 10 vouchers are available. The quantity seems arbitrary at first glance. However, the lower the number of vouchers in circulation, the higher the price will be that a buyer must pay and vice versa.[15] Therefore, the quantity is appropriate.

Fifthly, the proposed voucher system is restricted with regard to time as the incentive system will automatically terminate after 15 years.

Sixthly, after that time period, it will be evaluated whether the voucher proved to be efficient.[16]

Seventhly, and practically important, a voucher can be quickly and relatively easily implemented at EU level compared to alternative incentives systems, which is a crucial advantage.

Overall, it is obvious that there is no first-best solution as all incentive systems have major drawbacks. Thus, a second-best solution must be found. Given that time is limited, and action is urgently needed, the EU level voucher incentive approach – even though it is certainly not flawless – is a proportionate compromise to incentivise the development of new antimicrobials in Europe and should therefore be introduced as one of the measures to tackle AMR[17] and the lack of effective antimicrobials.

### 1.3 Environmental Risk Assessment (ERA)

Scientific research has shown that medicines can have a negative impact on the environment, for example through production, use and incorrect disposal.[18] Pharmaceutical residues enter the soil and waters and can have an impact on human and animal health.[19] Furthermore, with an ageing society the consumption of medicines will increase, meaning that without effective countermeasures, there is the risk of increasing the unintended negative impact on the environment.[20] Measures to address this problem need to find a balance between the impact on public health with regard to access and availability of medicines, on one hand, and environmental protection, on the other hand.

One of the tools currently foreseen to ensure this is the obligation to conduct an environmental risk assessment (ERA). The Reform will not change this. However, the Commission Proposal foresees two substantial amendments to the current situation: 1) the introduction of an (obligatory) reason for refusal of a marketing authorisation on grounds of an "insufficient" ERA and 2) the introduction of a mandatory ERA for certain medicines authorised prior to October 2005. These two proposals will be evaluated separately.

**ERA for Future Medicines: New Grounds for an Obligatory Refusal of a Marketing Authorisation**

The Reform foresees an "insufficient" ERA as a reason for which the marketing authorisation of a new medicine must be refused – both nationally and at EU level [Art. 15 (19) (d) Regulation Proposal and Art. 47 (1) (d) Directive Proposal]. This does change the current system drastically. Whereas patient protection and access to a new medicine is currently the main focus, the proposed regulations could lead to the refusal of the authorisation of a new medicine, with a positive health-related benefit-risk-balance, on grounds of environmental concerns.

However, the current legislation does not provide for measures to enforce compliance with the requirements of an ERA as part of the marketing authorisation procedure. This may explain the high proportion of marketing authorisations that get approved without a complete or with an insufficient ERA. For example, in Germany, only 51% of products assessed between 2018 and 2020 complied with the ERA requirements at the time of marketing

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15 European Commission (2023), Study in support of the evaluation and impact assessment of the EU general pharmaceutical legislation: impact assessment report, p. 84.

16 Evidence on IP-based incentives for novel antimicrobials remains scarce so far and have to address several challenges such as to show whether novel antimicrobials would have brought to the market if these incentives had not existed. See generally Batista, P.H.D. / Byrski, D. / Lamping, M. / Romandini, R. (2019), IP-Based Incentives Against Antimicrobial Crisis: A European Perspective, in: IIC – International Review of Intellectual Property and Competition Law, 50, 30-76.

17 See Nolen, N. / Stockebrandt, P. / Wolf, A. (2023), Antibiotics: A Multi-Perspective Challenge, Antibiotics: A Multi-Perspective Challenge, cep**Input** 2/2023.

18 European Commission (2023), Frequently Asked Questions: Revision of the Pharmaceutical legislation.

19 OECD (2019), Pharmaceutical Residues in Freshwater, p. 6 and see generally Rothe, C. / Stockebrandt, P. (2020), Pharmaceuticals in the Environment, cep**PolicyBrief** No. 02/2020, p. 1 and 3.

20 Rothe, C. / Stockebrandt, P. (2020), Pharmaceuticals in the Environment, cep**PolicyBrief** No. 02/2020, p. 1 and 3.

authorisation. For 27% of the medicines the ERA remained an open issue and no further commitments were made. For 22% of the medicines a commitment was made to conduct an ERA. However, less than half of those 22% of medicines had an ERA conducted within the agreed timeframe.[21]

On the other hand, compliance with ERA requirements for products approved at EU level is much better, with a compliance rate of 80% at the time of marketing authorisation and with most applicants meeting the requirements post-authorisation within the agreed deadline.[22] Overall, analysis showed that in 2021, on the one hand, 80% of the medicines (69 out of 86) were approved through the EMA procedure with a complete ERA at the time of marketing authorisation. On the other hand, the remaining 20% of medicines without a complete ERA included those with a potential environmental concern.[23]

Given the relatively large number of ERA's conducted after the deadline or in an insufficient manner, and the environmental risks involved,[24] it is appropriate to implement measures which may improve enforcement of compliance with ERA requirements. However, the Commission's proposal that the marketing authorisation must be refused if ERA requirements are not met is a disproportionate measure. This is particularly true when the health benefits of a new medicine with a favourable health-related benefit-risk balance are weighed against the benefits to the environment of compliance with all ERA requirements at the time of marketing authorisation. Refusal of the marketing authorization based on ERA grounds could hinder patient access to new safe and effective medicines.

Altogether, compliance with ERA requirements is important and it should be an obligatory part of a marketing authorisation. However, rather than introducing an obligatory reason for refusal into the European authorisation systems, with possible negative impact on patient access to new medicines, a more targeted approach should be taken: the proposed provisions [Art. 15 (1) (d) Regulation Proposal and Art. 47 (1) (d) Directive Proposal] should be substituted by a phased and proportionate, post-authorisation enforcement mechanism in the form of a combination of warnings, sufficiently deterrent fines and – only as a last resort – the possibility of revocation of a marketing authorisation. This would balance the need for environmental protection, on the one hand, and safeguarding access to new safe and effective medicines, on the other.[25]

**Retrospective ERA for Medicines Authorised before October 2005**

Most medicines authorised before October 2005 do not have a proper ERA as it was not then part of the marketing authorisation procedure.[26] This may explain why, for example on the German market, ERA data is missing for 281 out of 404 active pharmaceutical ingredients (APIs) used in medicines.[27] The Commission

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21 Gildemeister, D. / Moermond, C.T.A. / Berg, C. et al. (2023), Improving the regulatory environmental risk assessment of human pharmaceuticals: Required changes in new legislation, p. 3.

22 This data concerns the years before 2021 and was given by an EMA spokesperson in: Wickware, C. (2022), One in five drugs approved by EMA in 2021 lacked full environmental risk data.

23 Wickware, C. (2022), One in five drugs approved by EMA in 2021 lacked full environmental risk data.

24 The importance of compliance can be surmised if one looks at studies by the German Federal Environmental Agency which concluded that 10% of the 120 medicines for which a complete ERA was evaluated between 2006 and 2014 posed a potential environmental risk; Küster, A. / Adler, N. (2014), Pharmaceuticals in the environment: scientific evidence of risks and its regulation, p. 1 and p. 3. Data used is relatively old because more recent data on the outcome of ERAs is generally not publicly available. This number is also referred to in more recent publications. See for example OECD (2019), Pharmaceutical residues in fresh water, p. 7. Another study found that more than 80% of medicines in Europe have a low environmental risk. See also Gunnarsson, L. / Jason, R.S. / Verbruggen, B. et al. (2019), Pharmacology beyond the patient – The environmental risks of human drugs, p. 328.

25 Practically, such a phased approach could be initiated with a fine if the ERA requirements are not fulfilled alongside an administrative order to fulfil these requirements within a certain time-period. If this commitment is not fulfilled on time, the marketing authorisation holder could receive a warning followed by an increased fine. As a last resort, another warning could be given with the subsequent possibility of revocation of the marketing authorisation in case of non-compliance.

26 Küster, A. / Adler, N. (2014), Pharmaceuticals in the environment: scientific evidence of risks and its regulation, p. 3 and Gildemeister, D. / Moermond, C.T.D., / Berg, C. et al. (2023), Improving the regulatory environmental risk assessment of human pharmaceuticals: Required changes in new legislation, p. 2.

27 Gildemeister, D. / Moermond, C.T.D., / Berg, C. et al. (2023), Improving the regulatory environmental risk assessment of human pharmaceuticals: Required changes in new legislation, p. 2 and Gildemeister D. / Buck, A. / Hein, A. et. al. (2022), Improving environmental protection in EU pharmaceutical legislation, p. 12.

proposes that those medicines which are identified by the EMA as potentially harmful to the environment be required to have a post-authorisation ERA conducted. A risk-based approach would be used for prioritisation.

From an environmental protection perspective, it is important that a measure is taken regarding these medicines as many of the existing substances used in medicines without an ERA are found in the environment.[28] Generally, medicines are used in large quantities, some of which have seen a significant increase[29] in usage.[30] An obligation to conduct ERA´s for certain medicines – those that are potentially harmful to the environment – using a risk-based approach is appropriate and should be left in the legislative proposal as presented by the Commission.

## 1.4 New Mechanisms to Manage Shortages of Medicines

Medicine shortages represent a growing threat to public health. The root causes are multifactorial, including but not limited to supply chain disruptions and vulnerabilities affecting the supply of key ingredients. The COVID-19 pandemic has exacerbated the situation.[31]

In order to further mitigate the risk of shortages the Commission aims to introduce several precautionary mechanisms which, e.g., introduce new obligations to marketing authorisation holders to, inter alia, notify shortages. These include the obligation to notify temporary disruptions in the supply of a medicine 6 months in advance as well as shortage prevention plans for all medicines.

**Obligations to Notify in Advance**

Marketing authorisation holders, for example, are obligated to report a temporary disruption in supply six months ahead. Generally, the rationale makes sense, but a temporary disruption usually cannot be predicted six months in advance.[32] As a consequence, marketing authorisation holders may overreport potential temporary disruptions as a precaution in order to comply with the obligation and to exclude liability. Consequently, this would trigger unnecessary checking and monitoring mechanisms for national authorities and the EMA, whose working capacity is also already limited. Therefore, it should be sufficient to give notice on temporary disruptions in supply two months in advance.[33]

**Shortage Prevention Plans for all Medicines**

The Regulation Proposal also obligates all marketing authorisation holders to have in place a shortage prevention plan for any medicine in their portfolio. It is crucial to prevent shortages, but this obligation for all medicines is too far-reaching as it puts a lot of bureaucratic burden on marketing authorisation holders. Particularly, small and medium-sized enterprises (SME) will likely be overburdened with these requirements as they may lack the necessary expertise and human resources to comply. Regulatory burden and high bureaucratic costs are already

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[28] Küster, A. / Adler, N. (2014) Pharmaceuticals in the environment: scientific evidence of risks and its regulation, p. 3. Environmental risks of these products cannot be ruled out. See for example Gildemeister, D. / Moermond, C.T.D., / Berg, C. et al. (2023), Improving the regulatory environmental risk assessment of human pharmaceuticals: Required changes in new legislation, p. 2.

[29] An example of a medicine which had a significant increase is metformin. In Germany usage of this medicine tripled between 2002 and 2012. See also Küster, A. / Adler, N. (2014), Pharmaceuticals in the environment: scientific evidence of risks and its regulation, p. 3.

[30] Küster, A. / Adler, N. (2014) Pharmaceuticals in the environment: scientific evidence of risks and its regulation, p. 3 and Gildemeister, D. / Moermond, C.T.D. / Berg, C. et al. (2023), Improving the regulatory environmental risk assessment of human pharmaceuticals: Required changes in new legislation, p. 5.

[31] See Stockebrandt, P. / Wolf, A. (2023), How to Prevent Future Medicine Shortages, cep**Input** 12/2023, p. 28.

[32] Many factors may influence such a situation. For instance, new evidence on the impact of a medicine to be effective for other health issues can lead to a soar in demand and subsequent temporary disruption in supply. This was, for instance, shown for a medicine which is intended for diabetes patients but was promoted to be effective for weight management as well. See The Guardian (2023), Shortage of diabetes medication Ozempic after TikTok users promote drug for weight loss.

[33] The requirements would also obligate pharmaceutical firms to stockpile pharmaceutical ingredients which they find it hard or impossible to comply with. As regards medicines derived from plasma (generally see Nolen, N. / Stockebrandt, P. (2022), Substances of Human Origin, cep**PolicyBrief** No 15/2022, for example, it will be a struggle as the production process is lengthy and the stockpiling requirements would put an additional burden on them.

a negative factor with regard to EU global competitiveness.[34] Generally, it is more appropriate to put such an obligation in place for medicines which are on the list for "critical shortages"[35].

Overall, the pharmaceutical reform proposed by the Commission takes a rigid planning approach to shortages. The intention is good, but this approach will not help prevent medicine shortages substantially. Instead, additional regulatory complexity will be created which could overburden the stakeholders involved and may lead, for example, to overreporting. Instead, the notification obligations should be differentiated, and each based on a realistic time frame as already suggested. Also, a shortage prevention plan should only be mandatory for critical medicines.

### 1.5 Security of Supply of Critical Medicines

The Reform entails new regulations on securing the supply of "critical medicines". The idea behind it is that these medicines are so important to society at large[36] that identification and management must be handled at EU level with the Member States, the EMA and the Commission working together. This is going to be a major undertaking which will incur costs. Yet, given the risks involved to social welfare and public health in case of shortages of "critical" medicines[37], it is appropriate to strengthen EU-level coordination in that regard.

This includes, as envisaged by the Reform, the development of a common methodology for identifying which medicines are "critical" and listing them in an EU list of critical medicines[38]. Given the high information costs resulting from the diversity of medicines, this requires strict prioritisation Any medicine will of course be crucial for patients who need it but not all medicines can be categorized as "critical". In view of the fundamental consequences that a categorization of products as "critical medicines" can have for the well-being of citizens, such prioritization must in any case be based on objective, scientifically well-founded criteria.[39]

Once a medicine is on the EU list of critical medicines, recommendations on security and supply measures can be made, inter alia, to the marketing authorisation holders of such a medicine. This and other such proposed mechanisms in the reform proposals can be used to manage risk. Yet, they are unable to address the wider issue of EU dependencies. The majority of Member States[40] are therefore calling for a legal framework to reduce dependencies for critical medicines and ingredients, particularly for products where there are only a few supplying manufacturers or countries. Specifically, they want to follow the example of the Critical Raw Materials Act and ask the Commission to present a proposal for a Critical Medicines Act.[41] Whereas this matter can generally be handled in a separate legislative proposal, it would be more efficient and coherent to include it in the reform proposals during the ongoing legislative process. That way, the legislator would be better able to safeguard a coherent and consistent framework regarding critical medicines. The regulations to be included in a possible "Critical Medicines Act" could very well be placed alongside the regulations on critical medicines in the Regulation Proposal. These aspects should be thought of and deliberated together.

### 1.6 Competitiveness and Efficiency

Regulatory burden can be a negative factor especially with regard to EU global competitiveness.[42] Therefore, the Reform also aims to reduce regulatory burden, e.g., by reducing the regulatory timeframe for the approval of new medicines at EU level. Accordingly, the EMA's scientific evaluation period will be reduced to 180 days from currently 210 days. The final authorisation decision then needs to be made by the Commission no more than 46

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34 See for example Küsters, A. / Reichert, G. / Vöpel, H. / Wolf, A. (2023), Quo vadis, Europa?, p. 33 et seq.
35 See Section A, 6.3.
36 In legal terms of the proposals, a medicine is "critical", if insufficient supply of it results in serious harm or risk of serious harm to patients [Art. 2 (13); Art. 127 Regulation Proposal].
37 To this regard, effective antibiotics can be mentioned, as these are needed to make many modern medical procedures, including cancer treatment, organ transplants and open-heart surgery possible; see Nolen, N. / Stockebrandt, P. / Wolf, A. (2023), Antibiotics: A multi-perspective challenge, cep**Input** 2/2023, p. 5.
38 Formally: "Union list of critical medicinal products".
39 Stockebrandt, P. / Wolf, A. (2023), How to Prevent Future Medicine Shortages, cep**Input** 12/2023, p. 25.
40 That is 19 of 27.
41 See Stockebrandt, P. / Wolf, A. (2023), How to Prevent Future Medicine Shortages, cep**Input** 12/2023, p. 6 et seq.
42 Generally see Küsters, A. / Reichert, G. / Vöpel, H. / Wolf, A. (2023), Quo vadis, Europa?

days from the time that the competent scientific EMA committee[43] has rendered its opinion, thereby reducing it from the current 67 days. Overall, this is appropriate and adequate as it allows earlier availability of medicines for patients which benefits public health. It also decreases regulatory burden and thereby also the cost for companies, and increases their turnover due to the possibility for earlier market launch.

In part, this is made possible due to a reduction in the number of EMA-Committees involved in the assessment of new medicines. Of those currently involved in the assessment and decision, only two will remain.[44] As already described elsewhere with regard to EU health policy in general terms, the aim should be to consolidate committees, agencies, and steering groups at EU level and to combine tasks in a clear structure.[45] Therefore, the foreseen consolidation is appropriate and adequate.[46]

However, in the area of orphan designation, changes to the current legislation will have a negative impact on efficiency. Under the current legislation there is an appeal mechanism available to those companies who disagree with a negative opinion regarding an orphan designation decision. They can appeal against opinions directly to the EMA without having to go to court.[47] This appeal mechanism is comparable to other ones found, e.g., in the UK and Australia.[48] The advantage of this mechanism is that it is easily accessible and time and cost efficient.[49] However, this option does not exist in the proposed legislation. It will be left to the applicant to go to court to challenge a decision, which will be a lengthier and costlier process. It would be much more efficient to keep the appeal mechanism – as internationally usual –in order to avoid lengthy court proceedings which will have an impact on the cost of developing these special kinds of medicines. The existing appeal mechanism in the current legislation should therefore be kept.

### 1.7 Electronic Packaging Leaflets

The Commission also – rightly – aims to reduce regulatory burden through further digitalisation, or greater use of electronic data. Therefore, one aspect of the Reform is the possibility for Member States to decide if the mandatory packaging leaflet of a medicine is provided electronically, in paper format or both. Either way, though, patients would have a right to request a free printed copy.[50] In addition, the Reform also includes giving the Commission the power to make electronic-only packaging leaflets mandatory via a delegated act 6 years after the Reform enters into force [Art. 63 (5) Directive Proposal].

Electronic packaging leaflets do have advantages, such as the possibility of faster patient access to updates of packaging information. However, the introduction of mandatory electronic-only packaging leaflets should be assessed carefully as it could also have a major impact on patient protection as part of public health policy.

Even though digitalisation is becoming a more integral part of the daily lives of all patients, one cannot neglect the fact that some patient groups and their carers do not yet seem to be properly equipped or prepared for an electronic-only packaging leaflet. This creates a difficult situation, especially against the background of a

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43 That is the Committee for Medicinal Products for Human Use (CHMP).

44 These are the Committee for Medicinal Products for Human Use (CHMP) and the Pharmacovigilance Risk Assessment Committee (PRAC).

45 Janda, C. (2022), Die Europäische Gesundheitsunion – Vorschläge der Kommission, in: Spiecker genannt Döhmann, I. (ed.), Mehrebenensystem im Gesundheitswesen, p. 38.

46 Whereas patient group involvement is safeguarded in the final decision making within the two remaining EMA committees (CHMP and PRAC), such involvement should be safeguarded in the preliminary work as well as. Generally, as shown elsewhere, including patient groups early on can be beneficial – see on the aspect of patients as part of the design of clinical studies e.g. the presentation of Bakker, A. (2023), Innovative Solutions to Accelerate the Path of Approval, minute 34:00 to 35:30, held during the Webinar of Clinical Trials Access in Europe on the influence of Revisions to the EU Pharmaceutical Legislation.

47 EMA (2023), Questions and answers: Orphan-designation application and EMA (2022), Procedural advice for orphan medicinal product designation.

48 Medicines and Healthcare products Regulatory Agency (2021), Guidance: Orphan medicinal products and Australian Government (2018), Orphan drug designation.

49 For more details on the appeal procedure see for example EMA (2020), Procedural advice on appeal procedure for orphan medicinal product designation or review of orphan designation criteria at the time of marketing authorisation.

50 See Art. 63 Directive Proposal and Section A, 8.

problematic "digital divide" between generations, meaning the unequal access to digital technology, including smartphones, tablets, laptops, and the internet.[51]

Patients increasingly expect to be able to access information to make informed decisions. Self-care relies heavily on patients having sufficient, high-quality information on which to base their decision-making. Here, written information has an increased importance for safe use of a medicine as, for many people, the primary or only source of information about their medicine is the packaging leaflet supplied with all medicines.[52]

Even though the Reform includes a right to a free printed copy, the proposal leaves it completely open as to who should provide this copy to the patient or where such copy needs to be made available. This adds uncertainty. Additionally, the question of financing this service is completely left out of the Reform. In practice not all patients may be able to get the free copy right away though its information could be crucial to a patient before taking a medicine.

Overall, access to the information provided in a packaging leaflet is essential to a patient and is a public health policy matter. In that regard, a first best solution would be to make the information available both electronically as well as in a packaging leaflet for all medicines. Whereas the digital transition and more data usage is surely needed, it seems unwarranted at this point to introduce electronic-only packaging leaflets, especially in view of the digital divide and the importance of the information on the packaging leaflets for each patient, as described earlier. Leaving the issue to the Member States, as proposed in the Reform, can therefore be regarded as a second-best option, as it would allow Member States to make decisions based on their country-specific situation. Consequently, the power for the Commission to decide upon the introduction of electronic-only packaging leaflets [Art. 63 (5) Directive Proposal] should be removed.

# 2 Legal Assessment

## 2.1 Legislative Competence, Subsidiarity, and Proportionality vis à vis Member States

The Commission proposals are unproblematic regarding the division of legislative competences, especially since the EU can adopt measures setting high standards of quality and safety for medicines and medical devices [Art. 168 (4) (c) TFEU]. The regulatory proposals do not constitute an infringement of the principle of subsidiarity or of the principle of proportionality with respect to Member States.

## 2.2 Compatibility with EU law in other respects

It must be noted, however, that the proposals contain a plethora of delegations of power to the Commission to make important legislative decisions via delegated acts. In other words, the Commission will be able to independently determine key elements of pharmaceutical policy and law.

An EU law may delegate to the Commission the power to adopt "non-legislative acts of general application" only to "supplement" or "amend" certain "non-essential elements" of the subject matter [Art. 290 (1) (1) TFEU]. The purpose is to ensure that the complex legislative procedure is not overburdened by detailed technical provisions and to facilitate fast and flexible adaption to new developments.[53]

The "essential elements" of the subject matter are, however, reserved for the legislative act and therefore cannot be delegated [Art. 290 (1) (2) TFEU]. The concept of "essential elements" in favour of the EU legislator – i.e.,

[51] The are several aspects to be considered here, ranging from digital literacy, technical availability of constant internet access, and operability with different (also older) electronic devices; see generally on accessibility to certain electronic health services: Küsters, A. / Stockebrandt, P. (2023), The Right Recipe for the Metaverse, cep**Input** 8/2023, p. 16 et seq. Generally see also Ada Lovelace Institute (2023), Access denied?, Socioeconomic inequalities in digital health services.

[52] See Medicines and Healthcare products Regulatory Agency UK (2005), Report of the Committee on Safety of Medicines Working Group on Patient Information, Always Read the Leaflet, p. 8.

[53] See Gellermann, M. in: Streinz, R. (2018), EUV/AEUV, 3rd Edn., Art. 290 TFEU, para. 1. See also Schwind, S. / Stockebrandt, P. / Reichert, G. (2023), European Right to Repair, cep**Input** 10/2023, p. 14.

Parliament and Council – aims to safeguard the institutional balance between EU organs and prevent the primary task of the EU legislator from being eroded by the transfer of legislative powers to the Commission.[54]

Against this background, three delegations of power to adopt delegated acts stand out:

(1) the power to amend the list of medicines which must be authorised at EU level [Art. 3 (5) Regulation Proposal];

(2) the power to decide on mandatory electronic-only packaging leaflets for medicines [Art. 63 (5) Directive Proposal]; and

(3) the power to change the criteria of the Environmental Risk Assessment (ERA) [Art. 213 Directive Proposal].

(1) The Regulation proposal enables the Commission to amend the list of medicines which require an EU level marketing authorisation [Art. 3 (5) Regulation Proposal]. The inclusion of new medicines in the scope of the Regulation by the Commission will result in extensive rights and obligations for the actors involved. Due to this far-reaching legal effect, the definition of the medicines covered by the Regulation is clearly an "essential" regulatory element which must be decided upon by the EU legislator itself within the framework of the ordinary legislative procedure and cannot be delegated to the Commission.[55]

(2) The Directive Proposal also empowers the Commission to introduce mandatory electronic-only packing leaflets 6 years after the Reform enters into force [Art. 63 (5) Directive Proposal]. As previously discussed, the introduction of mandatory electronic-only packaging leaflet is not only a matter of digitalisation or reducing regulatory burden but of patient protection as part of public health policy, as well as a substantial health policy decision.[56] Such a far-reaching delegation of power to the Commission violates the concept of reserving "essential elements" of law for the EU legislator. Therefore, this delegation of power [Art. 63 (5) Directive Proposal] must be scrapped.

(3) Usually, powers delegated to the Commission are specifically regulated within the article that covers the subject matter concerned. Most interestingly, the Directive Proposal allows the Commission to make amendments directly to the legal text of Art. 22 of the future directive , specifically paragraphs 2-4 and 6, which cover the Environmental Risk Assessment (ERA) [Art. 213 Directive Proposal].

Firstly, this is a most unusual approach as the very relevant delegation of power is "hidden" in the "Final Provisions" of the Directive Proposal under the heading "Amendment to Annexes". This is not a transparent approach which already warrants correction.

Secondly, also in terms of content, the delegation of the power to change the legal text of Art. 22 of the future directive, covering the ERA requirements, is a violation of the concept of reserving "essential elements" of law for the EU legislator. Changes to the requirements of an ERA will most certainly have far-reaching effects because they may affect a decisive factor of a marketing authorisation. This references the fact that, under the Commission Proposal, an "insufficient" ERA must lead to the refusal of a marketing authorisation.[57] With the power to change the legal text of Art. 22 of the future directive, the Commission can act alone in making changes to ERA requirements. Hence, it can decide on its own what constitutes a "sufficient" ERA. It is unclear why the Commission should be empowered to amend the corresponding legal text of the directive (secondary EU law). All of this goes beyond what is permissible. The delegation of powers in Art. 213 Directive Proposal regarding Art. 22 of the future directive must therefore be scrapped.

# D. Conclusion

The Commission coins its reform proposals under the umbrella terms "access and affordability", "availability" and "innovation", all of which are legitimate aims – the devil is, as always, in the detail. The proposed reform of pharmaceutical legislation, while primarily focused on technical aspects, does though recognize the pressing need to revitalise the pharmaceutical framework to ensure its relevance for the next two decades. This Reform

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[54] Gellermann, M. in: Streinz, R. (2018), EUV/AEUV, 3rd Edn., Art. 290 TFEU, para. 38 citing further references. See also Schwind, S. / Stockebrandt, P. / Reichert, G. (2023), European Right to Repair, cep**Input** 10/2023, p. 14.

[55] Similarly see the argumentation in Schwind, S. / Stockebrandt, P. / Reichert, G. (2023), European Right to Repair, cep**Input** 10/2023, p. 14.

[56] See Section C, 1.7.

[57] Additionally, see already the considerations done in Section C, 1.3.

must be seen and evaluated accordingly, while keeping in mind the division of health policy competences between the EU and the Member States, as this places limits on European regulations in certain areas which are the domain of the Member States, like pricing and reimbursement of medicines. Yet, the Reform is crucial not only for safeguarding the health and well-being of European citizens but also for maintaining the EU's competitiveness on the global stage. As geopolitics, industrial policy decisions, vulnerable dependencies on certain raw materials and an ageing society with an increased demand for medicines become more decisive factors, the Reform, moreover, addresses issues of public health security and resilience. It suggests tools to manage shortages of medicines and to ensure the supply of the most critical ones. This is particularly significant for incentivising the development of antibiotics and other antimicrobials, given that the absence of such products poses a substantial risk to societies not only in Europe but worldwide. Generally, the Reform contains good approaches, however, it is also evident that amendments to the Commission proposals are necessary. These must be addressed during the legislative process and are essential to strike a balance between the multifaceted goals at hand. Of the many issues addressed above, 4 key areas stand out: (1) Regulatory Data Protection, (2) Data Exclusivity Voucher, (3) Electronic Packaging Leaflets, and (4) Powers Delegated to the Commission.

**Regulatory Data Protection**

Many factors will influence the EU's long-term success in achieving its goal of being an attractive location for innovation in global competition. These include intellectual property protection as it forms the basis for supporting the development of new medicines and bringing them to the European market. Regulatory data protection ("RDP") is a decisive factor in this regard as it rewards innovative performance.

The Commission proposal foresees a reduction of the basic RDP period from 8 to 6 years combined with a cumulative approach for earning additional years if certain conditions are met. If all the conditions are met, RDP could be extended by 4 additional years. At its core, the Commission Proposal tries here to balance out incentivising innovation, on the one hand, and supporting better availability and affordability of medicines across the EU, on the other.

Even though the idea of the cumulative approach is well-intentioned, it has various practical weaknesses. It tries to address innovation, access, affordability, and availability of medicines simultaneously, but is unable to eliminate the trade-offs. Essentially, the cumulative approach will on average lead to a reduction in RDP. The Commission's intention is to enable earlier market entry of generics and biosimilars to foster the necessary internal competition. This could lead to a decrease in prices and enhance affordability. A general average decrease in RDP may also however lead to less or at least delayed access to innovative medicines and hamper investment in Europe. Such negative impacts should be avoided. Therefore, the basic RDP should be 7 years instead of 6 years as proposed. Furthermore, to be workable and predictable for all stakeholders, the requirements for additional RDP within the cumulative approach, particularly the condition for "continuous supply" in all Member States, must be clarified right away. Only then can such a cumulative approach successfully incentivise the development of urgently needed innovative medicines.

**Data Exclusivity Voucher**

The provision of new and effective antibiotics and other antimicrobials is a key challenge for European and national health policy. The increase in antimicrobial resistance (AMR) is rendering the available antimicrobials ineffective and, at the same time, too few new products are being developed. Those directly affected as well as society at large are thus facing a dire situation. A clear and present danger exists.

The holder of a Data Exclusivity Voucher ("voucher") will be granted 1 year of additional regulatory data protection (RDP) for the development of a new antibiotic or other antimicrobial. That mechanism in itself is not criticized, as it directly rewards innovative work. However, the voucher can also be sold on to another company which will then be able to use the additional RDP for one of its own medicines. This very likely scenario will place a burden on national healthcare systems and patients as, most likely, a "blockbuster" medicine will then be protected by one more year of RDP thereby delaying competition through generics and biosimilars. The costs facing national health systems and patients will be increased monopoly prices for these profitable medicines which will only decrease due to competition at a later stage.

Any incentive system to ensure the development of new antibiotics and other antimicrobials will have drawbacks, as has the transferable voucher. Yet, in the end, its introduction as proposed in the Reform is proportionate. Mainly, because the set requirements for granting a voucher are restrictive enough and the

transfer is limited to a single transfer ("one voucher, one transfer"). Furthermore, the proposed regulations foresee a limitation to 10 vouchers within 15 years after which the incentive system will automatically terminate. It is a crucial advantage of such a voucher, especially in view of the ageing society with an increased demand for medicines, that it can be quickly and relatively easily implemented at EU level compared to alternative incentives systems.

**Electronic Packaging Leaflets**

Initially, it is left to the Member States to decide if the mandatory packaging leaflet for a medicine is provided electronically, in paper format, or both. However, the Reform also includes giving the Commission the power to make electronic-only packing leaflets mandatory via a delegated act 6 years after the Reform enters into force [Art. 63 (5) Directive Proposal].

At first sight, the decision on introducing electronic-only packaging leaflets could simply be regarded as a "technical issue" and a further step towards a needed digitalisation of healthcare. And even though digitalisation is becoming a more integral part of the daily lives of all patients, one cannot neglect the fact that some patient groups and their carers do not yet seem to be properly equipped or prepared for an electronic-only packaging leaflet yet. This creates a difficult situation, especially against the background of a problematic "digital divide" between generations, meaning the unequal access to digital technology, including smartphones, tablets, laptops, and the internet, is unlikely to be overcome in the near future. Even though a right to a free copy is also introduced, the Reform fails to clarify the issue of "who" and "where" and that of the financing of such a service.

Access to the information provided in a packaging leaflet is essential to a patient, and is a public health policy matter. In that regard, the issue should be left to the Member States thus allowing them to decide based on their country-specific situation. Consequently, the power for the Commission to decide upon the introduction of electronic-only packaging leaflets [Art. 63 (5) Directive Proposal] should be removed.

**Powers Delegated to the Commission**

The proposals contain a plethora of delegations of power to the Commission to make important decisions via delegated acts – as already described regarding electronic packaging leaflets. Although the Commission can be empowered to decide on "non-essential elements" of subject matter, the "essential elements" are reserved for the EU legislator, i.e., Parliament and Council. This principle is not just a mere "technicality" as it follows from the principle of democracy, according to which the essential decisions should be taken by the directly democratically legitimised legislator and not by the executive.[58]

Of the different powers delegated to the Commission, Art. 213 of the Directive Proposal particularly stands out. This allows the Commission to change the legal text of Art. 22 of the future directive covering the requirements of an Environmental Risk Assessment (ERA), .

Firstly, this delegation of power is "hidden" in the "Final Provisions" of the Directive Proposal under the heading "Amendment to Annexes". It is not a transparent approach which in itself warrants correction. Secondly, changes to the requirements of an ERA will have far-reaching effects on those addressed by the law. The Commission could act alone in making changes to ERA requirements and it is unclear why the Commission should be empowered to amend the legal text of the directive (secondary EU law) here. All of this goes beyond what is permissible. The corresponding delegation of powers in Art. 213 Directive Proposal must therefore be scrapped.

[58] See also Schwind, S. / Stockebrandt, P. / Reichert, G. (2023), European Right to Repair, cep**Input** 10/2023, p. 14.