TEN YEARS OF THE MEDICINES ACT

The first of September 1981 marked the tenth anniversary of the implementation of licensing under the 1968 Medicines Act. It is appropriate therefore that Drs Griffin & Diggle (1981) have surveyed the experience of the past decade and essential for us to extract any lesson from that experience in order to deal more readily with the problems of drug regulation. The executive power within the Medicines Act machinery has been conferred on the four health ministers who constitute the licensing authority and it is this authority which determines the applications that are submitted to the Committee on Safety of Medicines (CSM), one of several advisory committees set up under Section 4 of the Medicines Act. It is then the function of the CSM to scrutinize the efficacy, quality and safety of new drugs before the granting of a *clinical trial certificate* and prior to the marketing of drugs before the granting of a *product licence*. The licensing authority has, in addition, routinely sought the advice of the CSM on all new chemical entities and on major new indications for use of therapeutic substances.

The recorded data of the past decade show an impressive body of work. There has been a progressive increase in the number of product licence applications of which about 8% have had to be returned as invalid. In 1978 there was 835 applications, rising to 1180 in 1980, although the number referred to the CSM remained constant at about 160 per annum. The latter now probably contain a greater proportion of 'difficult problem' applications since the proportion of applications referred to the CSM which were initially rejected, increased from 28% in 1978 to 65% in 1980, a fact which explains the mounting load of appeals to the CSM since 1980. The grounds for concern involved safety in 76% and efficacy in 69% and quality in only 30% in a survey of 103 applications withdrawn following Section 21(1) letters during the period 1973-77. It must be stated, however, that the great majority of applications not achieving immediate acceptance are finally concluded in favour of the applicant after a written representation and/or hearing. Indeed in the 5 year period between 1973 and 1977 only 27 applications were technically refused by the licensing authority.

In contrast to the position of product licence applications, clinical trial certificate applications have shown a progressive fall in number from 170 in 1972 to 87 in 1980. It has been suggested that the reason for this fall has been, amongst others, the excessive demands for pharmaceutical and toxicological data and the administrative delays prior to acceptance.

Certainly it would seem clear that a significant proportion, some say as much as 60%, of early clinical trials originating within the British pharmaceutical industry have been conducted in continental Europe or in the United States. The data requirements for clinical trials have now been thoroughly reviewed by the Grahame-Smith Working Party and in addition a scheme has been introduced for the pharmaceutical industry allowing them to claim exemption from the need to hold clinical trial certificates subject to certain additional requirements and obligations based on the Grahame-Smith proposals. The effect of these two procedures on the number of clinical trial applications over the next few years will be awaited eagerly. They may well provide a further stimulus to the practice of clinical pharmacology in this country.

Another important and rather sobering fact to emerge from this paper has been the number of new chemical entities reaching the market which currently is about 20 per year—considerably less than the 50 new chemical entities reaching the United Kingdom in the early 1960s. This has mirrored the fall of new chemical entities reaching the world market during the same period. The reasons for this fall must be complex, more complex indeed than the simple correlation with 'stringent licensing requirements', although the growing cost to industry of the latter must in some way affect the finance required for research and development. It will be of considerable interest to see the extent to which the new fields of genetic engineering and improved pharmaceutical delivery systems will influence the number and quality of therapeutic innovations throughout the next decade.

Looking to that future, the CSM must steer a middle course between those who believe that 'drug regulating authorities suffocate all creative action and thinking in a welter of bureaucracy' and on the other hand the pressure groups and individuals who expect the impossible dream of a 100% safety for any new drug. The new requirements relating to clinical trials and the procedure for exemption are each attempts to streamline the ritual surrounding clinical trial certification without weakening the safeguards for patients. Any escalation of drug regulatory controls must be justified in terms of drug safety to the patient and cost effectiveness to the community. The drug regulatory authorities and their advisory committees must be sufficiently informed and flexible to respond to the challenge of the major new scientific advances. There is a growing understanding of the problems associated with drug safety, not just in industry and in

the professions, but also by the community which augurs well for the future.

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Reference

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