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COMMISSION STAFF WORKING DOCUMENT

Subsidiarity Grid

Accompanying the document

**Proposal for a REGULATION OF THE EUROPEAN PARLIAMENT AND OF 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, amending Regulation (EC) No 1394/2007 and Regulation (EU) No 536/2014 and
repealing Regulation (EC) No 726/2004, Regulation (EC) No 141/2000 and Regulation
(EC) No 1901/2006**

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Subsidiarity Grid

- **As proposed by the Committee of the Regions with guidance in blue**
- **Obviously, the answers to the questions below, the explanatory memorandum and – if applicable – the impact assessment should be consistent. This may require some iterations.**
- **Please try to stay under 10 pages.**

1. Can the Union act? What is the legal basis and competence of the Unions' intended action?
1.1 Which article(s) of the Treaty are used to support the legislative proposal or policy initiative?
The proposal is based on Articles 114(1) and 168(4)(c) of the Treaty on the Functioning of the European Union (TFEU).
1.2 Is the Union competence represented by this Treaty article exclusive, shared or supporting in nature?
While the internal market and common safety concerns in public health matters fall within a shared competence of the EU and Member States, once the EU adopts harmonised legislation in such an area, Member States can no longer exercise their own competence. This is the case for the EU pharmaceutical legislation. The proposal respects Member States' exclusive competence in the provision of health services, including pricing and reimbursement policies and decisions as well as the prescription of medicines (cf. Article 168(7) of the TFEU).
2. Subsidiarity Principle: Why should the EU act?
2.1 Does the proposal fulfil the procedural requirements of Protocol No. 2¹:
<ul style="list-style-type: none"> - Has there been a wide consultation before proposing the act? - Is there a detailed statement with qualitative and, where possible, quantitative indicators allowing an appraisal of whether the action can best be achieved at Union level?
<ul style="list-style-type: none"> - To collect all relevant views and engage with stakeholders as much as possible, different consultation methods were combined. DG SANTE consulted with stakeholders via (i) the publication of inception impact assessments for feedback, (ii) two online consultations (one concerning general medicines, the other one targeted at medicines for children and rare diseases), (iii) targeted stakeholder surveys, (iv) interviews, (v) focus groups to discuss some of the main issue of the revision of the provisions relating to medicines for children and rare diseases, (vi) a validation workshop on the impact assessment findings. Summaries of all consultation activities and their outcomes are provided in Annex 2 – Synopsis report of the respective Impact Assessment SWDs. - The explanatory memorandum and the impact assessment SWD (chapter 3) contain a section on the principle of subsidiarity (see also question 2.2 below).

¹ <https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:12016E/PRO/02&from=EN>

2.2 Does the explanatory memorandum (and any impact assessment) accompanying the Commission’s proposal contain an adequate justification regarding the conformity with the principle of subsidiarity?

Common standards of quality, safety and efficacy for the authorisation of medicines constitute a cross-border issue for public health that affects all Member States and thus can effectively be regulated only at EU level. EU action relies also on the single market to achieve a stronger impact as regards access to safe, effective and affordable medicines, as well as the security of supply across the EU. Uncoordinated measures by Member States may result in distortions of competition and barriers to intra-Union trade for products that are relevant for the entire EU, and would also likely increase administrative burden for the pharmaceutical companies which often operate in more than one Member State.

At the same time, the proposed revisions of the pharmaceutical legislation respect Member States’ exclusive competence in the provision of health services, including pricing and reimbursement policies and decisions.

2.3 Based on the answers to the questions below, can the objectives of the proposed action be achieved sufficiently by the Member States acting alone (necessity for EU action)?

While the internal market and common safety concerns in public health matters fall within a shared competence of the EU and Member States, once the EU adopts harmonised legislation in such an area, Member States can no longer exercise their own competence.

As diseases do not know borders, common provisions for the authorisation of medicine are necessary. Uncoordinated measures by Member States could result in distortions of competition and barriers to intra-Union trade for products that are relevant for the entire EU, and would also likely increase administrative burden for the pharmaceutical companies which often operate in more than one Member State. Furthermore, a specific objective of the revisions is to ensure timely patient access in all Member States, including in smaller Member States, which can partially be impacted by the EU pharmaceutical legislation.

1. Are there significant/appreciable transnational/cross-border aspects to the problems being tackled? Have these been quantified?

Diseases do not know borders. Common provisions for the authorisation of medicines constitute a cross-border issue for public health that affects all Member States and thus can effectively be regulated only at EU level, given that the authorisation of medicines is fully harmonised at EU level.

Data collected in the impact assessment SWD have shown that concerning access to medicines no major improvement over the last years have been observed. Indeed, there is a 90% variance between Northern and Western European countries and Southern and Eastern European countries in terms of patient access to new medicines, which also largely corresponds to the launch patterns according to market size and purchasing powers of these countries. The average delay between market authorisation and patient access can vary from as little as 4 months to 29 months.

<p>(a) Would national action or the absence of the EU level action conflict with core objectives of the Treaty² or significantly damage the interests of other Member States?</p>
<p>Uncoordinated measures by Member States could result in distortions of competition and barriers to intra-Union trade for products that are relevant for the entire EU, and would also likely increase administrative burden for the pharmaceutical companies which often operate in more than one Member State. Furthermore, the proposed revision of the EU pharmaceutical legislation should guarantee a high level of public health by ensuring the quality, safety and efficacy of medicines for EU patients. The proposal is based on Articles 114(1) and 168(4)(c) of the Treaty on the Functioning of the European Union (TFEU).</p>
<p>(b) To what extent do Member States have the ability or possibility to enact appropriate measures?</p>
<p>The proposed revision of the pharmaceutical legislation respects Member States' exclusive competence in the provision of health services, including pricing and reimbursement policies and decisions.</p>
<p>(c) How does the problem and its causes (e.g. negative externalities, spill-over effects) vary across the national, regional and local levels of the EU?</p>
<p>The problem and its causes are similar in all Member States as most of the provisions in the pharmaceutical field are harmonised since long time. However, concerning access <u>to medicines across the EU</u> the situation varies between the Member States. The number of authorised medicines in the EU has increased over time: 1 160 centrally authorised medicines (CAPs) were authorised in the period 2005-2020 and more than 17 000 medicines, primarily generic medicines, were authorised through mutual recognition and decentralised procedures in the same period. However, patient access to medicines varies considerably across the EU. The number of EU countries in which CAPs are launched has been steadily decreasing. Evidence shows that, whilst in Germany 133 out of 152 (i.e. 88%) new medicines authorised between 2016 and 2019 at EU level were accessible to patients, small Member States such as the Baltic Member States or Member States with comparatively low prices or with low GDP, like Romania, had fewer than 50 of these available. The time to patient access is also significantly longer for most of these latter countries, e.g. approximately two years or more after marketing authorisation in Romania compared to four months in Germany.</p>
<p>(d) Is the problem widespread across the EU or limited to a few Member States?</p>
<p>The problem is affecting all Member States</p>
<p>(e) Are Member States overstretched in achieving the objectives of the planned measure?</p>
<p>Some specific expertise, for example on innovative products or novel technologies, might not be easily available in all Member States, therefore the necessity to bring simplification and efficiency in the current legislative. The same is true concerning digital interoperability; expertise and infrastructure which are not sufficiently available across the Member States and the EU regulatory network.</p>
<p>(f) How do the views/preferred courses of action of national, regional and local authorities differ across the EU?</p>

² https://europa.eu/european-union/about-eu/eu-in-brief_en

<p>Pharmaceutical legislation is implemented at national level in the Member States. There is an overall consensus among competent authorities – as confirmed in the context of the various above-mentioned consultation activities - on the necessity to streamline and simplify and make the current legislative framework future-proof.</p>
<p>2.4 Based on the answer to the questions below, can the objectives of the proposed action be better achieved at Union level by reason of scale or effects of that action (EU added value)?</p>
<p>Common standards of quality, safety and efficacy for the authorisation of medicines constitute a cross-border issue for public health that affects all Member States and thus can effectively be regulated only at EU level. Furthermore, provisions at European scale reduce burden amongst others for companies and preserve the single market. There will also be benefits for national authorities (streamlining of procedures and simplification will enhance efficiencies at all levels, for instance).</p>
<p>(a) Are there clear benefits from EU level action?</p>
<p>Common standards of quality, safety and efficacy for the authorisation of medicines constitute a cross-border issue for public health that affects all Member States and thus can effectively be regulated only at EU level. EU action relies also on the single market to achieve a stronger impact as regards access to safe, effective and affordable medicines, as well as the security of supply across the EU. For example, a harmonised approach at EU level also provides greater potential for incentives to support innovation and for concerted action for development of medicines in areas of unmet needs.</p>
<p>(b) Are there economies of scale? Can the objectives be met more efficiently at EU level (larger benefits per unit cost)? Will the functioning of the internal market be improved?</p>
<p>Having provisions at European level reduces the administrative burden and preserve the single market for pharmaceutical companies which often operate in more than one Member State ensuring a strongly positive environment for the pharmaceutical industry to continue to develop its cutting-edge products within the EU. The revision will also aim at improving the affordability of medicinal products benefiting national health systems. A simplified and better integrated regulatory system will benefit national regulators.</p>
<p>(c) What are the benefits in replacing different national policies and rules with a more homogenous policy approach?</p>
<p>The sector is already completely harmonised since many years. The first legislation in the area of medicines was adopted in 1965.</p>
<p>(d) Do the benefits of EU-level action outweigh the loss of competence of the Member States and the local and regional authorities (beyond the costs and benefits of acting at national, regional and local levels)?</p>
<p>The proposal will not impact the existing national competencies with regard to Member States' exclusive competencies in the provision of health services, including pricing and reimbursement policies and decisions.</p>
<p>(e) Will there be improved legal clarity for those having to implement the legislation?</p>
<p>Yes, the proposed, revised legal framework will clarify definitions, introduce classification mechanisms as well as further streamlining and simplification. This will reduce administrative</p>

burden for companies and authorities and hence improve efficiency and attractiveness of the EU system.

3. Proportionality: How the EU should act

3.1 Does the explanatory memorandum (and any impact assessment) accompanying the Commission's proposal contain an adequate justification regarding the proportionality of the proposal and a statement allowing appraisal of the compliance of the proposal with the principle of proportionality?

The initiative does not go beyond what is necessary to achieve the objectives of the revision. It does so in a way that is conducive to national action, which would otherwise not be sufficient to achieve those objectives in a satisfactory way.

The principle of proportionality has been reflected in the comparison of different options evaluated in the impact assessment. For example, trade-offs are inherent between the objective of innovation (promoting the development of new medicines) and the objective of affordability (which is often achieved by generic/biosimilar competition). The revision maintains the incentives as a key element for innovation, but they are adapted to better encourage and reward product development in areas of unmet medical needs and to better address timely patient access to medicines in all Member States. The explanatory memorandum reflects the above considerations.

3.2 Based on the answers to the questions below and information available from any impact assessment, the explanatory memorandum or other sources, is the proposed action an appropriate way to achieve the intended objectives?

The initiative does not go beyond what is necessary to achieve the objectives of the revision and is appropriate to achieve them. The choice of the legal instrument is justified and as simple as possible and coherent. The proposal does not modify the current repartition of competences.

(a) Is the initiative limited to those aspects that Member States cannot achieve satisfactorily on their own, and where the Union can do better?

The proposed Regulation introduces a large number of amendments to Regulation (EC) No 726/2004. It also incorporates part of the current provisions and amendments to Regulation (EC) 1901/2006 on medicines for children, as well as current provisions and amendments to Regulation 141/2000/EC on medicines for rare disease. A new Regulation (rather than an amending Regulation) is therefore considered the appropriate legal instrument as it will bring more legal clarity.

(b) Does the Union action leave as much scope for national decision as possible while achieving satisfactorily the objectives set? (e.g. is it possible to limit the European action to minimum standards or use a less stringent policy instrument or approach?)

The proposal does not modify the repartition of competencies between the Union and the Member States compared to today.

(c) Does the initiative create financial or administrative cost for the Union, national governments, regional or local authorities, economic operators or citizens? Are these costs commensurate with the objective to be achieved?

For **health systems**, public health budgets would also benefit from the modulated incentive scheme

since more EU citizens will have access to treatments, which results in savings due to more effective treatment and reduced hospitalisations. They will also benefit from stronger competition and transparency measures around public funding for clinical trials. There would be additional societal benefits for families and carers too, in terms of both quality of life / independence and earning potential. Overall, the new incentives will come with costs for healthcare budgets but the public health benefits should outweigh those.

For **regulators**, the effects of the proposed changes would be overall positive especially due to various horizontal measures, which will allow to better coordinate, simplify and accelerate regulatory processes to the benefit of industry and launch new digitalisation programmes to improve the integration and efficiency of the regulatory system overall (as well as its interfaces with other regulatory systems).

Budgetary implications for the Union budget are mainly related to additional tasks to be carried out by the European Medicines Agency in terms of providing scientific, administrative and IT support in the following main areas:

- Enhanced pre-authorisation scientific and regulatory support
- Decision-making on orphan designations and management of Union Register on designations of orphan medicines
- Active substance master file assessment and certification
- Inspection capacities in third countries and support to Member States
- Environmental Risk Assessment
- Shortage management and security of supply

(d) While respecting the Union law, have special circumstances applying in individual Member States been taken into account?

Special circumstances linked to certain Member States have been taken into account in the proposal for a Directive, linked to this proposal.