

Life Sciences Update

December 2009

A periodical update on legal and regulatory developments in the life sciences sector

In this edition, we have reported on a range of recent developments, at EU and national level, relating to pharmaceutical patent litigation, regulatory updates and recent industry news. We hope you enjoy reading this update and are happy to address any comments or questions you may have, either through your usual contact or through any of the contacts on the back page of this update.

International Life Sciences Group

Patent & SPC articles

EU: Patent settlements under the authorities' magnifying glass

Drug prices are currently a key area of discussion in many countries around the globe. Agreements that limit price competition in the pharmaceutical sector can have severe adverse effects on public health and national budgets. Given the current political debate in the United States on healthcare reform and the downward pressure on healthcare budgets in general, competition authorities are scrutinising any kind of agreement that would limit price competition (for example, by delaying entry of generic competition).

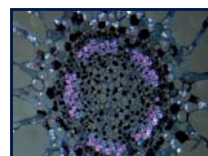
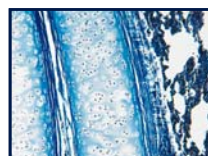
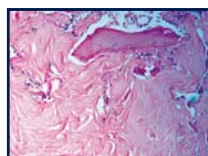
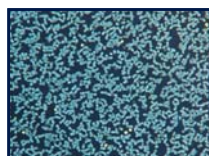
In its final report on the Pharmaceutical Sector Inquiry, delivered last July, the European Commission underlined its concerns regarding patent settlement agreements between originator and generic companies. According to the report, about half of the 207 assessed settlement agreements limited the generic companies' ability to market their products.

Since then, the first competition cases against originator and generic firms have been opened¹. In addition, it has been reported that the Commission is currently contemplating requesting copies of all the patent settlement agreements of pharmaceutical companies entered into between July 2008 and December 2009 in order to review their legality.

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¹ Case COMP/39612 – Servier (perindopril).



On the other side of the Atlantic, patent settlements have also come to the attention of the US antitrust authorities who have stated as their enforcement priority those agreements aimed at delaying the entry of generic drugs onto the market. The recent *Solvay* and *Cephalon* cases brought by the FTC before American courts confirm this trend. Political support for such enforcement is now emerging strongly, with draft legislation being introduced in the US Congress to establish a rebuttable presumption of illegality of patent settlements which include any value transfers to the generic company involved. This has limited exceptions, such as authorisation to market the product or sums to cover litigation expenses.

Since the European Commission has not yet provided clear criteria on how it will evaluate patent settlement agreements, the development of US legislation is no doubt of great interest in assessing the different options for antitrust enforcement.

Given this current trend on both sides of the Atlantic, any life sciences company potentially involved in patent settlement agreements should assess the legality of past agreements and the drafting future agreements with utmost care.

Jose Rivas, Brussels

UK: Recent judgments from the English Court on obviousness

Leo v Sandoz

On 17 November 2009, the Court of Appeal handed down its judgment in *Leo Pharma v Sandoz*². The case was an appeal by Sandoz against Floyd J's judgment of 15 May 2009 (the first instance decision was reported in the July edition of the *Life Sciences Update*). The only issue in the appeal was the validity of Leo Pharma's European Patent (UK) No. 0 697 154.

The Court of Appeal referred to the principles applicable to an appeal and in particular the so-called *Biogen* principle³. The principle relates to issues which involve mixed findings of fact and law and states that it can be shown that a judge has made an error if he reached a conclusion without taking into account all the relevant evidence, both technical and non-technical. As a result, this appeal was characterised as one based on perversity i.e., the judgment was one which no judge could reasonably have reached on the evidence before the court.

The 154 Patent itself was directed to a single crystalline chemical entity namely calcipotriol monohydrate (which was said to have superior stability and technical properties useful in the manufacture of suspension formulations). Calcipotriol and the process for making it had been disclosed in a much earlier Leo Pharma

patent as well as in a paper by Calverley. In the Calverley paper, the internal designation MC903 had been used to refer to the anhydrous form of crystalline calcipotriol. The cited prior art relied upon by Sandoz (referred to as the acne use patent) contained six examples, four of which used MC903. Three of the examples concerned recipes for making creams and the fourth concerned a milling process.

The Court of Appeal agreed with Floyd J that on the evidence it was not established that by employing the milling example the monohydrate would inevitably follow. The Court stated that the appeal against the finding of lack of anticipation over the milling example in the acne use patent was hopeless and should have never have been advanced.

The appeal against the finding of non-obviousness was based on four different approaches:

- Obviousness over the acne use patent because it was obvious to conduct a full polymorph screen, during which the monohydrate and its properties would have been discovered;
- Obviousness over the acne use patent because a product screen would have revealed the monohydrate and its technical properties;
- Obviousness over the acne use patent because wet milling instead of dry milling would have produced the monohydrate and its technical properties would have then been revealed;

² *Leo Pharma A/S, Leo Laboratories Limited v Sandoz* [2009] EWCA Civ 1188 17 November 2009

³ [1997] RPC 1 at p.45 per Lord Hoffman

- Obviousness in the light of common general knowledge alone because experiments into crystallisation would have revealed the monohydrate and its technical properties.

The obviousness case was considered by the Court to be unusual. Sandoz argued that the skilled person would, using his technical knowledge, have come across the invention (namely the hydrate and its beneficial technical properties) without any expectation of successfully finding a better product.

The Court of Appeal considered the evidence in relation to each of the four obviousness attacks and held in each case that Floyd J had taken all the relevant factors into account, had weighed them up carefully and had come to a conclusion which could not be faulted.

For example, once Floyd J had found it was not universal practice to conduct a polymorph screen and that a skilled team would not regard such a screen as mandatory, he was correct to find it was not obvious to use the screen and so find the hydrate. Again, although the wet-milling was accepted at first instance to be an obvious variant to dry milling, as the hydrate would only have been produced 50% of the time, Floyd J was correct to conclude that it did not make the hydrate obvious.

Teva v Merck

In a judgment handed down by Floyd J on Friday 20 November 2009⁴, Teva succeeded in invalidating at first instance a

patent owned by Merck concerning a co-formulation for the treatment of glaucoma on the basis of obviousness.

In his judgment, Floyd J reviewed the law of obviousness in light of the House of Lords judgment in *Conor v Angiotech*. He then went on to apply the law to the facts in the case which were somewhat unusual in that the only clinical example of the use of the combination in the patent in suit was effectively the same as the single piece of prior art being cited in support of the obviousness case. The cited prior art was in fact an abstract of a paper to be presented at a conference after the priority date of the patent but published in the conference papers shortly before the priority date. In both cases, the use was of co-administration of the two actives rather than administration of a co-formulation of the two actives.

Although the abstract referred to one of the two actives by reference to an internal code, the judge held that there was no invention in ascertaining the identity of that active at the relevant time.

On the basis of his detailed findings on the state of the common general knowledge, the Floyd J concluded first that on the basis of the information contained in the abstract, it would have been "startlingly" obvious to the skilled team at the relevant time to have considered co-formulating the two actives and further, that it would have been obvious for the skilled team to have proceeded to co-formulate the two actives and then to have tested the co-formulation first pre-clinically on animals and then clinically on humans. He

dismissed various arguments raised by the patentee as to the difficulties which would have been faced by the skilled team in both co-formulating the two actives and also carrying out the pre-clinical and clinical trials.

It was held that had the patent not been invalid for obviousness, it would regardless have been invalid for insufficiency on the basis that the patent contained no more information about the co-formulation than the abstract had done.

It was also held that an amendment to an independent process claim, so as to narrow the pH range of the co-formulation, was not permitted because it added matter to the application. In any event, Floyd J's finding of obviousness applied to the amended claim as well as the unamended claim, it being obvious to co-formulate the two actives at a pH within both the wider and the narrower pH ranges.

As Floyd J noted in his judgment at paragraph 98: *"One must proceed with caution when faced with an obviousness attack based on a suggestion that the skilled person would embark on a research program in the course of which he would discover that a product or compound was effective. This is particularly so where the technical effect is one which is newly discovered, or impossible or very hard to predict. That is because the expectation of success may be zero, or inadequate to drive the research forward. In the end it will all depend on weighing the various factors as they appear from the evidence in the case"*.

⁴ *Teva UK Ltd v Merck & Co. Inc* [2009] EWHC 2952 (Pat)

On the basis of the particular piece of cited prior art, coupled with the evidence adduced by the parties through their experts at the trial, it was held that the expectation of being able to successfully co-formulate the two actives and test the co-formulation pre-clinically and clinically was sufficiently high to lead to a finding of obviousness. The judgment demonstrates however how difficult this task remains in most cases.

Conclusions

The Court of Appeal judgment in *Leo Pharma v Sandoz* re-iterates the difficulty of overturning on appeal a first instance finding on the issue of obviousness. The recent judgment of Floyd J in *Teva v Merck* provides an excellent illustration of how the courts now assess "obvious to try" attacks on inventive step in the light of *Conor v Angiotech*.

Neil Jenkins & Mary Smillie, London

UK: Court of Appeal refers further questions on the interpretation of the SPC Regulation to the ECJ

On 10 May 2009, the High Court handed down its judgment in *Generics (UK) Limited v Synaptech Inc*⁵ holding that the "first authorisation to place the product on the market in the Community" in Article 13 of the EC Council Regulation 1768/92 (the "SPC Regulation") referred only to marketing authorisations granted in accordance with Directive 65/65/EEC.

Synaptech obtained European Patent EP (UK) 0 236 684 protecting galantamine for the treatment of Alzheimer's disease, which expired on 16 January 2007. Synaptech applied for, and was granted, an SPC for this product in the UK which is due to expire on 15 January 2012. In its application for this SPC, Synaptech cited the Swedish marketing authorisation granted in 2000 (and not the earlier Austrian or German authorisations) as the first authorisation to place the product on the market in the Community within the meaning of Article 13 of the Regulation. Accordingly, the SPC was granted with the maximum term of five years.

On 16 October 2009, the Court of Appeal decided to refer questions to the ECJ which to a degree overlap with those referred earlier in 2009 by the English High Court in *Synthon v Merz* in a similar case concerning memantine (Case C-195/09). The Court of Appeal has requested that these cases be joined.

Mary Smillie, London

France: Preliminary injunctions in the case of an imminent infringement

On 20 October 2009, the Lyon Court of Appeal upheld a decision of the President of the First Instance Court, and became the first jurisdiction in France to elaborate an exhaustive reasoning with regards to one of the new provisions of Law n°2007-1544 of 29 October 2007 on the "*Fight against Infringement*".

This provision (new article L.615-3 of the French Intellectual Property Code) gives the patentee the possibility of requesting that the judge in charge of summary proceedings order preliminary measures to prevent an imminent infringement if it is likely that the patentee's rights are about to be infringed. Previously the Court could only forbid the continuation of the infringing acts.

In this case, the pharmaceutical company Grünenthal, the exclusive licensee of a patent covering a controlled release formulation of Tramadol (an analgesic) owned by Mundipharma, asked the judge of the summary proceedings to order preliminary measures against Mylan. Mylan had obtained a marketing authorisation for an "essentially similar" generic drug Tramadol Merck which was about to be launched on the French market and which fell within the scope of protection of Grünenthal's patent.

The marketing authorisation mentioned the manufacturers of the generic drug: Medochemie (a Cypriot company) and FAL (a Dutch company).

The difficulty for Grünenthal was to demonstrate the "imminent infringement" in the absence of any infringing product actually on the French market. Another difficulty lay in convincing the judge not to act as if ruling on the merits as regards the validity of the patent. This was strongly disputed by Mylan.

The Court provided a solution which is to a great extent favourable to the patentee: it firstly refused to make an "*in depth and critical analysis of the validity*" of the patent at stake, which is the role of the judge ruling on the merits.

⁵ ([2009] EWJC 659 (Ch))

The judge merely verified that the invoked rights indeed existed, presuming that the patent granted by the EPO was valid and considered that the arguments raised by Mylan with regard to the alleged invalidity of the patent could not lead to the refusal of the request for a preliminary injunction.

Rather, the judge focused on gathering evidence to demonstrate the imminence of infringement. Demonstration of the imminence of the infringement was done in two stages:

1. To evidence the infringement itself, Mundipharma and Grünenthal seized other generic products, manufactured by Medochemie and FAL, and sold by other generic companies in three other European countries (Sweden, Czech Republic, Austria). Mundipharma and Grünenthal had conducted technical reports on these generic products which demonstrated that they did fall within the patent.

Grünenthal argued that there was no reason to believe that Medochemie and FAL would manufacture a different product for the French market and that it was likely that the product launched in France would be identical and therefore infringing.

The defendants only argued on the insufficiency of evidence of the infringement, stating that the analysis which had been made regarding the other generic products had not been a process in which both parties were heard. Yet Mylan did not really contest the fact that the generic product about to be launched in France would be identical to these products, nor that the generic products already sold in the other European countries fell within the

scope of the patent. For these reasons, the judge ruled that it was likely that the launching of the product on the French market would infringe the patent.

2. Next, the difficulty was to demonstrate the "imminence" of the infringement.

Having noted that the mere fact of obtaining a market authorisation is not sufficient to constitute a willingness to immediately place the drug for sale on the market (and therefore before expiry of the patent), the judge identified positive acts carried out by Mylan from which it was possible to deduce the imminent launch of the product :

- the fact that Tramadol Merck was manufactured by Medochemie and FAL who were already the manufacturers of the other generics being sold in different European countries and falling within the patent;
- the advertisement placed in trade publications by Mylan in January 2008, announcing the availability of the drug from February 2008; and
- a letter sent by Mylan to the French Economic Committee of Health Products in charge of setting the price of drugs, in which Mylan confirmed its intention to launch the product "as soon as the price is fixed".

From all these observations, the judge concluded that infringement was imminent and added that the launch of this generic drug would cause serious harm to Mundipharma and Grünenthal and that the preliminary injunction appeared to be an appropriate and proportionate measure.

This decision is very important since it was the first time that a French judge has ordered a preliminary measure in a case of imminent infringement. It is also remarkable considering that it remains very difficult to obtain preliminary injunctions in patent cases in France (either on imminent or actual infringements). In particular, the Paris Court continues to make an in-depth analysis of both the validity of the patent and the infringement, which often leads to the refusal of the preliminary injunction in patent cases.

This decision was probably one of the last decisions of the Lyon Court in patent cases as the Paris Court now has exclusive jurisdiction over patent litigation (Decree of 9 October 2009). It is hoped that the Paris Court will strike a balance between the two interpretations and be more favourable to the patentee by refusing to act as a judge ruling solely on the merits.

Yves Bizollon & Pauline Debre, Paris

Regulatory

State of play for cells and tissues and Advanced Therapies in Belgium

On 30 December 2008, the European Regulation on Advanced Therapy Medicinal Products ("Regulation 1394/2007" or "ATMP Regulation") came into force. Like any other European Regulation, it has direct effect in all its provisions, and does not require any implementing measure in order to be enforced in the Member States. Since 30 December, any new ATMP has to comply with the provisions of Regulation 1394/2007.

The first ATMP to be authorised is the ChondroCelect, developed by the Belgian company TiGenix. It was authorised by a Commission decision of 5 October 2009.

The ATMP Regulation is part of a legal framework which encompasses the regulatory provisions applicable to cells and tissues. As a matter of fact, Regulation 1394/2007 provides that the donation, procurement and testing of those cells or tissues have to be made in accordance with Directive 2004/23/EC of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells (hereafter, "Directive 2004/23"). Directive 2004/23 provides that those operations have to be performed in so-called "tissue establishments".

Therefore, the implementation of Directive 2004/23 in the Member States was crucial

for the actors of the pharmaceutical industry that intend to develop ATMP. In Belgium, the implementation process of Directive 2004/23 is now close to completion. It is the purpose of the present contribution to provide a general overview of the new Belgian legislation applicable to cells and tissues, which (partially – see below) entered into force on 1 December 2009. It does not examine the other aspects of the legislation on ATMPs, which are laid down in the pharmaceutical legislation, more specifically in the ATMP Regulation. The precise focus of this text is the implementation of Directive 2004/23 in Belgium, and its implications on the manufacturing of ATMPs.

The law of 19 December 2008

The first parliamentary discussions on the implementation of Directive 2004/23 date back to 2006. The legislative process resulted in the adoption in Belgium of the law of 19 December 2008 on the procurement and use of human corporal material intended for medical human applications or for scientific research (hereafter LHCM).

Its scope is broader than the scope of Directive 2004/23. First of all, the LHCM is intended to apply to scientific research, be there a human application or not in the framework of that research. Whereas Directive 2004/23 only applies to the cells or tissues intended for human applications, and scientific research without human application thus falls outside the scope of Directive 2004/23.

Secondly, as far as ATMPs are concerned, the LHCM does not limit its scope to the donation, procurement and testing of the human corporal material intended for the

manufacturing of such products. It is, in principle, applicable to all operations carried out on human corporal material intended for the industrial manufacturing of ATMPs. However, a specific regime is provided for autologous ATMPs, for which the standards of quality and safety are only applicable to the donation, procurement and testing phases, the other operations being solely subject to the standards applicable to ATMPs, as defined in the pharmaceutical legislation. For allogeneic ATMPs, the standards of quality and safety apply throughout the whole manufacturing process, in addition to the standards defined in the pharmaceutical legislation. This differentiation made by the Belgian legislator between autologous and allogeneic ATMPs, which does not exist in the European legislation, creates an overlap between the quality and safety requirements resulting from the legislation on cells and tissues and the pharmaceutical legislation respectively.

The LHCM makes a distinction between four types of structures: the *banks for human corporal material* ("BCM"), the *intermediary structures* ("IS"), the *production establishments* ("PE") and the *biobanks*. The BCM must be operated by hospitals and can be accredited to perform any operation with the human corporal material. The IS may be accredited for the processing, preservation, storage and distribution of human corporal material, but they have to conclude an agreement with a BCM in order to do so. The PE can be accredited to perform any operation (testing excepted) without the consent of a bank, as far as the human corporal material is intended for the industrial manufacturing of autologous ATMPs. Finally, the biobanks are structures

accredited to store human corporal material and make it available, exclusively for scientific research purposes provided it is not intended for any human application.

The LHCM organises different regimes, depending whether the human corporal material is intended for the manufacturing of ATMPs or not. If it is intended for the manufacturing of ATMPs, a distinction must be made between the autologous ATMPs and the allogeneic ATMPs.

Allogeneic ATMPs may only be produced in a BCM or an IS that concluded an agreement with a BCM. The autologous ATMPs may only be produced in a PE. In this case, the human corporal material may be transferred directly from the place where it has been collected to the PE, without having to transit through a BCM. In all other hypotheses, the human corporal material has to transit through a BCM.

The system organised by the LHCM is rather complex. Moreover, not less than six Royal Decrees implementing its provisions have been published in the Belgian Official Gazette so far. Those Royal Decrees relate to the general requirements applicable to BCM, IS and PE, to the quality and safety standards for the operations performed on human corporal material, to the hospital standards, to the notification of serious adverse reactions and events, and to the specific regime that is applicable to reproductive cells. The LHCM and the first Royal Decrees entered into force on 1 December 2009.

The Federal Agency for Medicines and Health Products is in charge of the surveillance of the compliance of the activities carried out with cells and tissues.

Aside from the implementation measures cited above, other decrees are worth mentioning here, notably the Royal Decree of 7 December 2008 on the conditions applicable to the intervention of the mandatory healthcare insurance in the costs of delivery of human tissues and establishing the list of those tissues, as well as the Ministerial Decree of 14 October 2009 determining the price of human corporal material.

A seventh Royal Decree, defining the specific regime applicable to biobanks, should be published shortly. It is currently under review by the legislation division of the Council of State. When the regime specific to biobanks will enter into force is not yet known with certainty. However, it can already be stated that this regime will provide for an accreditation procedure which will require a favourable opinion of an ethics committee. Once the accreditation is granted, no additional opinion of the ethics committee will be required in the course of the biobank's activities, as long as those activities fall into the scope of the accreditation itself.

It is crucial for the healthcare biotechnology sector to follow the implementation process closely, as critical aspects of their activities fall into the scope of the new legal framework.

**Marc Martens & Nicolas Carbonnelle,
Brussels**

Directive 2001/83: proposal creating legal framework for provision of information from the pharmaceutical industry

Recently, the biggest consumer association in The Netherlands offered a widely supported petition to the Dutch Minister of Health, requesting a ban on disease awareness or symptom awareness advertisements.

Currently, advertising 'prescription only' medicinal products is subject to the rules set out in Title VIII of Directive 2001/83. However, dissemination of information relating to human health or diseases without reference to medicinal products is excluded from the ban on advertisement, and is therefore not subject to EU rules.

There can be little doubt that it is in the overall interest of patients and consumers that objective and reliable information on medicines is available. In this context it is important to realise that patient representation groups, hospitals and healthcare providers or other parties benefit from this exclusion to communicate about healthcare and diseases for educational or counselling purposes outside of a treatment relationship. Also, a complete prohibition as suggested in The Netherlands would be against the fundamental principle of freedom of speech. All in all there seems to be no reasonable justification to exclude

the provision of objective and unbiased information on medicinal products to consumers, regardless of the source of information. However, the ECJ recently decided⁶ that dissemination of information about a specific medicinal product by an independent third party may be regarded as advertising even when the third party is acting on his own initiative.

Due to a lack of description as to what constitutes information as opposed to unlawful advertisement, divergent interpretations exist throughout the Member States of the EU. The mere fact that information about diseases is being communicated by the pharmaceutical industry should, as such not make such information promotional of character. However in some Member States that is the overall assumption. In other Member States the content of information provided is determinative.

From the *"Report on current practices with regard to the provision of information to patients on medicinal products"* it has become clear that restrictions on what information can be available and by which sources varies greatly among the EU Member States. The European Commission considers access to reliable information on medicines important as it will help EU consumers to make more informed decisions whilst being protected against hidden advertisement.

As part of the "pharmaceutical package" a proposal for the amendment of Title VIII was issued. Whilst maintaining prohibition of direct to consumer advertising the proposal seeks to achieve the following aims:

- to lay down clear rules on information provided by pharmaceutical companies
- to ensure a high level of quality, objective, reliable and non promotional character of information
- ensuring (and limiting) the use of appropriate distribution channels
- ensuring compliance by pre and post monitoring and enforcement measures.

Important changes allowing far wider possibilities for marketing authorisation holders to communicate about their products include:

- Information that presents the medicinal product in the context of the condition to be prevented or treated will be allowed;
- Information may not be distributed via (web) television or radio;
- The information shall not include comparisons between medicinal products;
- The source of information must be revealed as well as statements indicating the prescription-only status and that the information is not intended to replace healthcare contact;
- Initiating direct consumer contact is not allowed. However providing written answers to unsolicited questions is permitted. Notably, information must include contact details allowing consumers to send comments to marketing authorisation holders. Maybe, this route of contact also provides a platform for wider direct communication with consumers; and
- Content is subject to prior approval by national competent bodies, which

control may also be executed on the basis of self regulation by self regulatory bodies. Further, internet websites are subject to approval by the national competent authorities where the website is registered. The principle of mutual recognition applies insofar as translated information disseminated in other countries is the same as the approved information.

It is likely that this proposal will be further discussed in the first quarter of 2010.

Machteld Hiemstra, The Hague

Spain: New regulations for medical devices

On 6 November 2009, two new regulations reshaping the framework for medical devices were published in the Spanish Official Gazette. Royal Decree 1591/2009, on Medical Devices, and Royal Decree 1616/2009 on Active Implantable Medical Devices are the result of the implementation of European provisions (including amendments made by Directive 2007/47/EC to Directive 93/42/EC on Medical Devices) as well as adaptation to national Law 29/2006 on Medicines. These new regulations will come into force from 21 March 2010. Until then, authorisation, certification and notification proceedings will continue to be carried out according to Royal Decree 414/1996 (the regulation to be repealed by the new regulations).

The medical devices sector is becoming particularly important in Spain, with more

⁶ C-421/07, 2 April 2009

than 12,000 operative companies, 30,000 working professionals and a turnover breaking the €6,000 million barrier (8.6 % of European market share). Following these considerations, the new regulation recently passed by the Spanish government pursues several objectives: to implement European legislation; to consolidate rules together within one updated text so as to make compliance easier; and to move towards electronic management procedures thereby reducing administrative burdens for businesses and individuals. But, despite these formal broad statements, it must be remembered that EU legislation leaves little room for Member States to adopt specific rules on medical devices. Accordingly, the regulation laid down by the Spanish government is far from completely new. Indeed, there are no further additions over and above the MD Directive on important issues such as the medical devices essential requirements, classification rules, CE marking procedures and development of medical device surveillance systems.

On the other hand, there are other areas in which the regulations have introduced new aspects:

- The authorisation procedure for carrying out clinical research using medical devices has been redeveloped. This procedure is quite similar to that for clinical research with medicinal products and is to be followed by the Spanish Medicines Agency, the relevant Ethics Committee and, where necessary, by the regional health authorities.
- Individuals or companies established in Spain must obtain from the Spanish Medicines Agency an operating license covering activities as well as facilities.

Once granted, the license may be denied, suspended or revoked if, upon assessment of documentation provided or inspection reports, there is no assurance that the company has suitable means, facilities, procedures or professionals for the proper development of its activity, or if the conditions in which the license was granted no longer exist.

- Individuals or companies also have reporting obligations to be carried out before the Spanish Medicines Agency or regional health authorities. This is the case when the individual or company starts its activity for the first time on Spanish territory (in which case, formal notice should be issued to the relevant regional health authority); or whenever a medical device is released for the first time onto the Spanish market (the same individual or company issuing a communication to the Spanish Medicines Agency at the time of the effective release). Finally, together with other cooperation/information/traceability duties to authorities, there are also other important reporting obligations to be complied with concerning medical devices surveillance systems, as well as precautionary measures to be taken directly by the individual or company involved. The information must be addressed in Spanish to the Medicines Agency and, where necessary, to the Regional Health authorities as soon as possible.
- Other Spanish particularities further to the Medical Devices Directive concern payment of expenditures resulting from non-conformity authorities checking (whenever this check requires carrying

out any assessment or clinical trial of the device or its technical documentation); adoption of market restriction measures whenever a health risk is detected (market device withdrawal; retrieving from wholesalers or directly from buyers; devices tracking; etc.); identification upon the Medicines Agency's request for providers of devices, or wholesalers to whom devices have been sold (this obligation must be upheld for at least five years); distributors must ensure that the device has the CE marking and the device comes with the legal information and any other user information that is legally required. For active implantable medical devices, an 'Implantation Card' is required, including any relevant detail concerning the device itself as well as the applicable surgery it is to be used for.

Notwithstanding the above, perhaps the most important aspect concerns the distribution, retailing and advertising, and in particular remote retailing and advertising of certain self-testing devices. As a general principle arising from Law 29/2006 on Medicines, remote retailing (either by post or by phone) is not permitted for medical devices subject to doctor's prescriptions. If a product can be deemed as a self-testing device (within the meaning of Directive 98/79/EC: "*Any device intended by the manufacturer to be used by lay persons in a home environment*"), then remote retailing would not be permitted at all, except for those devices designed to test pregnancy, fertility and to determine glycemic levels. These same considerations apply with respect to advertising and promotion of *self-testing* devices. In this respect, article

25.8 of Royal Decree 1662/2000 on Medical Devices for in Vitro Diagnosis (implementing EC Directive 98/79), as amended by 2nd Final Provision of RD 1591/2009, declares that *"Advertising and promotion of self-testing devices addressed to general public is hereby prohibited, except for those products concerned with pregnancy and fertility diagnosis. It is also prohibited to advertise genetic diagnosis medical devices"*.

Raquel Ballesteros Pomar, Madrid

Italy: Insurance policies for clinical trials

On 14 September 2009, the Decree of the Ministry of Labour, Health and Social Policy of 14 of July 2009 - ("Decree") was published in the Italian Official Journal ("Gazzetta Ufficiale"). The Decree, awaited for over six years⁷, sets out a number of requirements for insurance policies relating to clinical trials to be conducted, wholly or in part in Italy. It also provides for severe sanctions in case of non compliance.

The Decree can essentially be summarised as follows.

Scope of the Decree

The Decree applies to interventional and non-profit⁸ clinical trials ("CTs"). Non-

interventional (observational) clinical trials are expressly excluded (see article 4 of the Decree).

The certificate of insurance

Sponsors of CTs ("Sponsors"), in addition to the documents already required by law, should submit to the relevant competent ethics committee ("EC") a specific insurance policy certificate ("Certificate").

The Certificate, which should be based on the relevant insurance policy, should comply, in particular, with the following requirements: it should be drafted in Italian; signed by the relevant insurance company; include reference to the CT concerned; include the essential elements referred to in the template attached to the Decree (i.e. the maximum coverage, the duration, the franchise (none permitted), exclusions from coverage).

The insurance policy

The insurance policy concluded by Sponsors (hereinafter, the "Insurance Policy") should comply with the following requirements:

Type of liability

The Insurance Policy should cover civil liability of both Sponsors and investigator for damages to clinical trials subjects ("Subjects") arising out from CTs.

Duration

The Insurance Policy should be in force and effective for the entire duration of the

CT. For this purpose, when necessary, it should be renewed by Sponsors, notified and treated by EC as a "non-essential amendment" under legislative decree 211/2003.

Maximum coverage (per Subject⁹ and per Protocol)¹⁰

The maximum coverage should not be less than €1,000,000 for each Subject and not less than the amounts below for each clinical trial protocol¹¹ ("Protocol"):

- €5,000,000 for CTs concerning not more than 50 Subjects;
- €7,500,000 for CTs concerning more than 50 but less than 200 Subjects;
- €10,000,000 for CTs concerning more than 200 Subjects.

No franchise is permitted in the Insurance Policy.

Claims

Under the Insurance Policy, Subjects should be entitled to claim compensation for damages not later than 24 months from the termination of the CT and for which formal requests have been submitted not later than 36 months from the termination of the CT.

A CT should be considered terminated at the time of the last medical/surgical/diagnostic/therapeutic visit being performed in compliance with the Protocol, on the last Subject enrolled¹².

Extension of the terms above is possible in case of a CT potentially causing damage

⁷ Article 3(1)(f) of legislative decree 211/2003 provides that a clinical trial can be initiated only where provisions have been made for insurance or indemnity to cover the liability of the investigator and sponsor towards clinical trials subjects (see also art. 3(2)(f) directive 2001/20/EC). The Decree also provided that a subsequent Ministerial decree should indicate minimum requirements for such policies.

⁸ It should be noted that Sponsor of these studies are required to extent existing policies covering ordinary assistance to patients or put in place

additional policies in order to comply with the requirements of the Decree.

⁹ In case of multinational CTs, for Subjects should be intended number of Subjects to be enrolled in Italy only.

¹⁰ The top coverage below will be periodically reviewed every three years (see article 2, par. 4, of the Decree).

¹¹ Please note that in case of multicenter CT.

¹² As to multinational CT, reference should be made to the last Subject enrolled in Italy.

which may appear only after longer periods (see article 1, par. 4 of the Decree). A minimum of 10 years coverage should apply in cases of CTs concerning minors and/or gene and cell therapies and radiopharmaceuticals (see article 1, par. 4 and 5).

Type of damages

The Insurance Policy should cover physical damage such as death, health and bodily injury (permanent and transient) as well as direct economic loss (i.e. which are the direct and immediate consequence of the participation of the Subject to the CT).

Claims for unintentional damages caused accidentally and/or due to negligence, recklessness, unskilfulness, should not be excluded by the Insurance Policy provided that the relevant claims comply with the terms highlighted above.

Additional obligations

The Decree also imposes upon the investigator the obligation to clearly inform Subjects (e.g. via informed consent) of the insurance coverage and the conditions applicable for claiming damages under the Insurance Policy. Subjects should also be made aware that beyond the applicable terms the Insurance Policy will be unenforceable.

Sanctions

The Decree introduces important and severe sanctions in case of non compliance such as the prohibition on using the results of the CT for applying for a marketing authorisation for a medicinal product¹³.

Any positive EC opinions/competent authority decisions on the CT should also be considered void.

Final considerations

The Decree, whilst introducing minimum common requirements for Insurance Policies for CTs, also raises some interpretation issues:

It remains unclear which CTs should actually benefit from the extension for claiming damages under the Insurance Policy provided by article 1, par. 4, cited above, who should identify them and which criteria they should be based upon. In a country like Italy, where there are currently 269 ECs¹⁴, a harmonised interpretation seems to be needed.

Maximum coverage of the Insurance Policy risks being considerably undermined by circumstances such as the level of damages occurred during a specific CT and/or the amount of other expenses (e.g. attorney's fees)¹⁵.

Finally, it is also unclear whether and to what extent the compulsory reference to the relevant and specific CT in the Certificate will have an impact on existing practice. It should be noted that insurance policies covering risks arising from clinical trials in general, therefore non-Protocol specific, could no longer be considered in line with Italian legislation and no longer accepted by an EC.

Entry into force

The Decree will enter into force on 13 March 2010 and it will apply to

applications submitted to ECs from this date (see article 6 of the Decree).

Mauro Turrini, Milan

France: Comparative advertising of a generic medicine

It is not necessary within the meaning of Article L. 713-6 of the French Intellectual Property Code ("CPI") to mention the brand of the reference product in comparative advertising for a generic medicine, as the healthcare professionals to which the advertising is directed have other means (namely, the INN - international non-proprietary name) by which to identify the corresponding reference product.

G Gam, having obtained Marketing Authorisation for its generic Paroxétine G Gam 20mg, in May 2003, informed healthcare professionals via the specialist press of the "upcoming marketing of Paroxétine G Gam (generic of Deroxat (...))". Beecham (owner of the Deroxat trade mark) and GSK (operator) brought an action against G Gam for trade mark infringement. On appeal, the Court confirmed the infringement on the grounds that the advertisement in question was not of the comparative advertising 'type', which might have allowed the G Gam to use the trade mark without Beecham's consent (CA Paris, 3rd May 2006).

¹³ This provision, which essentially confirms what previously stated by legislative decree 211/203 for CTs conducted not in compliance with Good Clinical Practices (GCPs), expressly states the non compliance with GCPs of CTs not in line with the Decree.

¹⁴ CINECA data at http://oss-sper-clin.agenziafarmaco.it/formazione/dispensa_corso_CE_09.pdf.

¹⁵ Please note that, according to the relevant Italian law, attorney fees may also concur reducing the top coverage provided by the Insurance Policy.

However, this decision was quashed by the Commercial Chamber, on the grounds that by presenting Paroxétine G Gam as the generic of Deroxat®, G Gam was only comparing the “essential, pertinent, verifiable and representative” characteristics of these products (same composition, bioequivalence, etc.), which is permitted by the legislation governing comparative advertising (Cass. Com., 26 March 2008 n°03-18.366P).

On referral of the case, after the decision had been quashed, the Cour d'appel de Versailles, although carefully avoiding any questioning of the qualification of comparative advertising, nevertheless upheld that the generic producer may not avail itself of Article L. 713-6 of the CPI (under the terms of which, reference to another brand name must be necessary to indicate for whom the product is destined).

According to the Versailles court of appeal, it is not necessary to quote the trade mark Deroxat® in advertising for healthcare professionals – to whom the advertisement was solely destined – to be able to identify Paroxétine G Gam 20 mg as a generic of Deroxat® : “(...) although mentioning the brand name is a convenient and easy solution, it is not however, necessary, since there exists for this [specialised group] other means [the ICN] by which to identify those the generic is destined for (...)”¹⁶.

Any decision of the Cour d'appel may still be quashed, so this may not be the final outcome.

Alain Gorny, Paris

Generics in France: towards an exemption from trade mark rights and a two-tier system?

On 26 November 2009, the French Senate voted on the law on 'Financing the National Social Security for 2010'. This law, if endorsed by the Constitutional Council, will amend the Public Health Code, and introduce a new article L. 5121-10-3 relating to generics:

“The owner of an intellectual property right that protects the appearance and the texture of oral pharmaceutical forms of a reference product within the meaning of article L. 5121-1 may not prohibit the oral pharmaceutical forms of a generic drug substitutable to this product under article L. 5125-23, from showing a similar or identical texture or appearance.”

Accordingly, the makers of substitutable generic drugs would be in a position to freely mimic the shape and colour of the tablets or capsules of the brand-name drug. The legislator's intention was to limit risks associated with mistaken intake by the patient, by precisely facilitating the identification (!) of generic drugs, especially by elderly subjects.

If validated by the Constitutional Council, this provision will amount to a significant exemption from trade mark and design rights. Further, besides an increased likelihood of confusion for the public,

difficulties can be expected when enforcing such trade marks or designs by Customs seizures pursuant to EC Regulation 1383/2003, for example against unauthorised generic goods (only substitutable generics would benefit from said exemption). Also, from a copyright perspective, it is unclear whether this provision would bar the author or creator of a shape from seeking compensation by solely asserting his/her moral right.

In a widely reported case remitted from the French Supreme Court, on 27 September 2005 the Appeal Court of Versailles had confirmed the validity of Roche's three-dimensional trade mark 'comprimé baguette', corresponding to Lexomil®'s oblong tablet shape bearing three break marks. Under the proposed new provision, such a trade mark could not be used to oppose generic forms of Lexomil®.

By contrast, in a very recent case (also reported in this Update), also remitted from the French Supreme Court, the Appeal Court of Versailles, on 17 September 2009, found for infringement in the case where a generic maker made mention of the trade marked drug brand-name on marketing material. It was held that there is no requirement to refer to the protected brand-name, where the INN (international non-proprietary name) is available. Such analysis would not be impacted by the proposed provision.

The above is still subject to approval from the Constitutional Council. No specific objections were raised against this IP

¹⁶ CA Versailles 17 September 2009 n°08/06287

provision in particular. Overall, a two-tier system may arise, wherein a name but not the shape or the colour of a tablet, may be used to protect a drug.

Isabelle Leroux & Gaelle Bourout, Paris

The Netherlands: refund system allowed under self regulation rules

In its decision of 17 September 2009 the Appeal Committee of the Dutch self regulatory body concerning pharmaceutical advertising, upheld the decision in first instance that a refund system set up by Pfizer for their products Detrusitol and Toviaz is allowed. This decision is a clear departure from earlier decisions in which the mere existence of a refund system would be qualified as unlawful advertising.

On the basis of the refund system, patients either do not need to pay the price difference between the fixed reimbursable price and the actual price of prescription drugs to the pharmacist or they will be reimbursed. The pharmacist must either fill in a form or provide such form to the patient to send to a third party who will make the payments. This case was initiated by a pharmacist.

This is an important decision as under the Dutch reimbursement system medical practitioners are under great pressure to prescribe medicinal products on the basis of active substance rather than brand name. Patients will only receive full reimbursement (directly or via their

pharmacy) for medicinal products indicated by health care insurance policy unless a prescription contains a brand name. Pharmacies are not allowed to simply deliver a generic version if a branded medicinal product is prescribed. In such a case, a pharmacist, prescribing doctor and patient will mutually decide whether the branded product is necessary for treatment.

The Appeal Committee ruled that compensation schemes set up by pharmaceutical companies are as such not in conflict with the relevant legislation or self regulatory statute. So long as the rules on medical advertising are adhered to, pharmaceutical companies are free to determine and use mechanisms resulting in competition on prices for end users/patients.

The Committee considered that the refund system does not constitute unlawful advertising, mainly because patients were not confronted with any promotional elements within the context of obtaining payments. Further, the Appeal Committee considered that medical practitioners were not involved and would, when becoming aware of the option for patients to be refunded, not be influenced in making professional choices based on the best indicated medicine. As pharmacists do not receive any compensation for providing forms to patients or filling in forms to receive reimbursement, the services requested from pharmacists do not constitute unlawful advertising either.

The issue raised by the pharmacist, that the refund mechanism is in conflict with the legislation determining fixed prices for reimbursement of medicinal products, was

not dealt with by the Appeal Committee. This is because the issue falls outside the competence of the Committee which is strictly limited to pharmaceutical advertising.

Machteld Hiemstra, The Hague

Finland: The Finnish Medicines Agency (Fimea) starts operations in November 2009

Finnish Medicines Agency Fimea (www.fimea.fi), the new state authority for medicines in Finland, began running its operations in November 2009. Fimea is responsible for most of the regulation and authorisation work previously handled by the Finnish National Agency for Medicines NAM.

Ms Sinikka Rajaniemi has been appointed as the Director General of Fimea. Ms Rajaniemi previously acted as the Director of the Pharmaceuticals Pricing Board in Finland.

As reported in previous Life Sciences Updates, the establishment of Fimea is part of a larger reorganisation of the pharmaceuticals administration in Finland.

Ella Mikkola, Finland

Industry news

UK High Court rejects judicial review of NICE's abatacept refusal

In April 2008, NICE refused to recommend abatacept as a treatment option for patients suffering from rheumatoid arthritis. Bristol Myers Squibb (BMS), as manufacturer of abatacept, sought judicial review of this guidance but on 6 November 2009, the High Court rejected its application¹⁷.

In its original submissions to NICE, BMS provided a model setting out a ratio figure based on the cost effectiveness of abatacept, which was then reviewed by an independent review group appointed by NICE under its appraisal process. BMS' model was amended by the group to produce a higher ratio figure. After an appraisal committee produced a consultation document, NICE considered the differences between the models and concluded that the drug would not be cost-effective. Article 6 of [Directive 89/105](#) requires Member States to communicate to the European Commission the criteria used to decide whether to include medical products on a list for use in their national health insurance systems or to exclude them from such systems. NICE complied with this obligation by notifying six criteria to the Commission. The fifth provided that a product could be excluded where its expected cost could not be justified.

Following NICE's final recommendation that abatacept be excluded from approved NHS list, BMS applied to have the decision judicially reviewed. In addition to alleging that NICE had breached the requirements of the Directive, BMS argued in particular that it was unfair for NICE to make an appraisal of abatacept based upon the review group's amended model without first giving BMS the opportunity to make representations on those amendments. NICE argued that if it was required to disclose the model to BMS, it would also have to disclose it to BMS' competitors despite the fact it contained commercially-sensitive information.

The High Court (Blake J) considered that NICE's guidance on its appraisal processes was publicly available and well-known. It held that the requirements of the Directive to notify the Commission of the inclusion/exclusion criteria had been met by NICE. If, by applying a more detailed analysis of cost-effectiveness, NICE decided that abatacept was not cost-effective to justify its inclusion for being supplied on NHS prescription, then this was in compliance with the inclusion/exclusion criteria already notified to the Commission. NICE was under a duty to act fairly to BMS before issuing guidance about the cost-effectiveness of abatacept but fairness did not necessarily require disclosure of the model used. BMS had been able to make informed and effective representations without having access to the version of its model that the review group might have used.

This decision from the High Court again shows the difficulties that stakeholders

face in attempting to have the final guidance of NICE overturned by recourse to judicial review proceedings. NICE's guidance has been challenged before the courts on a number of occasions recently¹⁸ but, to date, whilst criticising certain procedural aspects of NICE's appraisal processes (in particular in relation to the degree of disclosure as to the economic models used), the Court has not ordered NICE to reconsider its basic underlying guidance on whether or not a particular drug should be made available on the NHS. It is not for the court to decide whether NICE had reached the correct decision but merely whether the procedures and evidential evaluation carried out during its appraisal process had been done in an irrational or unfair manner. As such, the threshold that must be met by applicants to achieve anything other than a pyrrhic victory against NICE's decisions remains very high.

Ewan Grist, London

The Netherlands: Customs seizures of generic medicines

The Dutch practice

As reported earlier in relation to customs seizures based on Anti Piracy Regulation 1383/2003, Dutch Courts, including the Supreme Court, have often applied a *legal fiction* to cases concerning the transit of goods through The Netherlands. In other words, counterfeit goods in transit are treated as if they have been manufactured

¹⁷ *R (On the application of Bristol-Myers Squibb Pharmaceuticals Ltd) v National Institute For Health & Clinical Excellence* [2009] EWHC 2722 (Admin)

in The Netherlands.¹⁹ This essentially means that intellectual property right holders can enforce border measures if the goods are considered to be counterfeit according to Dutch laws.

The most recent and controversial ruling is the extensively motivated judgment rendered by the Vice President of the department of the District Court of The Hague in the *Sosecal v Sisvel case*.²⁰ The Court took all relevant previous judgments into account and analysed the *Montex/Diesel* judgment in depth, thereby considering the objectives of the Regulation. The Court considered that there is no indication that *Montex/Diesel* impairs previous ECJ decisions and cited remarks made by the European Commission, who stated that custom authorities 'can stop suspected fakes during import, export, transit or transshipment.' The Court concluded that *Montex/Diesel* was not intended to stop right holders from objecting to the transit of counterfeit goods under the Regulation and that the legal fiction should be applied.

Brazil and India complain to the World Trade Organization about Dutch customs policy

This view is not widely shared, as became clear when Brazil and India recently complained to the World Trade Organization about the Dutch Customs policy after Dutch customs detained a shipment of generic medicines shipped from India en route to Brazil. The Permanent Representative of Brazil stated

that the measure taken by the Dutch authorities clearly violated the freedom of transit.

In its response the European Community emphasised that the generic medicines were temporarily detained by Dutch Customs based on provisions in the Regulation which are in line with TRIPS.

The Dutch Government also commented on this specific issue, stating that Dutch customs acted in conformity with European and national laws. Despite this, it seems as though the Dutch Government has taken the international outrage seriously, as it has asked the European Commission to further investigate this matter.

The European Commission responded by announcing that it would prepare an 'explanatory memorandum' in which it would point out how custom authorities can use the Regulation in a way that does not negatively impact the transit of generic medicines.

No unified European practice

It is thus currently still possible for intellectual property right holders to stop the transit of infringing goods through The Netherlands. This situation is the exact opposite to the situation in the United Kingdom, where Justice Kitchin J recently dismissed Nokia's application for judicial review of the HMRC's refusal to detain a shipment of counterfeit phones and accessories after reviewing the ECJ case law.

United Kingdom and Belgian Courts refer 'transit' questions to European Court of Justice

On 9 November 2009 the Court of Appeal decided to refer questions to the ECJ in the case of *Nokia v Her Majesty's Revenue and Customs [2009] EWHC 1903 (Ch) (27 July 2009)*. At the time of publishing, the exact formulation of the questions was unclear. However, it is expected that the questions will address whether non-Community goods in transit from one non-Member State to another, fall under the definition of 'counterfeit goods' as stated in Article 2 (1) (a) of the Regulation, in cases where there is no evidence that the goods will be released or otherwise made available in the European Union.

And on 4 November 2009 in the case of *NV Koninklijke Philips Electronics v Far East Sourcing Limited* AR No 02/7600/A, the Court of First Instance of Antwerp referred the following question to the European Court of Justice ('ECJ'):

"Is Article 6.2(b) of Council Regulation 3295/94²¹ of 22 December 1994 (the old Customs Regulation) a rule of standardised Community law that must be observed by the Court of the Member State that has been applied to by the holder of that right in accordance with Article 7 of the Regulation, and does that rule mean that the court, in making its assessment, may not take into account the temporary storage status /the transit status and must apply the legal fiction that the goods were manufactured in that same Member State, and must subsequently decide, while

¹⁸ *Eisai v NICE* [2008] EWCA Civ 438, *Fraser & Short v NICE* [2009] EWHC 452 and *Servier v NICE* [2009] EWHC 281

¹⁹ Supreme Court, 19 March 2004, IER 2004, 50; District Court of The Hague, 13 July 2005, 02/2947; District Court of The Hague, 24 March 2006, B9 1823.

²⁰ District Court of The Hague, 18 July 2008, KG ZA 08-617.

²¹ It should be noted that the question relates to the Regulation 3295/94 which is the predecessor of the current Anti Piracy Regulation 1383/2003 ('Regulation').

applying the law of that same Member State, whether such goods infringe the intellectual right in question?"

An ECJ decision on this topic is thus both much needed and wanted, as the current status creates uncertainty and inequality amongst right holders throughout the European Community. Although neither referrals deal with patent rights, the outcome of the ECJ rulings is important to the life sciences field, as the rulings will be able to apply *mutatis mutandis* to cases concerning patent infringement and therefore also medicinal products.

**Siobhan Rueter & Armand Killan,
The Hague**

The Netherlands: Treatment guidelines and influence by the pharmaceutical industry - legislation on its way

In the July 2009 edition of the Life Sciences update we reported on investigations by the Dutch Health Inspectorate in relation to marketing mechanisms used to influence health care practitioners, particularly the use of seeding trials to increase or initiate prescriptions. On 26 October 2009 another report by the Dutch Health Inspectorate was presented about investigations in relation to the involvement of pharmaceutical industry in the development of treatment guidelines.

Treatment guidelines present an important role in choices to be made by healthcare providers to prescribe certain medicinal products, either as first choice treatment or follow up treatment. Treatment guidelines also play an important role in determining best care practice and are used by large groups of healthcare providers.

The objective of this study was to give a better insight into mechanisms used by pharmaceutical companies to influence members of working groups responsible for establishing treatment guidelines and to provide better understanding of the ties between working group members and the industry. The Inspectorate selected six treatment guidelines and formularies which were considered to be highly susceptible to unwanted industry influences.

The Inspectorate concludes that creation of treatment standards is influenced by various mechanisms, most notably, by offering medicinal products at reduced prices but also via relationships between industry and working group members. Due to a lack of standardised systems for revealing these sorts of relationships the exact extent of relationships is not transparent. Use of a so-called "declaration of interest" is often not part of the selection procedure to qualify as a working group member. Also, no detailed questions are being asked about the nature of ties and financial implications. Even though, in the view of the Inspectorate, influencing treatment standards may be regarded as pharmaceutical advertising, the Inspectorate at the same time concludes that it has no enforcement power to prevent this type of advertising.

The Inspectorate conducted an expert meeting to challenge their findings against the opinions of representatives of patient groups, health care professionals and institutes of the industry. The Inspectorate reports that there is an overall consensus that agrees that ties between working group members and the industry should be fully transparent. The creation of a "guideline for creation of treatment guidelines" appears to be widely endorsed. The Inspectorate seems to recognise that the industry may play a part in the creation of treatment guidelines; however, such role should be limited to providing comments in a round of "field consultations" after adoption of a draft guideline by working groups.

In an earlier report of the Inspectorate in May 2007, suggestions to increase transparency of industry connections in relation to the development of treatment guidelines were presented. No actions were taken though. In reaction to the current report, the Minister of Health has announced that the window for the industry to optimise transparency by self regulation is closing and that he is preparing legislation which will impose the obligation on the industry to make their relations with health care providers and scientific institutes known.

Machteld Hiemstra, The Hague

UK Treasury Pre-Budget Report: Tax "Patent Box"

In his pre-budget report to Parliament on 9 December 2009 the UK Chancellor of the Exchequer announced the Government's intention to introduce a "Patent Box" under which income derived from patents would be taxed in the UK at a reduced rate of corporation tax (10%). Although the proposal was met with approval by some quarters of innovative industry, the published report makes it clear that the proposal will only apply to patents *granted* after the Finance Bill 2011 has been passed and even then only to income arising after April 2013.

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