Consultation submission cover sheet

This form accompanies a submission on:

The document 'Evidence required to support indications for listed medicines (excluding sunscreens and disinfectants)'	
Name and designation	Ian Gamble. Technical and Regulatory Manager
Company/organisation name and address	Amway of Australia 46 Carrington Rd, Castle Hill, NSW, 2154, Australia
Contact phone number	02 9843 2215

I would like the comments I have provided to be kept confidential: *(Please give reasons and identify specific sections of response if applicable)*	☐ Yes ☒ No
I would like my name to be removed from all documents prior to publication and not be included within the list of submissions on the TGA website.	☐ Yes ☒ No

It would help in the analysis of stakeholder comments if you provide the information requested below.

I am, or I represent, a: *(tick all that apply)*

Business in the therapeutics industry *(please tick sector):*

☐ Prescription medicines ☒ Complementary medicines ☐ OTC medicines

☐ Medical devices ☐ Blood, tissues, biological ☐ Other

☐ Sole trader ☒ Business with 150 employees

☒ Importer ☐ Manufacturer ☐ Supplier ☐ Industry organisation

☐ Government ☐ Researcher ☐ Professional body

☐ Consumer organisation ☐ Institution (e.g. university, hospital)

☐ Regulatory affairs consultant ☐ Laboratory professional

☐ Health professional – *please indicate type of practice*:

☐ Other - *please specify*:

It would help in the analysis of stakeholder comments if you provide the information requested below.

Comments

An assessment of how the proposed change will impact on you. That is, what do you see as the likely benefits or costs to you (these may be financial or non-financial). If possible, please attempt to quantify these costs and benefits.
* We strongly support the submissions of the Complementary Healthcare Council and the Australian Self-Medication Industry on the initial and subsequent drafts of the Evidence document. * The August draft still significantly increases the burden on some sponsors. It has not been demonstrated that increasing the regulatory burden will address the perceived "regulatory failure". A range of policy options should have been developed and considered according to COAG principles before detailed drafting of a specific proposal. * Compliant sponsors will either meet the additional requirements to ensure compliance or will discontinue products where it is not possible or economically feasible to comply. However, without any apparent provision for increased monitoring and enforcement, it is likely that some other sponsors will continue to be non-compliant. * There will be a number of herbal products which we would need to reformulate or discontinue because it is impossible to ensure that the particular extract that we use is has the exactly the same extraction conditions, solvent and extract ratio as the herbal extract referred to in a SEE (page 13). It should be sufficient to show that an extract is comparable. * The requirement to calculate the clinical significance is unreasonable for listed medicines. It is rarely provided in research papers. If enforced, this requirement would mean that almost the only products that could be on the market would be those that use a SEE as evidence.
Whether or not you support the revised Evidence Requirements. If not supported, please provide reasons why.
* The revised draft is still very difficult to read. We support the industry association suggestions of a legislative entry to refer to the principles of evidence requirements with clear, concise guidance on compliance being detailed in the ARGCM. * We support the deletion of the requirement for an independent expert to assess the evidence and the inclusion of Sources of Established Evidence lists in the August draft. * The relatively low risk of listed complementary medicines is not commensurate with some onerous evidence requirements that are still in the current draft. * Alternative approaches should be considered for biomarker claims. There should be a level playing field for listed complementary medicines and the health claims that are proposed for foods.
Any additional information on issues not asked in the above questions. If your comments relate to specific parts of the document please provide the page number and reference.

Comments in relation to weight loss:

The requirements for evidence for weight loss products are scattered throughout the draft - they should be consolidated into just one section to ensure a concise and easy to find list of requirements.

While it acknowledges the benefits of weight loss, this draft sets the criteria for scientific assessment at high levels making it unlikely that any existing research on listable complementary medicines would be acceptable to the TGA as supporting evidence for a weight loss indication.

We recommend that the following three parameters proposed in the TGA draft be deleted and that it should be the responsibility of the person reviewing the evidence that the evidence for a product supports the specific weight claim for the product.

> ”Studies relevant to weight loss indications must be of at least 6 months duration”
>
> Appendix 1 of the TGA draft lists sources of established scientific evidence that are acceptable to the TGA. This includes the Compendium of Monographs of the Natural Health Products Directorate, Health Canada. This Compendium includes a monograph for Green Tea Extracts:
> http://www.hc-sc.gc.ca/dhp-mps/prodnatur/applications/licen-prod/monograph/mono_greentea-thevert-eng.php
>
> This monograph supports the following statement of purpose for a specific green tea extract that contains caffeine and is high in catechins: “To be used with a program of reduced intake of dietary calories and increased physical activity (if possible) to help in weight management.”
>
> All the studies used to support this statement were of less than 6 months duration and all showed a reduction in body weight – most were 12 week duration. One study (Westerterp – Plantegna) demonstrated weight maintenance after weight loss in some groups - one month of very low energy diet followed by 3 months on a weight maintenance diet.
>
> Refer to “EFSA Guidance on scientific requirements for health claims related to appetite ratings, weight management, and blood glucose concentrations”:
> http://www.efsa.europa.eu/en/efsajournal/doc/2604.pdf
> Clause 4.1 says a reduction in body weight is considered a beneficial physiological effect for adults with excess body weight if body fat is reduced. It also says that evidence for a sustained effect with continuous consumption of the food/constituent over, for example, about 12 weeks, should be provided.
> Clause 4.2 discusses weight regain after significant weight loss (i.e. weight maintenance). It suggests studies supporting weight maintenance should be of about 6 months duration.
>
> While ongoing weight maintenance after weight loss is an ideal situation, it is important to note that EFSA regard weight loss (supported by 12 week trials) to be of beneficial physiological effect. Therefore, we suggest that the TGA draft remove the requirement for a minimum 6 month study.
>
> Comment: The Canadian monograph and EFSA scientific opinion show that beneficial effects can be demonstrated in weight loss studies of less than 6 months duration. The cost of a 12 week weight loss study is in the vicinity of $2 million. A 6 month study would cost considerably more and is beyond the financial capabilities of the complementary medicines industry. We are not aware of any complementary medicine weight loss product / ingredient with a 6 month clinical trial. By enforcing a 6 month minimum study period, the TGA would effectively preclude nearly all existing products from sale and inhibit any new research, even if shorter studies showed worthwhile benefits. The only weight loss products likely to

be listed would be those that are supported by SEE sources that, as shown above, are likely to rely on studies of less than 6 months duration.

50 per cent of the participants in the treatment group must have achieved a loss of at least 5 per cent of initial body weight.

Many pharmaceutical companies fund their own research and can easily calculate whether 50% of the study population lost >5% body weight. However, listed evidence substantiation is based mainly on third party research that does not report this level of detail.

Consequently, magnitude of effect based on the total study population analysed by appropriate statistical methodology should be sufficient.

A mean overall loss of at least 5 per cent initial body weight in the treatment group, which is at least 3 per cent greater (for RCT) or 5 per cent greater (for non-RCT) than that of the placebo / control group.

There may be many people who are moderately overweight (e.g. BMI of 27) who would be quite satisfied if a listed medicine, in conjunction with appropriate diet and exercise, enabled them to lose just a few kilograms. Also, page 50 of the draft supports that a reduction of one kg/m2 across a population could make significant impacts on the prevalence of obesity and overweight.

Listed medicines for weight loss are designed to augment a healthy weight loss program that includes kilojoule reduction and exercise. It is known that the magnitude of effect of the listed medicine is often less than that of prescription medicines and the trade off tends to be fewer adverse side effects.

Also, the action of some listed medicines for weight loss can be more easily impacted by other factors in the diet that may be difficult to tease out in a RCT. One example would be tea consumption, in particular, green tea.

Listed medicines for weight loss are marketed to generally healthy people, who, while not obese, may be overweight or just not at their personal goal weight. This population does not qualify for use of prescription medicines as the benefits do not outweigh the risks. Listed medicines combined with a diet and exercise program may be their primary alternative.

Therefore, mandating a mean overall weight loss of 5 per cent would result in some products not being available to satisfy some consumers. It could also increase the number of overweight people in the population and increase health burdens on the community.

CONCLUSION

High dropout rates, different diets and exercise programs and adherence to these programs can complicate interpretations of weight loss clinical trials.

It is shown above that other jurisdictions reach different conclusions to those proposed in the TGA draft. As listed medicines are low risk products, we propose that the parameters set by the TGA be deleted in favour of the reviewer being responsible for determining the specific indications that the evidence can support.

Weight loss indications should be quite specific so that the consumer has a clear understanding of what the evidence supports. Therefore, the TGA's Coded Indications project should provide

flexibility for adding new indications to ensure that consumers are fully informed about the efficacy of products they purchase.

For example, two different indications for different products with different evidence may be:

> Supports moderate weight loss in overweight people when taken in conjunction with an appropriate diet and exercise program for 3 months.
> Supports weight loss and maintaining reduced weight of overweight people when taken in conjunction with our recommended diet and exercise program for 4 months.

Satiety, increase in lean body mass and other similar measures should be permitted as indications provided they can be supported by SEE documents or by a scientific evidence report, but as highlighted in many reports, they should not be used to imply a weight loss claim.

If you would like to be kept informed about TGA activities, please subscribe to one of the TGA's email lists <http://www.tga.gov.au/newsroom/subscribe.htm>.