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IMPACT ASSESSMENT REPORT

Accompanying the document

Proposal for a Regulation of the European Parliament and of the Council

on fees and charges payable to the European Medicines Agency, amending Regulation (EU) 2017/745 of the European Parliament and of the Council and repealing Council Regulation (EC) No 297/95 and Regulation (EU) 658/2014 of the European Parliament and of the Council

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Glossary

Term or acronym	Meaning or definition
Abridged application	An application for a new marketing authorisation for a medicinal product for human or veterinary use should normally be accompanied by a 'full dossier' (see further below in this table). However, in certain instances applicants are permitted to submit a medicinal dossier that does not include all of the results required for a full dossier. This is called an abridged application. An applicant can choose to submit an abridged application instead of a full dossier when the results of an already authorised medicine are relevant to the new medicinal product and when reference can be made to these results. See also 'generic', 'biosimilar' and 'full dossier'.
Additional activities	Both EMA and NCAs undertake activities additional to the activities that were covered by the data gathering exercise of the EMA Management Board. These 'additional activities' do not concern time spent in and preparatory work for committees and working parties, nor any of the procedural activities covered by the external study. For more information, see Section 5.
Administrative fee	Fees charged on a one-off basis by EMA to undertakings for the provision of the following administrative services: negative administrative validation of an application, issuing of certificates outside of procedures, notifications of parallel distribution and variation worksharing (whereby a marketing authorisation holder (MAH) can submit the certain variations affecting more than one marketing authorisation from the same MAH in one application.). For reference of terms see also 'parallel distribution' and 'Variation; Type IA, IB and II'.
Advanced Therapy Medicinal Product (ATMP)	Medicinal products for human use based on genes, cells or tissues used to diagnose, prevent or cure diseases or to replace, repair or regenerate human tissue.
Advanced Therapy Medicinal	Any applicant developing a product based on genes, cells or tissues may request a scientific recommendation

Product (ATMP) classification	of the Agency with a view of determining whether the referred product falls, on scientific grounds, within the definition of an advanced therapy medicinal product. The Agency shall deliver this recommendation after consultation with the Commission and within 60 days after receipt of the request.
Annual fee	Fees charged annually by EMA to undertakings for services related to the maintenance of a valid marketing authorisation (e.g. databases). Two types of annual fees exist: (1) an *annual fee* for centrally authorised medicinal products (CAPs) for human and veterinary use (CAP annual fee) and (2) a *pharmacovigilance annual fee* for nationally authorised medicinal products (NAPs) for human use.
Basic fee	The full applicable fee before reductions (fee incentives) or additional amount (for the assessment of additional strengths, pharmaceutical forms or presentations) have been applied. See also under 'procedural fee'.
Biosimilar application	A biological medicinal product that is highly similar to an already authorised biological medicine ('the reference product') and for which not all test results need to be provided as for a full dossier. A biosimilar application is a type of abridged application. See also 'abridged application' and 'full dossier'.
Centrally authorised medicinal product (CAP)	Medicinal products authorised at European Union level. The marketing authorisation is granted by the European Commission and is valid in all Member States.
CAP annual fee	See under 'annual fee'.
Coordination group	The coordination groups for human medicinal products (CMDh) and veterinary medicinal products (CMDv) were set up for the examination of any questions relating to nationally authorised medicinal products, specifically related to disagreements on the grounds of potential serious risks to public health between Member States on pending initial marketing authorisation and variation procedures. The tasks also include certain

	pharmacovigilance activities related to nationally authorised products.
Data Analysis and Real World Interrogation Network (DARWIN EU®)	The Data Analysis and Real World Interrogation Network (DARWIN EU) is the EMA's infrastructure that will support regulatory decision-making by: · establishing and expanding a catalogue of observational data sources for use in medicines regulation; · providing a source of high-quality, validated real world data on the uses, safety and efficacy of medicines; · addressing specific questions by carrying out high-quality, non-interventional studies, including developing scientific protocols, interrogating relevant data sources and interpreting and reporting study results. The integration of DARWIN EU in the European Health Data Space (EHDS) (as a node in the digital infrastructure for secondary use of health data) will enable EMA's and national competent authorities' to use these data whenever needed throughout the lifecycle of a medicinal product.
European Health Data Space (EHDS)	The creation of a European Data Space is one of the priorities of the Commission 2019-2025, including the health sector. A common European Health Data Space will promote better exchange and access to different types of health data (electronic health records, genomics data, data from patient registries etc.), not only to support healthcare delivery (so-called primary use of data) but also for health research and health policy making purposes (so-called secondary use of data).
Extension of marketing authorisation (line-extension)	Procedure via which any of the following changes are made to an already existing authorisation: Changes to the active substance, strength, pharmaceutical form, and/or route of administration; Other changes specific to veterinary medicines to be administered to food-producing animals or the change or addition of target species.

Fee payer	Fee payers are mainly pharmaceutical companies, preparing or seeking to either (a) apply for a marketing authorisation to place a medicinal product on the market, or (b) amend an existing marketing authorisation. This includes multinational companies as well as smaller entities.
Full dossier	An application for a new marketing authorisation for a human medicinal product should normally be accompanied by results of pharmaceutical (physico-chemical, biological or micro-biological) tests, pre-clinical (toxicological and pharmacological) tests and clinical trials (Article 8i of Directive 2001/83/EC). In the case of veterinary medicinal products these are results of pharmaceutical (physico-chemical, biological or micro-biological) tests, safety and residue tests, pre-clinical and clinical trials, and tests assessing the potential risks posed by the medicinal product for the environment (Article 12j of Directive 2001/82/EC). Applications that are submitted in accordance with these requirements are called a 'full dossier'. See also 'abridged application'.
Generic application	Application for a medicine containing the same active substance(s) and used at the same dose(s) to treat the same disease(s) as an already authorised medicine ('the reference medicine'). A generic application is a type of abridged application. See also 'abridged application' and 'full dossier'.
Generic medicine	A generic medicine is developed to be the same as a medicine that has already been authorised, called the reference medicine. A generic medicine contains the same active substance(s) as the reference medicine, and it is used at the same dose(s) to treat the same disease(s). However, a generic medicine's inactive ingredients, name, appearance and packaging can be different.
Health technology assessment (HTA)	HTA bodies provide recommendations on medicinal products and other health technologies with regard to their properties and direct and indirect impact as well as unintended consequences. It is mainly aimed at informing policy and decision-making in health care, especially on how best to allocate funds in terms of

	reimbursement.
Immunological veterinary medicinal product/ immunologicals	A veterinary medicinal product intended to be administered to an animal in order to produce active or passive immunity or to diagnose its state of immunity.
Inspection	Medicine developers and (future) marketing authorisation holders should ensure that they and any parties working for them comply with standards set out in Union legislation and guidelines for good clinical practice (GCP), good laboratory practice (GLP) and good manufacturing practice (GMP) for investigational and to be authorised or already authorised medicinal products. Compliance with these standards is verified by the national competent authorities during (GCP/GLP/GMP) inspections. When it concerns products that are to be authorised or have been authorised via the centralised procedure, EMA is responsible for coordinating the inspections by NCAs.
Limited market	A market for one of the following medicinal product types: (a) veterinary medicinal products for the treatment or prevention of diseases that occur infrequently or in limited geographical areas; (b) veterinary medicinal products for animal species other than cattle, sheep for meat production, pigs, chickens, dogs and cats;
Management Board data gathering (MBDG)	In March 2014, the EMA Management Board set up a Data Gathering Steering Group to gather evidence on the time spent by staff of the EMA Secretariat and NCAs on EMA-related activities, to support the evaluation of the EMA fee system by the European Commission.
Maximum residue limit (MRL)	The maximum concentration of a residue of a pharmacologically active substance (veterinary medicine) which may be permitted in food obtained from an animal exposed to that substance.
Micro, small and medium-sized enterprise (SME)	The following definition is not specific to the pharmaceutical sector, but instead applies EU-wide

	(Commission Recommendation 2003/361/EC): Microenterprise: company which employs fewer than 10 people and which has an annual turnover and/or annual balance sheet total not exceeding €2 million. Small enterprise: company which employs fewer than 50 people and which has an annual turnover and/or annual balance sheet total not exceeding €10 million. Medium-sized enterprise: company which employs fewer than 250 people and which has an annual turnover not exceeding €50 million and/or a balance sheet total not exceeding €43 million.
Minor use/minor species (MUMS)	Veterinary medicines for the treatment of rare diseases in major animal species (cattle, sheep, pigs, chickens, salmon, cats and dogs) and for the treatment of minor animal species.
Nationally authorised medicinal product (NAP)	Medicinal products authorised at the national level in one or more Member States. The marketing authorisation is granted by the relevant National Competent Authority(ies) of the Member State(s) where the application is made.
National Competent Authorities (NCAs)	National regulatory authorities responsible for the regulation of medicinal products for human and veterinary use in the European Economic Area.
Orphan designation	The procedure via which it is evaluated whether a medicinal product fulfils the criteria of an orphan medicinal product.
Orphan medicinal product	Medicine used to diagnose, prevent or treat life-threatening or chronically debilitating diseases that are either rare or unlikely to generate sufficient return to justify the necessary investment, and where no satisfactory or better alternative already exists within the European Union. A condition is defined as 'rare' if it affects no more than five in 10 thousands people in the EU.
Paediatric investigation plan (PIP); waiver; deferral; modification	Development plan drawn up by a pharmaceutical company containing information on how that company intends to gather data on the use of the medicine concerned in children. The aim is to ensure that data are gathered that are necessary to approve use of a medicine

	in children. Normally, a PIP is required with each application for authorisation of a new medicine. However, under certain circumstances the applicant may request EMA to waive or defer the PIP. A waiver is granted if the development of a medicine in children is not needed or not appropriate, such as for diseases that only occur in adults. A deferral allows the applicant to delay development in children until, for instance, enough information is gathered about its effectiveness and safety in adults. An approved PIP can be modified at a later stage as knowledge increases or if it is proven that the implementation of the PIP is impossible or no longer appropriate.
Parallel distribution	The distribution of a centrally authorised medicine from one Member State to another by a company other than the owner of the medicine.
Peer-review(er)	One of the members of the CHMP or CVMP is appointed to review the scientific evaluation of the rapporteur and co-rapporteur conducted during the first phase of applications for a marketing authorisation and extensions of existing marketing authorisations, with the purpose of ensuring the quality and consistency of these evaluations. The peer-reviewer especially focusses on the draft list of questions compiled by the rapporteurs for the relevant scientific committee.
Periodic Safety Update Report (Singe Assessment) (PSUR/PSUSA)	Reports containing information and a critical analysis on a benefit-risk balance of an authorised medicinal product. The report is compiled by the owner of the marketing authorisation and submitted to the relevant competent authority for evaluation. Based on the assessment of a PSUR, the relevant competent authority can determine whether actions are needed to protect public health, for instance via the update of information for patients and health care professionals.
Pharmacovigilance	The monitoring of adverse effects (safety) of medicines or any other medicine-related problem after their placing on the market, with the aim to identify, assess and prevent such problems.

Pharmacovigilance annual fee	See under ‘annual fee’.
Pharmacovigilance procedural fee	Procedural fee related to pharmacovigilance activities (assessment of PSUR, PASS, pharmacovigilance referrals). See also under ‘procedural fee’.
Pharmacovigilance referral	Referral (arbitration) related to the safety of a medicine. See further under ‘referral’.
Post-authorisation safety study (PASS)	A study carried out after a medicine has been approved in order to gain more information on its safety or to measure the effectiveness of measures taken to reduce safety risks.
PRIority MEdicines (PRIME)	A voluntary scheme launched by the European Medicines Agency in 2016 to enhance support for the development of medicines that target an unmet medical need or that offer a major therapeutic advantage over existing treatments. Via participation in this scheme developers of medicines receive early and proactive support from EMA to optimise development plans and accelerate scientific evaluation with the aim of early access to patients. This scheme also provides fee incentives for scientific advice requests for PRIME products from micro-sized enterprises and SMEs as well as academic sector applicants.
Procedural fee	Fees charged by EMA to undertakings on a per-service basis. Procedural fees are applicable to a specific set of services provided either before or after the granting of a marketing authorisation (‘pre- and post-authorisation procedural fees’).
Protocol assistance	Protocol assistance is a special form of scientific advice specifically available for developers of orphan designated medicines. See further under ‘scientific advice’ and ‘orphan designation’.
(Co-)Rapporteur	Scientific committees of EMA appoint one of their members as rapporteur and may appoint a second one as co-rapporteur to lead the scientific evaluations of applications submitted to EMA. The rapporteurs are responsible for drafting the assessment reports submitted to the committees for discussion and adoption.

Referral (arbitration)	Procedure initiated to resolve issues such as concerns over the safety of an already authorised medicine or to resolve disagreement among Member States on the benefit-risk balance of a new medicine under evaluation. Referrals can be initiated by the European Commission, a Member State or the owner (marketing authorisation holder) of the product.
Regulation on a reinforced role for EMA	Regulation (EU) 2022/123 of the European Parliament and of the Council of 25 January 2022 on a reinforced role for the European Medicines Agency in crisis preparedness and management for medicinal products and medical devices
Renewal	A new marketing authorisation is only valid for five years from the date the Commission notifies the marketing authorisation holder the authorisation has been granted. An application for renewal of the authorisation shall be submitted timely (i.e. nine months before its expiry date) to ensure it remains valid. Once renewed, the marketing authorisation is valid for an unlimited period, unless the Commission decides, on justified grounds relating to pharmacovigilance, including exposure of an insufficient number of patients to the medicine concerned, to proceed with one additional five-year renewal.
Scientific advice	EMA can give advice to a developer on the appropriate tests and studies in the development of a medicine. This helps to facilitate the development and approval of a medicine.
Scientific services	Services provided by EMA upon application for any scientific advice or opinion by a scientific committee other than those related to scientific advice, initial marketing authorisation, inspection, variation, extension, renewal, referral, maximum residue limit, transfer of marketing authorisation, or the maintenance of a marketing authorisation. This includes any evaluation of traditional herbal medicinal products, any opinion on medicinal products for compassionate use, any consultation on ancillary substances, including blood derivatives, incorporated in medical devices, and any evaluation of plasma master files and vaccine antigen master files.

Synthetic year	A synthetic year is used to determine costs to EMA and NCAs incurred for EMA-related activities in a 'typical year'. The synthetic year "neutralises" differences in the reporting of data for EMA and NCAs. This was necessary to ensure that, for activities where NCAs are involved, the number and type of activities is the same for EMA and NCAs in the 'typical year'.
Unitary costs and unitary fees	Costs to EMA and NCAs or fees charged to industry for a given activity, such as the evaluation of a marketing authorisation application or variation.
Variation; Type IA, IB and II	Change to the terms of an existing marketing authorisation, e.g. the change in manufacturing site, the addition of an indication, the replacement of an excipient of the medicinal product. Type II variations concern major changes which may have a significant impact on the quality, safety or efficacy of the medicinal product. These variations require approval by the relevant competent medicine authority before they can be implemented. Type IA variations concern minor changes which have only a minimal impact or no impact at all on the quality, safety or efficacy of the medicinal product. These variations do not require approval by the relevant competent medicine authority prior to implementation ('Do & Tell'). Type IB variations concern changes that are neither Type IA nor Type II variations. These variations require approval by the relevant competent medicine authority before they can be implemented.
Veterinary Medicinal Product Regulation (VMP)	Regulation (EU) 2019/6 of the European Parliament and of the Council of 11 December 2018 on veterinary medicinal products and repealing Directive 2001/82/EC
Weighted average of NCAs' costs	In the model calculating costs and income of EMA and NCAs for a 'typical year' NCAs costs were determined as a weighted average of costs estimated for various NCAs, using as weight the frequency of involvement of the NCAs.

1. Introduction: Political and legal context

Within the European Union (EU), all medicinal products for human and veterinary use must be authorised either at EU (central) or Member State (national) level. At EU level, the Commission authorises these products based on the scientific assessment of their quality, safety and efficacy, as delivered by the European Medicines Agency (EMA), with the involvement of national competent authorities (NCAs) in the Member States. The EMA is a decentralised Agency of the Union. It charges fees to marketing authorisation holders and applicants for obtaining and maintaining EU-wide marketing authorisations for medicinal products for human and veterinary use. The EMA remunerates NCAs for their scientific assessment work. The services for which EMA charges fees include scientific advice, assessment of applications for a marketing authorisation, changes to existing marketing authorisations (variations and extensions), and other pre- and post-authorisation procedures, and annual fees for the maintenance of already authorised medicines. Pharmacovigilance activities conducted at EU level for nationally authorised medicines for human use are also financed by fees paid by marketing authorisation holders to EMA.

The broad purpose of this initiative is to provide the EMA with a sound financial basis for the future.

The proposed revision aims to address the shortcomings highlighted in the 2019 evaluation of the EMA Fee system, as defined in the two EMA fee regulations: (1) the **Fee Regulation** (EC) No 297/95 and its implementing rules and (2) the **Pharmacovigilance Fee Regulation** (EU) No 658/2014. The revision will also address the problems caused by, and the lessons learnt from the COVID-19 pandemic in order to make the new fee system even more effective, future proof and crisis-resistant.

This initiative is limited to revising the EMA fee system based on an assessment of the costs of the activities of EMA and NCAsas they are set by the current EU pharmaceutical legal framework. The role of EMA as defined in its Founding Regulation, the way in which the EMA's committees operate and the role of the NCAs in relation to their contributions to EMA are out of the scope of this impact assessment. Changes in the functioning of these operations and measures to improve efficiency of EMA[1] and NCA services may be considered in the ongoing revision of the pharmaceutical legislation and are therefore out of the scope of this revision.

[1] The EMA also regularly revises its operations to optimise its processes and identify efficiency gains. The Commission publishes, at least every ten years, a general report on the experience acquired as a result of the operations of procedures for authorisation and supervision of medicinal products. The last report was published in 2021: *'Commission report to the European Parliament and the Council on the experience acquired with the procedures for authorisation and supervision of medicinal products for human use',* https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021DC0497&qid=1642068705042

More detailed background information on the regulatory framework, specifically on the elements related to the authorisation, maintenance and monitoring of medicinal products, the tasks under the remit of EMA and their links with the EMA fee system are presented in Annex 5.

Legal Context

The general provisions laying down the composition of the EMA budget and the principles of remuneration to rapporteurs and experts are contained in the EMA Founding Regulation[2]. The specific fee amounts and levels of remuneration for the contributions of the national experts on the other hand are detailed in the main Fee Regulation[3] and its implementing rules[4] and in the pharmacovigilance fee regulation[5]. The requirement for a cost-based fee system, which is the backbone of the revised system, stems from the legal provisions in the main EMA fee Regulations (article 12 from the main fee regulation and recital 7 from the pharmacovigilance fee regulation.). The cost alignment objective stems from the main Fee Regulation[6] which stipulates that any review of the fees shall be based on an evaluation of the Agency's costs and on the basis of the related costs of the services provided for by the Member States.

The EMA Founding Regulation stipulates that EMA revenues and costs should be balanced. EMA revenues include fees which should cover, as part of the revenues of EMA, the costs of the Agency and the costs for remunerating NCAs for their contribution to EMA's tasks. The pharmacovigilance fee regulation specifically states that "Any future revisions of the pharmacovigilance fees or other fees levied by the Agency should be based on a transparent and independent evaluation of the costs of the Agency and the costs of the tasks carried out by the national competent authorities.". In addition, a number of sectorial legislations[7] provide incentives for specific types of products and/or applicants that are applied to the amount laid down in the regulations above.

The need to ensure that EMA costs are covered is linked firstly to the budgetary principle in the Financial regulation whereby revenue and expenditures shall be balanced (also reflected in the founding Regulation of the Agency) and, secondly, to the balancing nature of the contribution from the Union to the revenue of EMA. Both revenue sources (contribution from the Union budget and fees) are part of the revenue sources of the Agency, as per its Founding Regulation.

Recent amendments to the pharmaceutical framework have introduced provisions impacting the EMA Fee System. First, the 2018 revision of the founding regulation introduced the use of "charges" as an additional source of revenue for EMA. Furthermore, a requirement for the Commission to review the regulatory framework for fees payable to

[2] Regulation (EC) No 726/2004, Article 62 (3), Article 67 and Article 86a
[3] Council Regulation (EC) No 297/95
[4] Implementing Rules
[5] Regulation (EU) No 658/2014
[6] Council Regulation (EC) No 297/95, Article 12
[7] The SME Regulation (Regulation (EC) No 2049/2005), Paediatric Regulation (Regulation (EC) No 1901/2006), the Orphan Regulation (Regulation (EC) No 141/2000), and the Advanced Therapy Medicinal Products (ATMPs) Regulation (Regulation (EC) No 1394/2007)

the Agency by 2019 was also introduced. Secondly, the Veterinary Medicinal Products Regulation (Regulation (EU) 2019/6), which became applicable on 28 January 2022, updated the rules on the authorisation and use of veterinary medicines in the EU. Consequently, the current fee system is not fully aligned with the new and amended provisions put in place for the veterinary sector. Finally, the Regulation reinforcing EMA's role in crisis preparedness and management for medicinal products and medical devices[8] (hereafter referred to as Regulation on a reinforced role for EMA) was recently adopted to codify and further strengthen structures and processes established by EMA during the COVID-19 pandemic. One specific activity (DARWIN EU[9]) introduced as part of these changes was assigned an EU budget allocation only to the end of 2023. Therefore, the continued operation of DARWIN EU as of 2024 will require a new financing mechanism through the introduction of additional fee revenue (all other activities under said regulation are provided for and financed through an EU budget contribution to the EMA budget).

Political Context

The European Court of Auditors has repeatedly noted the need to introduce a system of remuneration for services provided by Member State authorities based on their costs[10].

The EMA fee legislation is crucial for the successful implementation of the underlying pharmaceutical legislation of the EU. By way of example, the Regulation on a reinforced role for EMA is an important pillar of the **European Health Union**. Similarly, the new VMP regulation aims inter alia at enhancing the EU's action against **antimicrobial resistance**. Appropriate cost-based funding of the relevant activities provided for in these regulations, as outlined above, is fundamental for equipping the Union with the necessary instruments to implement the new tasks. The EMA fee system plays an important role in such funding.

Furthermore, the fee system is closely linked to the underlying regulatory framework set by the Union pharmaceutical legislation. The ongoing revision under the **Pharmaceutical Strategy for Europe**, including the ongoing revision of the legislation on **orphan and paediatric medicines**, may have a direct impact on the fee system. Given the time constraints outlined above, the revision of the fees framework needs to move forward, ahead of the finalisation of these other legislative revisions. However, any new fee system will need to be agile and adaptable in order to respond to the rapidly changing landscape in the pharmaceutical sector to cater for any new provisions that may emerge from this revision process.

Finally, the COVID-19 pandemic has put strain on NCAs and their available resources, in particular for those called on to make an intensified contribution to the authorisation

[8] Regulation (EU) 2022/123 of the European Parliament and of the Council of 25 January 2022 on a reinforced role for the European Medicines Agency in crisis preparedness and management for medicinal products and medical devices (OJ L 20, 31.1.2022, p. 1)

[9] Data Analysis and Real World Interrogation Network (DARWIN EU) | European Medicines Agency (europa.eu)

[10] European Court of Auditors reports on the annual accounts of the European Medicines Agency for the financial years 2006 (OJ C 309, 19.12.2007, p. 34–39), 2010 (OJ C 366, 15.12.2011, p. 27–32) and 2011 (OJ C 388, 15.12.2012, p. 116–122).

processes for new vaccines and therapeutics and to monitor the availability of crisis-specific medicines. On 7 December 2021, the Council adopted Conclusions on Strengthening the European Health Union in which they invited the Commission to pay due attention when revising the EMA fee system in order to "avoid causing damage to national competent authorities" and to safeguard and strengthen the EU regulatory system for medicinal products, including the scientific contributions made by NCAs[11].

2. Problem definition

1.1. What are the problems?

The following section describes the main problems facing the EMA fee system, as identified by the recent evaluation[12]. It extends this analysis to include issues that arose subsequently due to the impact of the COVID-19 pandemic.

1.1.1. 2.1.1. Misalignment with provisions of new Union legislation [P0]

From a legal perspective, the main problem is the lack of alignment of the fee legislation with the new provisions introduced by the VMP Regulation (further compounded during the Covid-19 pandemic, see below *'Further elements identified following the COVID-19 crisis'*).

The VMP regulation introduced changes to regulatory procedures for which currently there are no fees. In addition, it broadened the scope of veterinary medicinal products eligible for the centralised procedure, which affects both EMA income and NCA remuneration as well as their costs related to veterinary activities.

As an interim measure to cover the new regulatory procedures for which no fees exist, the Implementing Rules of the current Fee Regulation have been amended, to guarantee continuity of funding from 28 January 2022, when the VMP regulation applied. Fees and remuneration amounts for new procedures have been introduced using existing amounts as benchmarks, whilst for amended procedures existing amounts continue to apply. This measure cannot be considered a sustainable solution as a) not all necessary fees can be introduced/amended through the implementing rules (annual fees) and b) the fee and remuneration amounts are not cost-based.

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[11] The Council conclusions acknowledged the concerns expressed during the meeting of the Heads of Medicines Agencies (HMA), held under the Slovenian Presidency of the Council of the EU on 15 and 16 September 2021, in relation to the anticipated update of the rules on fees payable to the European Medicines Agency and its potential implications for the national competent authorities (NCA) responsible for medicinal products. The concerns expressed were, inter alia, that the cost-based fee proposal would reduce existing centralised human medicines fees for NCAs at a time of stretched resources and increased pressure for input into the centralised system, would not reflect the value of services delivered, would be based on out-of-date information and would recognise only some of the costs incurred by NCAs; invites the Commission to pay due attention to the concerns expressed in order to avoid causing damage to national competent authorities and to safeguard and strengthen the EU regulatory system for medicinal products, including the scientific contributions made by national competent authorities.

[12] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system evaluation_ema_fee_swd2019336_en_0.pdf (europa.eu)

Weaknesses identified in the evaluation

The 2019 evaluation found that, although the existing fee system is generally effective and efficient, there are a number of weaknesses that might affect EMA's ability to meet its costs in the future, including the remuneration to NCAs for their scientific contribution.

1.1.2. 2.1.2. Misalignment of some fee levels with the underlying costs – a non-cost based system [P1]

The procedural activities, the timelines and actors involved with their respective roles are defined in the overarching pharmaceutical legislation. Based on the information collected on the frequencies of such procedures and the workload involved for the different actors, the evaluation showed that though the current fee system covers costs overall, it is not fully cost-based, as there are discrepancies between revenues and costs calculated per type of procedure.

Some fee levels are not aligned with the respective underlying costs.[13] More specifically, fee revenue for some procedures exceed the total EMA and NCA costs of delivering them whilst for some other procedures they fall short of costs.[14] For example, as shown in Figure 1, human medicine "variation"[15] fees amount to €72 million/year vs. €18 million/year of total underlying costs. The opposite can be observed for initial marketing authorisation procedures, with fees amounting to €27.5 million/year vs. €50 million/year of underlying costs. Similar discrepancies have been observed also for veterinary medicines, though on a much smaller scale, as shown in Figure 2[16]. The cost misalignment of individual fee levels with the average unitary costs drives a misalignment of the overall fee revenue per type of procedure and leads to a misalignment at the level of the system whereby overall procedural revenue is not aligned to the overall procedural cost, for all procedures taken together.

Furthermore, for some procedural activities there are no fees (e.g. procedures related to paediatric investigation plans and orphan designation), meaning that EMA has to rely on other sources of income (e.g. annual fees; EU and EEA budget contributions; etc.) to address any shortfall.

The misalignment of fees with the underlying costs also affects the fee payers, since they are charged fees that are not necessarily reflective of the workload required for the service provided.

[13] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 83
[14] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 83 section 6
[15] Variation : a change in the terms of an existing marketing authorisation
[16] This is separate from the misalignment in legislation explained in P0.

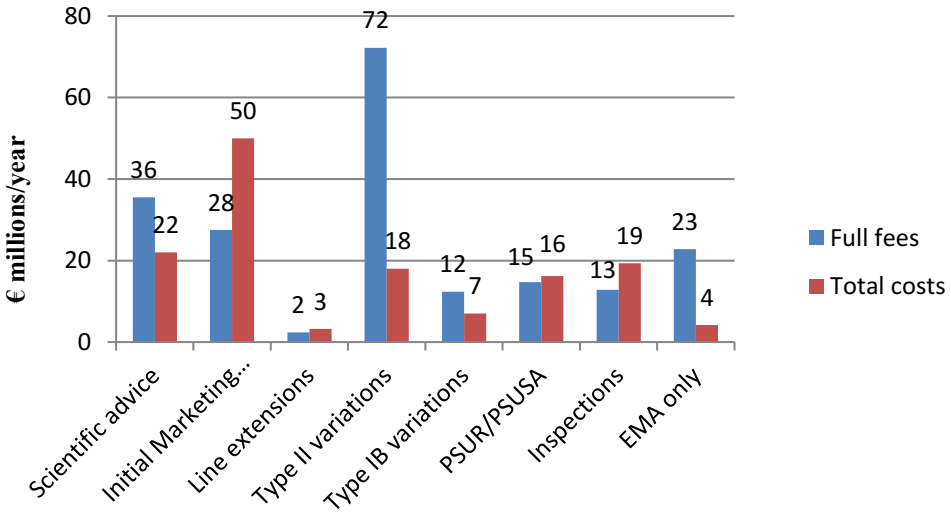


Figure 1: Comparison of total costs and fees for EMA and NCAs over one synthetic year[17] before incentives applied under the current financial model – human medicines only

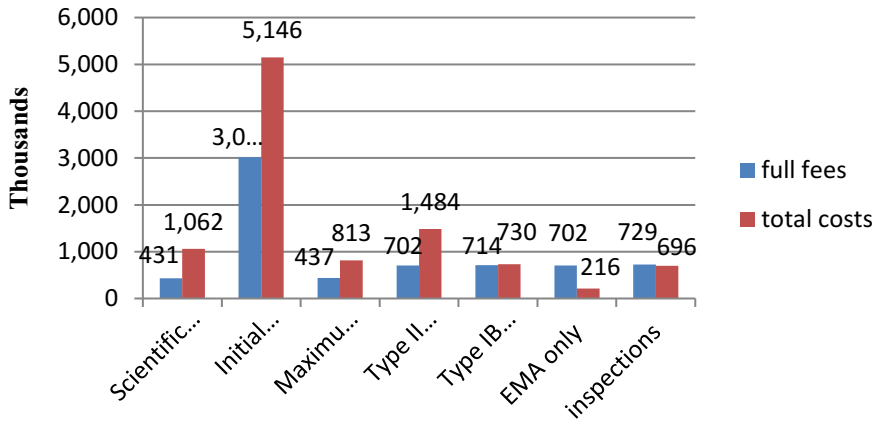


Figure 2: Comparison of total costs and fees for EMA and NCAs over one synthetic year before incentives applied under the current financial model – veterinary medicines only

[17] Synthetic year: A synthetic year is used to determine costs to EMA and NCAs incurred for EMA-related activities in a 'typical year'. The synthetic year "neutralises" differences in the reporting of data for EMA and NCAs. This was necessary to ensure that, for activities where NCAs are involved, the number and type of activities is the same for EMA and NCAs in the 'typical year'.

1.1.3. 2.1.3. Misalignment of some NCA remuneration with the costs incurred to undertake the work [P2]

At the level of individual activities, a high degree of variation exists in the extent to which remuneration aligns with costs.[18] NCAs receive more remuneration than their incurred costs for certain procedures (e.g. variations) and less for others (e.g. initial marketing authorisation procedures).[19] For example, as shown in Figure 3, for human medicine variation and scientific advice procedures the fee revenue is almost 3 times higher than the underlying costs incurred to undertake the work, whilst for initial marketing authorisations and inspections costs exceed the total remuneration received for those activities. Discrepancies are not as large for veterinary medicines, where only in the case of initial marketing authorisations are costs considerably higher than remuneration. Furthermore, for some procedural activities EMA fees do not exist and, consequently, no respective remuneration is provided to NCAs (e.g. procedures related to paediatric investigation plans and orphan designation).[20] This affects more or less all NCAs serving as rapporteurs for a procedure, with NCAs that undertake only veterinary activities (16 out of 48) being less likely to cover their aggregate costs, due to the lower fees applied to those procedures.[21]

In addition there is a difference between the approach taken for pharmacovigilance activities compared to other types of activities. The 2014 Pharmacovigilance Fee Regulation introduced fees and remuneration based on cost estimations whereas fees set under the main Fee Regulation, remunerates NCAs at 50% of the fee (i.e. not cost-based). The Court of Auditors has also repeatedly criticised the non-cost-based approach to remuneration of NCAs (in relation to the main fee regulation)[22].

The evidence suggests that misalignments at the individual activity level may lead to an imbalance in the overall level of remuneration to NCAs. Whilst the total remuneration for procedural activities exceeds the related costs, the overall remuneration received by NCAs is not sufficient to cover their aggregate costs when all the additional non-procedural activities they reported are included[23]. Such additional non-procedural activities are activities carried out by NCAs not directly linked to a specific procedure (e.g. activities not triggered by an application which have no defined timelines) and which an analysis is needed to determine whether they fall into the scope of remunerable services provided to

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[18] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 83 section 6

[19] Inception impact assessment - Revision of the EMA fee system page 4

[20] Inception impact assessment - Revision of the EMA fee system page 4

[21] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 83 section 6

[22] See the European Court of Auditors reports on the annual accounts of the European Medicines Agency for the financial years 2006 (Report on the annual accounts of the European Medicines Agency for the financial year 2006 together with the Agency's replies (2007/C 309/07), OJ C 309, 19.12.2007, p. 34–39), 2010 (Report on the annual accounts of the European Medicines Agency for the financial year 2010, together with the Agency's replies, 2011/C 366/06, OJ C 366, 15.12.2011, p. 27–32) and 2011 (Report on the annual accounts of the European Medicines Agency for the financial year 2011, together with the Agency's replies, 2012/C 388/20, OJ C 388, 15.12.2012, p. 116–122).

[23] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 59 section 5.1 and page 83 section 6

EMA by NCAs. Such activities include IT developments, audits, signal detection, reporting on adverse drug reactions etc. However, whether, and to what extent, the cost of these additional non-procedural activities should be covered by EMA fee remuneration, was the subject of a separate analysis (see Section 6.1. *Public authorities and budgets (including governance and good administration*) to determine their eligibility under the Founding Regulation. Annex 4 –Addendum 2 contains further information on NCA "additional non-procedural activities" eligible for remuneration, how they have been defined as well as the methodology used to calculate the costs eligible for remuneration.

These misalignments could affect the ability of NCAs to remunerate the needed expertise for the evaluation of EU-level procedures. Although the evaluation did not show any major problem of effectiveness of the EMA fee system it found that if NCAs were to reduce their involvement due to lack of financial resources for remunerable contributions to EMA this would negatively affect the sustainability of the regulatory network and the work of EMA.[24]

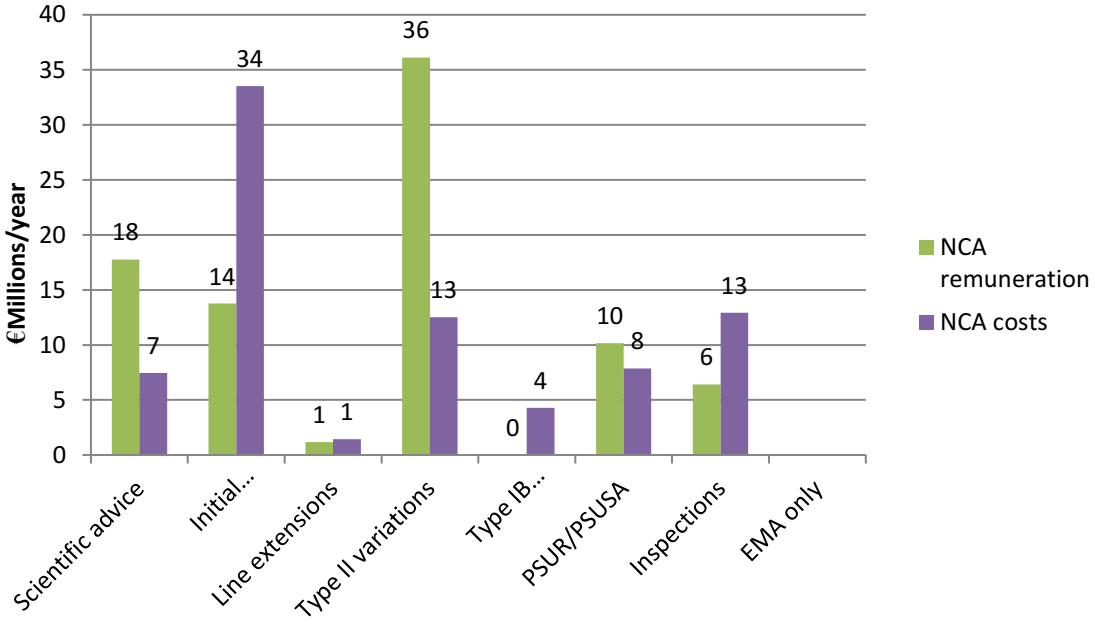


Figure 3: NCA costs and fee revenue/income over one synthetic (modelled) year with fee incentives applied as per current financial model – human medicines

[24] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 61 section 5.1

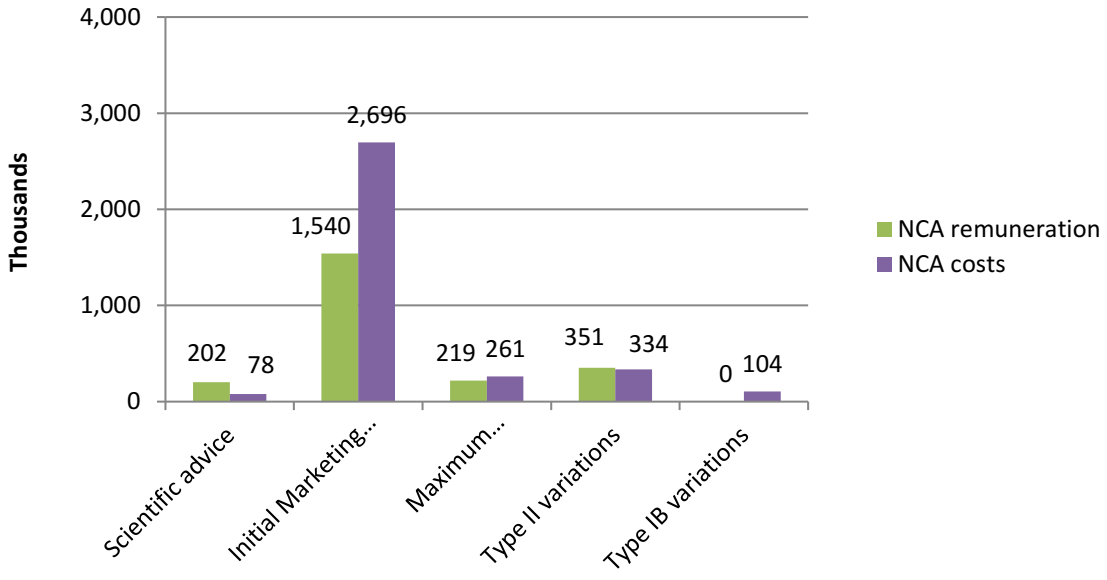


Figure 4: NCA costs and fees revenue/income over one synthetic (modelled) year with fee incentives applied as per current financial model – veterinary medicines

1.1.4. 2.1.4. The fee system is complex, partly inconsistent and not flexible [P3]

The structure of the fees paid by industry should be as simple as possible to apply in order to minimise the related administrative burden for all stakeholders (EMA, NCAs, industry)[25]. This need is not fully met by the current system. Around 90 basic procedural fees, relating to medicinal products for human and veterinary use, exist under the current system and additional amounts may be added to those basic fees. Whilst these additional layers contribute to fairness by allowing for a more detailed breakdown of fees and fee incentives, they also add to the complexity of the fee system (there is a large number of specific fee values to be calculated), and the resulting financial flows are not easily predictable for fee payers.[26] The administrative burden on EMA and industry is evident - in 2021, 32,967 sales orders[27] were triggered by EMA, resulting in over 18,000 invoices to pharmaceutical companies. SMEs and research organisations, also reported difficulty in navigating the rules and amounts for fees charged, and felt that the system is not always

[25] Council Regulation (EC) No 297/95 and Regulation (EU) No 658/2014.

[26] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 63 section 5

[27] Sales order is the technical equivalent for 'recovery order' within the meaning of Article 98(2) of the general financial regulation (= Article 65 of the Agency's and the Framework Financial Regulation), i.e. 'the act by which the authoring office instructs the accounting officer [..] to recover an amount receivable that the authoring officer has established'. A sales- or recovery order is followed by an invoice issued by the accountant.

transparent and easily accessible to them.[28] In 2021, around 8% of the sales orders and invoices issued by EMA were for SME applicants.

Secondly, the fee system is not fully coherent internally with certain pieces of legislation that govern and affect the fee system.[29] For example, in the main Fee Regulation incentives are applied *after* remuneration of NCAs (EMA absorbs the shortfall), whilst under the Pharmacovigilance Fee Regulation incentives are applied *before* NCA remuneration (the shortfall is shared proportionally by NCAs and EMA). There is no rationale for this divergence of approach, and it points to a problem of principle as to whether NCAs of Member States should share the burden of the incentives. Furthermore, the way NCA remuneration is calculated is not aligned across the two regulations; NCA remuneration in the main fee regulation is calculated as a percentage of the fee charged to industry, whilst NCA remuneration in the Pharmacovigilance fee regulation is expressed as finite amounts based on estimated underlying costs. The fee system is also not coherent with the Paediatric Regulation as it does not provide remuneration to NCA rapporteurs for their scientific assessments.

These inconsistencies affect NCAs in terms of the level of remuneration they receive for the various scientific services they provide. Furthermore, the different ways in which their remuneration is calculated means that remuneration does not fully reflect underlying costs.

While the main Fee Regulation currently provides some flexibility to accommodate changes in the regulatory system through implementing rules, the existing fee system cannot address some core issues, such as the variability in workload for assessments categorised under the same procedure type, or variability in complexity (e.g. for procedures relating to the latest innovations in medical science, such as gene therapy, personalised medicines) which would result in varying time required to complete the assessment.[30] It may also affect the distribution, in both number and type of activities across NCAs. As it stands, the only regular updating of fee levels foreseen is that which adjusts them in line with the rate of inflation. Consequently, the fee system is not flexible enough to accommodate significant fluctuations in EMA and NCAs' workload or, more specifically, the changes in time and budget needs related to varying complexity of the activities undertaken.[31]

The current possibility to adapt the fee system through 'implementing rules' of the current main EMA fee regulation is not fully adequate to ensure full alignment to legislative changes. For example, while it has allowed for a partial alignment to the new VMP provisions, it could not accommodate the new costs for DARWIN EU as changes in the amount of the annual fees require a full-fledged legislative procedure.

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[28] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 62 section 5.1. For SMEs, EMA operates a specific support structure, 'the SME office'.

[29] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 79 section 5

[30] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 66 section 5

[31] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 65 section 5.1

Elements identified following the COVID-19 crisis

The Regulation on a reinforced role for EMA was adopted to enable the Agency to act in preparation for and during major events and public health emergencies. The provisions in that regulation affect EMA and NCA, both financially and operationally. The increased workload has led to additional costs, for which no quantifiable data exists, and has further highlighted the importance of having a flexible system that would be able to adapt to meet changing costs on an objective basis to guarantee the sustainability of the operation of the regulatory network. In line with the Regulation on a reinforced role of EMA, additional payments have been put in place respectively in the current system, financed through the EU budget contribution.

The COVID-19 pandemic also showed the value of a flexible fee system. Upfront fee payments were introduced, via the implementing rules of the main fee regulation, for the "rolling review" approach[32], along with the possibility of additional remuneration (top-up payments) , beyond regular remuneration foreseen in the fee system, to NCA rapporteurs.

1.2. What are the problem drivers?

Regulatory drivers

1.2.1. 2.2.1. New and amended procedures for veterinary medicines (VMP legislation) and new estimated EMA costs as of 2024 for DARWIN (under the Regulation on a reinforced role for EMA) [D1]

New and amended procedures for veterinary medicines have been introduced by the VMP Regulation, which has become applicable in January 2022.[33] The current fee legislation does not provide fees for some newly introduced activities, whilst it includes fees and remuneration for procedures that are going to disappear.

An interim measure[34] has been put in place in order to ensure continuity of funding for the veterinary operations between January 2022 and the applicability of a new fee regulation. Nonetheless, this measure cannot be considered as a sustainable solution as some fees, such as annual fees, cannot be introduced/amended by the implementing rules and amended existing fees could not be fully benchmarked on the new regulatory processes, and therefore cannot be considered cost-based.

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[32] A rolling review is a regulatory tool that EMA uses to speed up the assessment of a promising medicine during a public health emergency. Normally, all data on a medicine or vaccine's effectiveness, safety and quality and all required documents must be ready at the start of the evaluation in a formal application for marketing authorisation. In the case of a rolling review, EMA's human medicines committee (CHMP) reviews data as they become available from ongoing studies. Once the CHMP decides that sufficient data are available, the company can submit a formal application. By reviewing the data as they become available, the CHMP can come to an opinion on the medicine's authorisation sooner.

[33] Some of the main benefits of the Regulation are reduction in the administrative burden, simplification of the regulatory environment (including indefinite authorisations, thereby obviating the need for renewals procedures), as well as the overhaul of some post authorisation activities.

[34] Rules for implementation of EMA fee regulation, EMA/MB/408059/2021, Annex II.8

Furthermore, with regard to the operation of DARWIN EU, financing via an EU budget contribution has been allocated until end of 2023 (time limited), following which financing will need to be ensured through fee revenue.

1.2.2. 2.2.2. The levels of fees and remuneration for EMA and NCAs for procedures are not fully cost-based [D2]

In accordance with the legislation, fees charged to industry should be based on the costs of the Agency and the costs of NCAs for services provided to the Agency. However, the current system was designed to be updated principally based on the annual inflation rate, and not to regularly track and cater for workload fluctuations over time. This has had a significant effect on the alignment of fees with underlying costs.

1.2.3. 2.2.3. The fee system is complex [D3]

The complexity of the current EMA fee system stems from (1) the wide variety of underlying services provided and activities carried out by EMA (most of them requiring the contribution of NCAs) and (2) the several layers of legislation governing and influencing the fee system.[35] Since the last amendment of the main Fee Regulation in 2005, several pieces of sectorial legislation established additional fee incentives. The adoption in 2014 of the Pharmacovigilance Fee Regulation has added to the overall complexity.

Divergent approaches on elements such as the application of incentives and the way NCA remuneration are calculated in both EMA fee regulations lead to even more incoherence in the resulting system.

Real world drivers

1.2.4. 2.2.4. Assessing innovative medicinal products (e.g. gene therapy, personalised medicines) is becoming more complex [D4]

Several NCA representatives reported that evaluating medicinal products has become increasingly complex in recent years due to more sophisticated innovations and advances in science (e.g. gene therapy, personalised medicines).[36] Contributors to this additional complexity include very innovative products without clinical data or with insufficient data and therefore potentially requiring in future more extensive assessment, big data, analysis of real-world data and patient experience data (including how to address differences in data standardisation), health technology assessments (HTA), and companion diagnostic reviews.[37] In the veterinary medicines sector, increasing complexity is also expected in

[35] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system.
[36] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 72 section 5.1
[37] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 72 section 5.1

activities related to monoclonal antibodies and stem cells.[38] There is currently no monitoring system to capture the possible significant effects of these developments on the relevant costs.

1.3. How likely is the problem to persist?

The misalignment of the fees regulations with new (and future) pieces of legislation represent a risk for the financial sustainability of EMA and the contributions of NCAs. EMA tasks linked to the veterinary pharmacovigilance procedures are not covered by specific fees and may in the long run be covered by an additional EU budget contribution.

The implementation of the Regulation on a reinforced role for EMA as of 2024 requires substantial input from fee revenue, with the current cost estimations, and may become a breaking point for the capacity of the current fee system to adapt to the anticipated costs. As presented, the EU budget contributions will cover costs for the operation of DARWIN EU[39] only until end of 2023, and a specific EU budget financing of that particular activity is no longer earmarked as of 2024.

Secondly, significant shortfalls in the EMA budget, arising from the misalignment of fees and costs, could negatively affect the financial sustainability of EMA in the future.[40] This in turn could affect the remuneration of NCAs and consequently their ability of to contribute to the EU regulatory system by providing expertise for the evaluation of EU-level procedures

The EU is experiencing fast technological transformation and there is a general trend towards convergence of industries, products, technologies and services.[41] These trends will influence the research and innovation landscape, including in health and will have an impact on the functioning of EMA.

In view of the current revision of the underlying pharmaceutical legislation, there may be more changes to the legal framework in the future. The fee system will have to adapt continuously, beyond the current revision, to provide appropriate fees and remuneration for the services provided.

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3. Why should the EU act?

[38] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 72 section 5.1

[39] Objective 3 of the financial statement for Regulation (EU) 2022/123 on a reinforced role for the European Medicines Agency

[40] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 84 section 6

[41] European Commission. (2021). Strategic Foresight Report: The EU's capacity and freedom to act. As of 25 October 2021: https://ec.europa.eu/info/sites/default/files/strategic_foresight_report_2021_en.pdf

1.4. Legal basis

The legal basis for EU action is that the proposed regulation would be based on a dual legal basis, Article 114 and Article 168(4)(c) of the Treaty on the Functioning of the European Union, and will aim to replace or amend as necessary the two EMA fee regulations.
The proposed regulation is based on Article 114 TFEU as differences between national legislative, regulatory and administrative provisions on medicinal products tend to hinder intra-Union trade and therefore directly affect the operation of the internal market. The EMA Fee Regulation ensures the availability of the necessary financial resources to apply the Union procedures for the assessment of medicinal products, which have been introduced amongst other things to prevent or eliminate obstacles that could result from parallel procedures at national level. Thereby this Regulation contributes to the well-functioning of the internal market and the common post-marketing surveillance of medicinal products.
In addition, the proposed Regulation is based on Article 168(4) (b) and (c) TFEU as it aims to support the goal of setting high standards of quality and safety of medicinal products and the protection of public health through measures in the veterinary field. It ensures the availability of sufficient financial resources to perform the activities that are necessary to guarantee that high standards are applied for the authorisation of pharmaceutical products and maintenance of those authorisations.
The EU budget contribution included in the current multiannual financial framework (MFF) will be taken into account too.[42]

1.5. Subsidiarity: Necessity of EU action

EMA is a decentralised Agency of the EU, therefore decisions on its funding and the fees it may charge are taken at EU level. Only the Union can act to enable the Agency to charge fees and to define the levels of those fees. The proposed legislation will not apply to fees charged by NCAs in their respective Member States, for which the EU does not have competence.

1.6. Subsidiarity: Added value of EU action

Since only the Union can act to enable the Agency to charge fees and to define the levels of those fees, the added value is inherent and is linked to the necessity of EU action.

4. Objectives: what is to be achieved?

1.7. General objectives

The general objective of this initiative is to provide a sound financial basis for EMA and its activities, including cost-based remuneration for the services provided by NCAs. This will

[42] The level of the Union contribution in the next MFF should take into account an evaluation of EMA needs and the level of fees established following a legal proposal based on this impact assessment, as per article 67(e) of EMA's founding regulation 726/2004.

be achieved by better aligning fees to underlying costs and to simplify as far as possible the system, while ensuring that the EMA budget is in balance. The EU budget contribution included in the current multiannual financial framework (MFF) is taken into account.

In addition, the initiative has to respect a number of fundamental overarching principles that are crucial for the sound functioning of the fee system.

The future fee system has to ensure that EMA's costs (including expenditure for cost-based remuneration to NCAs) are covered, taking into account the balancing subsidy of the EU budget contribution, as provided by the EMA founding regulation. This is aligned with the principle whereby the financing of certain services, for which a cost-based approach is not viable, is guaranteed by a redistribution of the costs for those services across all revenue sources of EMA (including fees, charges, EU budget contribution). These services concern activities for specific markets, applicants and product categories where fees are reduced or incentivised in legislation/ policy (e.g. veterinary medicinal products, SMEs).

Additionally, the fee system needs to guarantee an adequate level of agility to be able to adapt to future changes in the regulatory system, including relevant changes in the Union pharmaceutical legislation following the review under the Pharmaceutical Strategy for Europe.

While it is an overall objective of the fee legislation to ensure a level-playing field for SMEs, the evaluation did not identify any issue in that respect and therefore, this is not part of the specific objectives of this revision which are described below. The EMA fee reductions for SMEs are laid down in Commission Regulation (EC) No 2049/20053 which will continue to apply. In addition, it should be noted that facilitating the development and marketing of safe and effective medicines is an objective of the overarching EU pharmaceutical legislation and it is not an objective of this revision.

1.8. Specific objectives

Based on the problems outlined in Section 2, the specific objectives of the initiative are:

- Objective 1: to align the fee system to new legal provisions introduced by recent legislation. Specifically,
    - relevant changes to the rules applicable to the authorisation and monitoring of veterinary medicinal products (VMP), as introduced by the new VMP Regulation;
    - relevant changes in the cost basis for EMA operations introduced by the Regulation on a reinforced role for EMA

  Furthermore, it should take into account a new legal provision, which introduces "charges" as a possible source of revenue for the Agency in the EMA Founding Regulation as currently applicable.
- Objective 2.1: To better align procedural fees to respective costs while respecting fee incentives set in existing policies
- Objective 2.2: , To allow remuneration of NCAs based on their relevant costs;

- Objective 3: To simplify the fee system in order to minimise the administrative burden generated, as well as making the system more coherent internally by harmonising the current practices introduced by existing Regulations;
- Objective 4: To allow sufficient flexibility to accommodate fast-paced developments in the pharmaceutical sector and the increasing complexity of products submitted to the Agency for evaluation.

The objectives of simplification and flexibility stem from the experience gathered and the evaluation and, therefore, the Commission enjoys more discretion in that respect, as compared to the cost-based objective which is the backbone of this revision. In practical terms, the main trade-off is between cost-alignment and simplicity, since cost-alignment requires more procedural fees, while simplicity means less procedural fees and more reliance on annual fees. While flexibility can be seen as a horizontal feature (i.e. how fast and simple the procedure is to adjust the amounts of fees and remuneration), it is influenced by the balance between cost-based and simplification, i.e. it is in principle easier to monitor the cost and adjust the fee for a given type of procedure as compared to an annual fee.

5. What are the available policy options?

The policy options assessed were designed in order to address an increasing number of objectives set for the new initiative, starting from the bare minimum, and the expanding to the full scope. The policy options consist of:

- A baseline scenario that extrapolates what will happen in the absence of a legislative reform to the EMA fee system.
- Three main policy options that will change substantive aspects of the fee system in different ways.
- A number of horizontal measures that are used in combination with one or more of the main options to adjust a specific aspect of the system.

Table 1: Policy option descriptions (main options and horizontal measures)

Option category	Policy Option	Summary
Baseline	Do-minimum	Fee system adjusted to account for the 2018 VMP Regulation and revised EMA Founding Regulation current policy commitments as these already apply. This creates the baseline scenario to which all other options can be assessed.
Main policy options	1	In addition to the 'do minimum', cost-based fees are introduced for all veterinary medicines procedures, as per the new VMP regulation.
	2	Introduces a cost-based fee system for all EMA activities for both veterinary and human sectors. No changes to the fee system structure, but fees are included for additional procedural activities, for which no fees are charged currently (and no remuneration is paid). Unremunerated procedural activities in the current system become remunerated under this option.
	3	Cost-based fee system for human and veterinary activities, with a simpler fee structure.

Option category	Policy Option	Summary
	3 '*light*'	Implements a more limited simplification of the fee system structure described in option 3[43].
Horizontal measures	A	Veterinary fee reductions: (i) Cost-based fees for veterinary medicines with a general fee reduction only, i.e. all fees reduced by 50% (ii) Cost-based fees for veterinary medicines with a 50% general fee reduction and specific incentives for certain categories (iii) Cost-based fees for veterinary medicines with specific incentives for certain categories (iv) Same as (iii) but with larger incentives.
	B	Applies a country coefficient to NCA remuneration.
	C	Applies incentives to cost-based fees before remuneration to NCAs.
	C1	Based on C. Applies specific incentives for veterinary medicines (limited markets and some immunological products), combined with a 25% reduction of the veterinary annual fee.

1.9. What is the baseline from which options are assessed? (The do-minimum scenario)

The baseline (do-minimum scenario) is the reference scenario, against which the other options and horizontal measures are tested. It consists of the current fee system, which remains unchanged, while taking into account the newly introduced provisions for the veterinary sector (to the extent possible without legal change) and the Regulation on a reinforced role for EMA (i.e. an increased cost of EMA for Darwin EU). As a result, in the baseline scenario:

- The structure of the fee system is unchanged: granular fees charged per procedure and annual fees for maintenance of authorisation and for pharmacovigilance. NCA remuneration non cost-based, in general 50% of the fee.
- Relevant fee incentives are applied in line with existing legislation and rules.
- The veterinary sector is aligned with the new VMP Regulation rules to the extent possible without legislative change (resulting in the introduction of some new fees and the amendment of some other existing ones). The amounts for new and

[43] Under option 3, procedures for which no procedural fee is charged and the cost is covered instead through the annual fee are:

- human medicines: Renewals, Type IA variations, Type IB variations and Type II variations;
- veterinary medicines: five of the current six types of Variations, so that only Line Extensions still have a procedural fee;

and under option 3' *light*', the list of procedures for which no procedural fee is charged is reduced to:

- human medicines: Renewals, Type IA variations and Type IB variations;
- veterinary medicines: only one of the current six types of Variations ceases to have a procedural charge: Simple assessments; the other Variations fees are retained.

amended fees are benchmarked to existing fees (i.e. they are not cost-based). The current unitary fee amounts are applied to the fees of the remaining veterinary procedures unaffected by the VMP Regulation. The current remuneration system (50% of the fee) is applied to the new veterinary classification of procedures.

- The part of the fee system related to human medicine remains unchanged. The current unitary fee amounts and the current NCA remuneration system (50% of the fee) are applied.
- Aggregate fee revenue is expected to change due to the change of classification and frequency of procedures under the VMP regulation.
- The estimated cost of DARWIN EU appears in costs of EMA as of 2024, based on an estimation of the costs of the operational phase of DARWIN EU. This cost is covered neither by the EU budget nor by fees.

1.10. Description of the policy options

1.10.1. 5.2.1. Option 1

The first option is alignment of the fee system with the provisions introduced by new VMP regulation, including recalculation of fees for the veterinary sector in line with the cost-based principle (the effect of the Regulation on a reinforced role for EMA is taken into account) (Objective 1).

The three veterinary horizontal measures can be applied to this option (see below section *5.2.5.1*)

The overall architecture of the system (in terms of disaggregation of procedural fees vs annual fees) remains unchanged. For human medicines, fees and NCA remuneration remain unchanged. In addition, the mechanism of remuneration to NCAs remains unchanged, maintaining a percentage basis.

Hence, in this option:

- Cost-based procedural and annual fees are introduced for the veterinary sector.
- A pharmacovigilance annual fee for veterinary medicines is introduced to cover the cost of EMA pharmacovigilance activities in the veterinary sector. It is charged in the same way as the human pharmacovigilance annual fee in the current fee system, i.e. based on chargeable units for Nationally Authorised Products.[44]
- Fee incentives (i.e. discounted fee rates) for SMEs are applied in line with existing SME legislation but general reductions and product-specific reductions are not applied to veterinary medicines (these are explored through the horizontal measures dealing with veterinary incentives).

[44] Chargeable units were introduced for the purpose of charging pharmacovigilance fees. A chargeable unit can be construed as being equivalent to a harmonised definition for a single marketing authorisation of a medicinal product in all Member States.

However, taking into account the Regulation on a reinforced role for EMA and the estimated cost of DARWIN EU as of 2024, an additional element had to be added to the design to make it viable, by introducing additional fee revenue for the Agency as of January 2024 to balance the budget. Therefore, whilst procedural fees and respective NCA remuneration for human medicines remain unchanged, as compared to the current system, the estimated impact of DARWIN EU on EMA's costs is incorporated in the analysis from 2024 onwards and is covered by the human Pharmacovigilance annual fee (Pharmacovigilance annual fee) and human CAP annual fee in proportion 75% / 25%[45].

1.10.2. 5.2.2. Option 2

The second option also aligns the system with the new VMP Regulation and reinforced role of EMA regulation (objective 1) but also aligns fees and remuneration amounts to the respective costs of EMA and NCAs for carrying out the work (Objective 2). All horizontal measures can be applied to this option (see below sections *5.2.5.1- 5.2.5.3*)

Whilst the overall architecture of the system remains unchanged as compared to baseline and option 1, option 2 introduces a cost-based fee system for *all* EMA activities, i.e. calculates cost-based fees and NCA remuneration amounts for *both* veterinary *and* human medicines.[46]

Furthermore, in this option:

- Cost-based fees are introduced for some activities for which fees are not currently charged (including but not limited to orphan and paediatric procedural activities). In addition, NCA cost-based remuneration is introduced per procedure for these activities.
- The CAP annual fee (levied on Centrally Authorised Products) is calculated based on all other costs (non-fee generating and horizontal) and taking into account all available revenue sources to balance the budget. This includes the cost of financing DARWIN EU, as of 2024. NCAs are also remunerated via the annual fee for eligible additional activities.
- Costs and associated remuneration for pharmacovigilance activities are covered by the procedural pharmacovigilance fees and the Pharmacovigilance annual fee (calculated based on chargeable units for Nationally Authorised Products), for medicines for both human and veterinary use.
- Relevant fee incentives continue to apply in line with existing legislation and rules. Fees for some activities continue therefore to be waived. However, full cost-based remuneration is paid to NCAs.

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[45] This is the estimated proportion of number of medicinal products to which these two fee apply respectively.

[46] Cost-based fee and respective remuneration are calculated as weighted averages of cost multiplied by workload using the most recently available EMA- & NCA-obtained data on time and cost taken to complete activities, with distribution of relevant non-procedural EMA cost among all the revenue sources of EMA, as provided for in its Founding Regulation. More details are provided in the methodology.

1.10.3. 5.2.3. Option 3

The third option builds on option 2, not only introducing a cost-based fee system for human and veterinary activities, but also simplifying the fee system structure (objective 3) for both human and veterinary medicines. Horizontal measures can be applied to this option (see below sections *5.2.5.1 - 5.2.5.3*)

In this option the following simplifications are introduced:

- A reduced number of procedural fees are applied for post-authorisation non-pharmacovigilance activities for human and veterinary medicines. Procedural fees are levied for pre-authorisation activities (human and veterinary), inspections and only some major post-authorisation activities (e.g. referrals[47]). Due to technical complexities linked to the variety of products included in pharmacovigilance procedures and activities, pharmacovigilance procedures continue to attract procedural fees.

- The CAP annual fee covers a broader set of costs as compared to the current system including those non-pharmacovigilance post-authorisation procedures that would no longer levy a procedural fee. Furthermore, it includes the cost of financing DARWIN EU, as of 2024.

- NCA remuneration for those post-authorisation procedures that are charged under the CAP annual fee is no longer per-procedure and is included in the annual remuneration paid to NCAs via the CAP annual fee.

- The Pharmacovigilance annual fee cover costs of EMA horizontal pharmacovigilance activities in both the human and veterinary sectors.

In this option procedure-based fees are presented for pharmacovigilance procedures[48].

[47] Procedure initiated to resolve issues such as concerns over the safety of an already authorised medicine or to resolve disagreement among Member States on the benefit-risk balance of a new medicine under evaluation. Referrals can be initiated by the European Commission, a Member State or the owner (marketing authorisation holder) of the product.

[48] This represents a change since the inception impact assessment (IIA) whereby costs for pharmacovigilance procedures were included under the pharmacovigilance annual fee. However, during the initial stages of the study supporting the impact assessment, the modelling results showed that this was not feasible from an operational point of view, as it would lead to significantly increased complexity in calculating the fees and associated NCA remuneration.

1.10.4. 5.2.4. Option 3 'light'

This option implements a partial simplification of the fee system structure (i.e. a reduced version of Option 3). This responds to feedback received to the inception impact assessment to have an option with a more modest level of simplification, as compared to Option 3. A more limited set of activities are covered by annual fees (mainly minor variations and renewals of authorisations) while procedural fees are maintained for a larger number of activities (mainly major variations). This option is referred to as *Option 3 'light'* in the remainder of the Staff Working Document. All horizontal measures can be applied to this option (see below sections *5.2.5.1 - 5.2.5.3*).

1.10.5. 5.2.5. Horizontal measures

1.10.5.1. **A, B, C, C1** - Veterinary medicines

Three horizontal measures have been considered for the fees applied to veterinary medicines. These introduce general fee reductions and/or incentives for veterinary medicines only. Each can be applied in combination with option 1, 2, 3 or 3 '*light*'.

- Horizontal measure A introduces a 50% general fee reduction applied to all (cost-based) fees for veterinary medicines. No additional fee incentives are applied.
- Horizontal measure B introduces a 50% general fee reduction applied to all (cost-based) fees for veterinary medicines *and* further specific incentives. This horizontal measure is the same as Horizontal measure A, but it also includes in addition specific fee incentives that are applied for veterinary products for limited markets and some immunological products.
- Horizontal measure C introduces only specific incentives that are applied for veterinary products for limited markets and some immunological products. No general reduction is applied to veterinary medicines cost-based fees.
- Horizontal measure C1 is based on sub option C. It introduces specific incentives that are applied for veterinary products for limited markets and some immunological products, combined with a 25% reduction of the cost-based annual fee for centrally authorised veterinary products. No general reduction is applied to veterinary medicines cost-based fees.

1.10.5.2. **D** - Country coefficient applied to NCA remuneration

This horizontal measure applies a country coefficient to NCA remuneration. Application of country coefficients would result in an adjustment to remuneration that is linked to costs in each Member State. This horizontal measure could apply to Option 2, 3 or 3 '*light*'.

1.10.5.3. **E** - Sharing the cost of fee incentives between EMA and NCAs

In the main options, remuneration is to be calculated fully cost-based, even when fee incentives apply. This horizontal measure applies incentives to cost-based fees before remuneration to NCAs, which means that the NCA remuneration is reduced in proportion to the fee reduction (this mechanism applies currently for pharmacovigilance fees and remuneration under Regulation 658/2014). Fee incentives are also applied to NCA remuneration so that the cost of incentives is shared in proportion to the incentive rates between EMA and NCAs. This horizontal measure could apply to Options 2, 3 or 3 '*light*'.

1.11. **Options discarded at an early stage**

The following options were discarded early in the process as their impacts were largely undesirable and there was little, if any, support for them among stakeholders.

- Implementation of a fee system in which fees would be paid to the Commission, not EMA as is currently the case. In this scenario, EMA would be fully funded by the EU budget contribution and it is the Commission that would reimburse the NCAs. This was discarded as it is out of scope of the fee legislation: it is the EMA Founding Regulation that lays down the revenue sources available to EMA, i.e. fees charged by EMA itself and the EU budget contribution.
- Implementation of a flat fee system. This would mean for example that all post-authorisation procedures, including for pharmacovigilance, would no longer attract a fee and the respective cost would be included in the calculation of the annual fee. Whilst the evaluation indicated that such a design would be considered simpler, it also found it would be much less fair, e.g., payers of a flat fee would pay for procedures that do not concern their products. Therefore the option was discarded as it was considered that it would lead to less fairness and proportionality. Instead, option 3 was introduced and, following feedback from the inception impact assessment, a '*light*' version was introduced.

As presented in Section 5.1, the baseline ("do minimum scenario") consists of the current fee system, with unchanged fees structure and amounts through legislative action. The only changes are the introduction of fees and remuneration for most of the new provisions of the veterinary sector, to the extent possible without a legislative change. The output of the financial modelling applied to the baseline shows a significant negative balance (see table 3 and 6). This is because, whilst new provisions stemming from the new VMP Regulation can be partly addressed through non-legal changes with the introduction of new procedural fees and remunerations, costs which can only be covered by annual fees (e.g.: DARWIN EU, Vet Pharmacovigilance annual fee) would remain uncovered as it is only possible to change annual fees by amending the legislation. Furthermore, the targeted introduction of fees and remuneration for new procedures would not allow to reconsider the costs of the sector in a holistic way taking due account of changes in the frequencies of activities and in the workload involved. Overall, under the baseline, the Agency would not be able to balance its budget and the operation of its network would become unsustainable. Therefore the baseline is not considered as a possible option.

Finally, elements such as the scope of activities for which remuneration from EMA can be paid to NCAs and the scope and level of existing fees incentives were also considered out of scope, since this is provided for in EMA's founding regulation (the former) and in sectorial legislation (the latter).

6. What are the impacts of the policy options?

Given the nature and scope of the policy choices concerned, the impacts identified in the screening are purely of an economic nature. No significant social, environmental or fundamental rights impacts have been identified due to the nature and scope of this initiative. Table 2 lists the categories for which impacts are foreseen, distinguishing between the ones where more significant impacts are expected (✓✓) and those where some impact is at least possible (✓).

Economic Impacts	Significance of impact
Public authorities and budgets	✓✓
Administrative burdens on business	✓
Position of SMEs	✓✓
Innovation and research	✓
Functioning of the internal market competition	✓

Table 2 Categories for which impacts are foreseen

The impacts of the options were assessed based on the analysis of the outputs of the financial model delivered by an external study[49] as well on the feedback received from the targeted stakeholder consultations, which were carried out through an online survey and interviews. Further details on the stakeholder consultations can be found in the synopsis report, Annex 2.

1.12. Public authorities and budgets (including governance and good administration)

Under this heading, the impacts of the different options on the various public bodies involved with EMA's activities have been assessed. These include not only EMA, but also the different NCAs which provide the bulk of the scientific assessment work that is core to EMA's function as the agency for medicines assessment and surveillance of the EU for centralised products. The basic question that arises, is whether the different levels of fees that would be set under the different options are sufficient to enable both EMA and the NCAs to continue to fund their centralised activities in the future. This includes both

[49] Annex 6 and Annex 7

setting fees at a rate that is sufficient to cover the real and relevant costs incurred, and ensuring that the resulting revenues are fairly distributed between the different actors.

Tables presented below correspond to the calculations presented at the consultation stage, as presented in Annex 6

2024	Do minimum *(baseline)*	Option1	Option 2	Option 3	Option 3 *'light'*
EMA income ***(€'000)***					
Total industry procedural fees	225,236	230,466	183,513	144,976	164,037
Total industry annual fees	137,174	171,634	195,683	234,220	215,159
Total industry fees	*362,410*	*402,100*	*379,196*	*379,196*	*379,196*
Total EU budget contribution	34,000	34,000	34,000	34,000	34,000
Total EMA income	**396,410**	**436,100**	**413,196**	**413,196**	**413,196**
EMA expenditure ***(€'000)***					
Total expenditure on human and veterinary procedures	114,269	114,527	116,080	116,080	116,080
Total expenditure on other activities	162,141	162,141	162,141	162,141	162,141
Total remuneration to NCAs (*)	160,014	162,647	134,975	134,975	134,975
Tot EMA expenditure	**436,424**	**439,315**	**413,196**	**413,196**	**413,196**
Variance ***(€'000)***					
	-40,013	***-3,215***	***0***	***0***	***0***

Table 3

The financial model supporting this impact assessment was designed to respect the principle of a balanced EMA budget and it was tuned around the central year of the current MFF, 2024. **As a result, as shown in Table 3 above, the majority of the options, except option 1[50], calibrate the income from industry fees so that once combined with the EU budget contribution, they match the projected expenditures of the specific year.** The 'do-minimum' baseline scenario shows a significant negative balance, which is why it is discarded, demonstrating the need for legislative action to adapt the current system to newly introduced requirements and activities for the Agency and the network, which would remain otherwise uncovered (see Section 5.1.1).

[50] Policy option 1 also shows a negative balance, though a much smaller one, due to the fact that by design the option addresses only changes to the veterinary fees, without readjusting the rest of the system to guarantee the appropriate balancing.

The total NCA remuneration appears as an expenditure of the EMA budget. Moving to a cost-based system, by definition the remuneration amounts are calculated so to match the modelled costs for the identified eligible procedural and horizontal activities. Table 4 breaks down the distribution of remuneration for procedural and horizontal activities under the different options, with variations depending on the different options designs.

2024 *€'000*	Do minimum *(baseline)*	Option 1	Option 2	Option 3	Option 3 '*light*'
Total remuneration to NCAs (*)					
Remuneration from procedural activities	120,620	123,032	117,808	102,657	114,008
Remuneration from annual fees	39,394	39,615	17,167	32,318	20,968
Total NCA remuneration	**160,014**	**162,647**	**134,975**	**134,975**	**134,975**

Table 4

Whilst the model was tuned to correctly balance the budget of 2024, minor variances can be observed between the projected income and expenditures across the years. As shown in Table 5, even in presence of variances the balance is always positive for the majority of the options (varying from €2.1 million to €8.1 million in surplus), with the exception of Option 1, for the reasons already explained above. For Option 1 a negative balance of between €1.4 million and €3.2 million would be experienced for the years from 2024 to 2026[51].

Budget balancing p/year *€'000*	2022	2023	2024	2025	2026
Do-minimum	-14,958	-17,358	-40,013	-41,475	-42,666
Option 1	3,449	2,127	-3,215	-2,507	-1,437
Option 2	5,255	4,851	0	2,779	5,544
Option 3	4,218	8,142	0	2,707	5,711
Option 3 '*light*'	4,506	4,464	0	3,241	6,529

Table 5

EMA responded positively to options 2, 3 and 3 '*light*' in terms of the ability of balancing the agency budget, whilst option 1 would cause a significant shortfall given the level of EU budget contribution decided under the current MFF. EMA remarked that, whilst under all three of these options the agency would be able to balance its budget, the decrease in remuneration for NCAs could undermine the ability of the NCAs to contribute to the centralised system and ultimately put at risk the stability of the network.

From the NCAs side[52], the general opinion with the calculations presented for the consultation was that options 2, 3 and 3 '*light*' would worsen the current situation, as they

[51] As provided in Article 17 of the EMA financial regulation, any positive balance would be returned to the Commission and the amount then subtracted from the EU budget contribution provided for the subsequent year.

[52] Four features of the cost methodology were identified by NCAs and the HMA as responsible for the fact that the cost-based fee options (2, 3 and 3 'light') generate, in aggregate, insufficient funding for NCAs: (1)

would receive even less remuneration than under the 'do-minimum' baseline. Over half of NCAs and one ministry of health responding to the targeted survey indicated that option 1 would have no impact vis-a-vis the 'do minimum' baseline on their ability to undertake EMA activities, whilst implementation of options 2 and 3 would have a negative impact on their ability to undertake such activities. All five NCAs dealing only with veterinary medicines believed that option 1 could bring positive impacts in comparison to the current framework, whilst they were opposed to option 2 and 3 (NB their responses seemed to focus only on certain aspects, and not the fee system as a whole).

The HMA (Heads of Medicines Agencies in the Member States) stated that there are already some difficulties in meeting demand for rapporteurs and co-rapporteurs to carry out assessment activities and any option that reduced remuneration of NCAs would worsen this difficulty. Comments were also made that a strict approach to costs does not reflect the current situation and need for resources to cope with the Covid-19 crisis as well as the ever increasing workload and complexity of the products that regulators have to deal with. However, no further data usable by the study model was provided. In addition, the availability of resources in the national agencies has likely experienced an external shock, possibly due to the increased frequency and accelerated pace of assessment procedures for products related to the pandemic. A link between this possible structural problem and EMA remuneration has not been demonstrated.

The different parties consulted, including NCAs, did not express firm positions on the design of the different fee structures proposed under the various options. The consultation process above all revealed a broad consensus that the cost of additional NCA activities eligible for remuneration by EMA (i.e. in line with NCAs' role under the EMA founding regulation), and therefore included in the annual fee calculation, remained underestimated by the interim fee grids presented for consultation[53].

The annual fee amounts and eligible costs for NCA remuneration which are part of the cost base of that fee were therefore recalculated (Annex 7). The approach followed to identify additional NCA activities eligible for remuneration by EMA and estimate their amounts is described in Annex 4 addendum 2.. Table 7 in section 6.1 presents the cost of the additional activities as estimated post-consultation The output of the calculations of option 2, the annual remuneration to NCAs, are equal to the amount of eligible additional activities, since procedural fees are cost based and no procedural cost is included under the annual fee in that option. Options 2, 3 and 3 'light' adhere to the cost-based principle and, therefore, they all cover the same estimated costs for EMA and for NCAs.

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the cost basis from 2016 for the financial model is out of date (this comment does not address the updates described in this report); (2) centralised assessments are carried out by senior and more expensive staff (this comment does not address the fact that the costing during the evaluation and Management Board data gathering (MBDG) were based specifically on staff who were dealing with EMA procedures) ; (3) not all NCAs activities for EMA are considered for remuneration (this comment does not address, however, the eligibility criteria and the analysis made of the eligibility of additional activities for remuneration by EMA and presented in the consultation); (4) not all capacity-related costs are considered for remuneration (ibid).

[53] See Annex 4 for more information on criteria for eligibility of additional activities of NCAs and how they were applied with the bottom-up approach used for the consultations, as well as the updated approach applied after the consultation.

Table 6 below shows for the reference year 2024 the effect of the resulting recalculation on the remuneration provided to NCAs and its effect on the overall balancing of the EMA budget[54]. The overall output between the various options remains largely unvaried, with Do-minimum showing a considerable negative balances whilst Option 2, 3 and 3 '*light*' match exactly the projected expenditures for the given year, with the only difference of Option 1 showing this time a slightly positive balance.

Comparing Table 4 and Table 7, as a result of the recalculation, remuneration from annual fees has more than doubled in Option 2, 3 and 3 '*light*', reaching overall annual amounts ranging between €63 and 74 million. The recalculated remuneration results in a proportional increase in total recalculated revenue from cost-based fees.

Tables presented below correspond to the calculations post consultation

2024	Do minimum *(baseline)*	Option 1	Option 2	Option 3	Option 3 '*light*'
EMA income ***(€'000)***					
Total industry procedural fees	235,918	238,246	185,276	148,912	165,927
Total industry annual fees	141,690	173,683	223,751	260,116	243,101
Total industry fees	*377,608*	*411,929*	*409,027*	*409,027*	*409,027*
Total EU budget contribution	34,000	34,000	34,000	34,000	34,000
Total EMA income	**411,608**	**445,929**	**443,027**	**443,027**	**443,027**
EMA expenditure ***(€'000)***					
Total expenditure on human and veterinary procedures	113,436	113,436	113,218	113,218	113,218
Total expenditure on other activities	162,141	162,141	162,141	162,141	162,141
Total remuneration to NCAs (*)	167,669	167,669	167,669	167,669	167,669
Tot EMA expenditure	**443,246**	**443,246**	**443,027**	**443,027**	**443,027**
Variance ***(€'000)***					
	-31,637	***2,684***	***0***	***0***	***0***

Table 6

[54] Some other minor changes in the figures unrelated to this adjustment can be observed following further refinements and corrections of the model and calculations.

The two main factors behind the negative financial balance of the 'do minimum' baseline scenario presented in Table 6 above are the introduction of the VMP Regulation, which accounts for roughly 50% of the €31.6million deficit, and the introduction of DARWIN EU, which accounts for the other 50%. The shortfall linked to the VMP Regulation is mainly due to new pharmacovigilance activities introduced by this Regulation which cannot be covered by new annual fees under the current system. The second factor, i.e. the cost of the operational phase of DARWIN EU [16 € million as per estimated costs] would need to be financed through annual fees which cannot be introduced under the current system. These elements challenge the viability of the 'do-minimum' baseline scenario.

2024 *€'000*	Do minimum	Option 1	Option 2	Option 3	Option 3 '*light*'
Total remuneration to NCAs (*)					
Remuneration from procedural activities	126,562	128,271	108,394	92,864	104,215
Remuneration from annual fees	41,107	39,398	59,274	74,805	63,454
Tot NCA remuneration	**167,669**	**167,669**	**167,669**	**167,669**	**167,669**

Table 7

Also the effect on the balance of the EMA budget over the study years has not changed following the recalculation, with a positive balance for majority of the options (varying from €2.3 million to €8.5 million in excess) this time including also Option 1.

Budget balancing p/year *€'000*	2022	2023	2024	2025	2026
Do-min	-7,363	-9,364	-31,637	-32,681	-33,401
Option 1	8,539	7,687	2,684	3,729	5,113
Option 2	5,402	4,949	0	2,348	4,836
Option 3	4,353	8,233	0	2,649	5,322
Option 3 '*light*'	4,690	4,576	0	2,759	5,756

Table 8

In the analysis that follows, the level of performance of the options is assessed using indicators which are graded as Low/Medium/High, where higher means better. It has to be recalled that all options but option 1 are designed to cover overall the estimated costs. The assessment is based on indicators that may be either qualitative (e.g. whether a balance between a simple fee system and a cost-based system is achieved) or quantitative (e.g. whether aggregate costs are covered, whether individual fee and remuneration levels are aligned with respective cost assessment) elements. Performance levels are then assigned based on a comparison between the options, as far as such comparison is possible. For example options 2, 3 and 3 '*light*' are all deliberately designed to cover the aggregate costs, therefore the objective is considered fully achieved by all, and their performance is graded in each case as High. Option 1 does not achieve the objective (a deficit is calculated), its performance is therefore ranked as Low.

When the objective is considered to be achieved only to a certain extent by a given option, – neither complete failure, nor complete or sufficient success, the performance of the option in question is assessed as "Medium".

Overall, all options 2, 3 and 3 '*light*' being designed to cover all costs, they are assessed at the maximum (High) on this indicator, while option 1 is simply not cost-based, and so scores the lowest possible (Low).

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 1 : fee system covers relative aggregate costs	Low	High	High	High

1.12.1. 6.1.1. Alignment of fees with underlying costs

Cost-reflectivity of fees and remuneration reflects the will of the co-legislator expressed in the legal texts[55].

Moving to a cost-based system, by design the options align the level of fees and the remuneration amounts with the underlying costs. Tables 6, 7, 8 in the previous sections already showed how overall income from fees allows, when combined with the EU budget contribution, to cover total EMA expenditure, including NCA remuneration. On a more granular level, cost-reflectivity means better alignment of the individual fee and remuneration levels to their respective cost base.

Option 2 is scored high on the indicator of cost-reflectivity, given that by design this option sets cost-based fees to a very detailed level of granularity (as per current system). Option 1, on the other hand, is scored the lowest because only veterinary medicine fees/remuneration are cost-based in that option. Option 3 '*light*' has slightly less granular cost-reflectivity than Option 2 but because only some minor post-authorisation activities are included in the flat annual fee, the performance is overall the same. Option 3 is considerably less granular than Option 3 '*light*', as in this case the vast majority of post-authorisation activities are included in the flat annual fee. Therefore, Option 3 is scored Medium on the cost-reflectivity indicator.

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 2: Alignment of fees with costs of individual activities	Low	High	Medium	High

[55] Regulation 297/95, Article 12: *"Any review of the fees shall be based on an evaluation of the Agency's costs and on the basis of the related costs of the services provided for by the Member States. "*
Regulation 658/2014, recital 7: *"Any future revisions of the pharmacovigilance fees or other fees levied by the Agency should be based on a transparent and independent evaluation of the costs of the Agency and the costs of the tasks carried out by the national competent authorities."*

Effect of the horizontal measures

When the horizontal measures for different combinations of general reductions and specific incentives for veterinary medicines are considered, as the magnitude of the reductions/incentives increases, there is a decrease in the cost-based approach of the resulting net fees paid.

With fees being set at the same level regardless of the NCA in charge of the assessments, use of country coefficients would have no effect on fees paid by payers, not affecting the cost-based approach from their perspective. On the other hand, they would have an effect on the balance of the EMA budget as, whilst they would bring NCAs remunerations closer to the underlying costs, it would cause variations in EMA income according to which NCAs would take on the assessment activities.

Similarly to the application of a country coefficient, the distribution of the loss of revenue from the application of fee incentives between EMA and NCAs (or incurred, as now, by the EMA budget only, with the exception of fees for pharmacovigilance) would not affect the (net-of-incentives) fees paid by payers, and hence does not impact the cost base of the fees. Nonetheless, if NCAs were required to share the cost of incentives this would reduce NCAs' remuneration below the level of the costs the NCAs incur to undertake EMA activities. There is no mechanism for making good that NCA financial shortfall within the EMA fees system, though it could potentially be cross-subsidised from the national budget. By legislation, EMA has recourse to an EU budget contribution, set by the European Parliament and the Council ('the budgetary authority') based on an evaluation of needs and taking account of the level of fees set.

1.12.2. 6.1.2. Alignment of NCAs remuneration with costs incurred to undertake EMA activities

As was demonstrated in the evaluation of the EMA fees and remuneration system, the current fee and remuneration system leaves many differences between the costs incurred by NCAs when undertaking work on the individual procedures and the remuneration they receive for it from EMA[56]. On the aggregate level of the system, NCA procedural costs are fully covered, while the declared non-analysed cost of additional activities was covered at ca. €27.5 million which required further analysis of whether and to what extent such activities are compatible with a remuneration from EMA[57].

These differences in procedural remuneration are positive in some cases, negative in others, when analysed type of procedure per type of procedure. Moving to cost-based fees and remuneration should reduce or remove those differences, by design. Option 1 matches NCA costs and remuneration very poorly and is given a low level of performance; Option 2 matches costs and remuneration very closely and is therefore scored 'high'; Options 3

[56] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system page 53 figure 7 and figure 8.

[57] The approach to non-procedural activities of NCAs is discussed in detail in section 6.1 *Public authorities and budgets (including governance and good administration)*

'*light*' and 3 receive different scores (3 '*light*' performs better than 3), reflecting the fact that the loss of granularity relative to Option 2 is significant in Option 3 and the consequent scope for overall costs and remuneration for any individual NCA in any year to differ either negatively or positively[58] is higher in Option 3 then in Option 3 '*light*', while the difference generated by 3 '*light*' is not considered significant enough to trigger a different performance level than Option 2. NCAs who considered that option 3 negatively impacts financial predictability for their organisations (15 NCAs quoted below in the indicator on predictability) cited the potential risk of increased workload (that is of procedures included under the annual fee) not being appropriately remunerated, thereby having negative consequences. It follows also from this argument that option 3 '*light*' scores better in that respect as compared to option 3.

	Option 1	**Option 2**	**Option 3**	**Option 3 '*light*'**
Indicator 3: Alignment of NCA remuneration with NCA costs for EMA activities	Low	High	Medium	High

Effect of the horizontal measures

If the cost of the veterinary incentives (general fee reduction / general fee reduction *and* specific incentives / specific incentives *only*) is not shared with NCAs, there will be no effect on the gap between NCA costs and NCA remuneration for EMA activities.

Sharing the cost of incentives with NCAs would reduce NCA remuneration, for those activities where incentives apply. This horizontal measure consequently performs less well on this indicator than if the cost of incentives is not shared.

The application of country coefficients would, by design, bring NCA costs and remuneration closer together. However, country coefficients would add significant administrative burden and the effect of such measure is considered outweighed by the methodological approach to calculate NCA costs based on a weighted average.

1.12.3. 6.1.3. Fee system capacity to adjust to cost changes

The capacity of the fee system to adjust to cost changes is linked to how fees and remuneration amounts can be adjusted (i.e. which procedure is used to introduce the adjustments). The current EMA fee legislation permits updating of fees in line with general inflation via delegated act. Beyond inflation, the principle is that fee amounts can only be adjusted via full ordinary legislative procedure (co-decision of the European Parliament and the Council). Remuneration amounts are currently established by the EMA

[58] Such difference is due to the difference in the estimated average frequency of occurrence of procedures included in the costing of the annual fee under options 3 and 3 '*light*' and the real-life frequency observed year after year.

management board in relation to fees under regulation 297/95 and by the co-legislator in relation to fees under regulation 685/2014[59].

In line with the approach followed in the most recent update of the EMA fee legislation, i.e. regulation 658/2014, both fee amounts and fee-related remuneration amounts will be established in the revised legislation proposed here.[60] Updating of fees and remuneration based on inflation is maintained as a horizontal feature of the system in all options and independent of any horizontal measures applied. The contemplated mechanism is a delegation of powers to the Commission (delegated acts) to adjust the amounts, based on the outputs of a monitoring system that will be introduced by the proposed legislation. Further, a monitoring system would be needed whichever policy option was implemented[61]. Cost changes can be more precisely monitored in a more granular, thus less simple, system than in a system which relies to a greater extent on annual fees, but the cost and difficulty of monitoring would not vary significantly by option. However, considering that major procedures attract a separate fee under option 3 '*light*' and assuming that this increases the capacity of the system to adjust to significant changes in the costs of these specific procedures compared to Option 3 (while also being simpler than the structure retained under options 1 and 2) option 3 '*light*' performs Medium, i.e. higher than Option 3 (Low) and lower than options 1 and 2 (High). On this reasoning, the performance of Option 1 is assessed as on par with that of Option 2, because this indicator is indifferent to the fact that the principle of non-cost-based fees is maintained under Option 1 for human fees, focusing instead exclusively on the effect of the fee structure (which is the same in these two options) on future adjustments.

	Option 1	**Option 2**	**Option 3**	**Option 3 '*light*'**
Indicator 4: Capacity of fee system to adjust to cost changes	High	High	Low	Medium

Effect of horizontal measures

The capacity of the fee system to adjust to cost changes is independent of how the individual fees are initially calculated, the incentives applied to the fees whether country coefficients are used to determine NCA remuneration, and whether the cost of incentives is shared with NCAs.

[59] Regulation 658/2014 foresees some level of monitoring of underlying cost data. However, any update based on that monitoring requires co-decision procedure. Such data was used in the EMA Management Board Data Gathering (MBDG) as regards human pharmacovigilance procedures.

[61] Further reflection on a possible future monitoring system to indicate whether other changes to fees and/or remuneration would be appropriate in future is presented in Section 8.

1.12.4. 6.1.4. Balance between a simple fee system and a cost-based system

This indicator is based on the ability of the option to achieve a balanced approach between two contradictory objectives, i.e. a simpler fee system, and a fee system that is better aligned to underlying costs. The first objective requires fewer fee levels (the extreme scenario being one flat fee and no procedural fees), while the latter implies maximum granularity, i.e. calculating as many fee and remuneration levels as there are procedures and levels of complexity (the extreme scenario being charging fees and paying remuneration based on individual invoicing for each individual procedure). Feedback received, in particular from NCAs and fee payers, points to the need to achieve a balance between these objectives, as respondents seem to lean towards more or less granularity depending on their position and vision, without an indication that one should be given more weight than the other. For example, fifteen NCAs considered Option 3 would negatively impact financial predictability, because it is not granular enough, and therefore not sufficiently cost-based, while eleven and seven NCAs respectively considered the impact of Option 3 to be positive or remain the same, logically leaning more towards a simpler, less granular fee system. This indicates that options should also be assessed against an indicator of achieving a system that is balanced in that respect. The maximum performance level is attributed to 3 '*light*' as, compared to other options, it achieves balance by bringing some level of simplification through including some procedures in the scope of the annual fee, while catering for concerns expressed that potential increased workload for some procedures could not be captured, by leaving for example major variations outside the scope of the annual fee, as compared to option 3. Applying the same reasoning, option 3 performs less well (Medium) than 3 '*light*' (High) and option 2 scores less (Low) than option 3 (Medium) because, although it is more granular and, therefore, more reflective of the cost-based approach, it does not offer any simplification and, therefore, it does not introduce a balanced approach between a simplified system and a cost-based system, which is tracked by this indicator. Option 1 has the same score as option 2 (Low), as they both have the same fee system structure.

	Option 1	**Option 2**	**Option 3**	**Option 3 '*light*'**
Indicator 5: Balance between simplification and granular cost-based approach	Low	Low	Medium	High

1.12.5. 6.1.5. Fee system capacity to adjust to ensure financing of incentives

Under the current fees and remuneration system, the cost of incentives is, in the first instance, borne by the EMA budget (with the notable exception of incentivised fees for pharmacovigilance). The EU budget contribution amounts, pre-determined in the Multi Annual Financial Framework of the Union, provides a possible mechanism for ensuring EMA is funded sufficiently to bear the cost of incentives. This principle is laid down in the basic regulation 726/2004 and has therefore been assumed in this study and is retained in all options and independent of any horizontal measures that may be applied. Consequently,

the capacity of the fee system to adjust to ensure financing of incentives is the same in all options and horizontal measures.

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 6: Fee system capacity to adjust to ensure financing of incentives	Medium	Medium	Medium	Medium

1.12.6. 6.1.6. Adaptability of fee system to ensure EMA can effectively respond to exceptional circumstances related to public health and animal health

This indicator measures the adaptability of the fee framework during times of crisis. EMA, HMA and NCA responses to the survey highlighted the importance of a mechanism through which it would be possible to make rapid changes to the EMA fees system in exceptional circumstances[62]. Such a response mechanism would be a horizontal aspect and its precise nature would depend on the legal instrument used for the new regulation and the level of delegation of powers to the Commission and to the Agency (Management Board or Executive Director) that was possible under it. Therefore, there is no difference in how this indicator performs under the options and horizontal measures assessed here.

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 7: Adaptability to exceptional circumstances	Medium	Medium	Medium	Medium

1.12.7. 6.1.7. Predictability

1.12.7.1. Predictability of EMA income

Predictability for EMA translates as the ability of the Agency to rely over the medium to longer term on stable and predictable types of fees income (i.e. annual fees) that are not subject to fluctuations depending on external conditions (as is the case for procedural fees). The current fee system charges the majority of fees in the post-authorisation phase, particularly through the charging of an annual maintenance fee, which provides EMA with a more solid and stable platform for planning its activities. EMA considered that Option 1, even if it does not balance the EMA budget, would not fundamentally change this situation from the 'do minimum' baseline in terms of predictability, as only veterinary sector fees would be revised, and there would be no change in the granularity of fee levels.

[62] Such changes were made for example during the COVID-19 pandemic, with the introduction of upfront remuneration for rolling review and additional remuneration to NCAs to facilitate regulatory processes for medicines which had the potential to treat, prevent or diagnose COVID-19. The new Regulation 123/2022 which reinforces the role of the EMA in preparation for and response to public health emergencies, provides for the remuneration of rapporteurs from NCAs for assessment activities, in accordance with financial arrangements established by the EMA Management Board.

For options 2, EMA considered that outcome would be less predictable than 'do minimum' baseline or Option 1, because the proportion of revenue from procedures (such as initial marketing authorisation and inspection fees) which are inherently less predictable would increase.

	Option 1	Option 2	Option 3	Option 3 *'light'*
Indicator 8a: predictability of revenue for EMA	Low	Low	High	Medium

1.12.7.2. Predictability of NCA remuneration

As for EMA, predictability for NCAs also translates as the ability to rely on remuneration from more stable and predictable fee types (i.e. annual fees), that are less subject to fluctuations, to fund their EMA-related activities in the medium and longer term.

As reported in Annex 2, the survey and stakeholder interviews sought feedback on the impacts of the options on the NCA's financial predictability.

Table 7 in section 6.1 shows the distribution of remuneration between procedural and annual fees across the options at the time of the consultations.

Twelve NCAs responding to the survey reported that, compared to the 'do minimum' baseline, Option 1 would have either no impact or a positive impact on the financial predictability of their organisations. Other NCA reported a negative impact on predictability under this option, referring to the difficulty of predicting how the changes to the veterinary fees due to the VMP Regulation would impact NCA remuneration, and how companies will approach the new authorisations regime created by that regulation[63] (however, these comment relate to the predictability of the underlying VMP regulation, not to predictability related to the structure of the fee system under the options). Options 2 and 3 were considered likely to have a negative impact on financial predictability for their organisations by, respectively, ten and fifteen NCAs, with eleven and seven NCAs respectively considering the impact to be positive or remain the same. Veterinary industry representatives focused their feedback rather on fee incentives, thus leaving the actual question on predictability of the different fee structures under the options unanswered.

Increased revenue from annual fees considerably increases predictability for NCAs and EMA, as it is less dependent on the fluctuating flow of procedures[64]. In the evaluation phase, a possible option of funding EMA fully on annual fees and NCAs retaining 100% of procedural fees was discarded because it was considered that NCAs required more predictability, which can be provided by the annual fee. This was confirmed by the consultation feedback, where annual fee revenue emerged as a stabilising factor for NCA

[63] E.g. a larger scope of the centralised authorisation procedure for veterinary medicinal products. However, this argument does not relate to the predictability of the fee system per se.

[64] Fee structures relying more on annual fees exist in national fee systems, for example in Austria and the Netherlands.

contributions. For this reason, option 3 performs the best on this indicator, while 3 '*light*' performs lower (Medium) relative to 3 but higher than 2 and 1 (Low), as the latter are comparatively more dependent on procedural fee revenue.

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 8b: Predictability for NCAs	Low	Low	High	Medium

Effect of horizontal measures

The horizontal measures for veterinary medicine fees present different combinations of general reductions or/and specific incentives to respond to the concerns highlighted above. However, none of them were highlighted in the stakeholder feedback as contributing to predictability.

Application of country coefficients to NCA remuneration would add some unpredictability from year to year to the aggregate remuneration of NCAs by EMA – and hence the cost to EMA of remunerating NCAs. This is because remuneration would vary not only according to the EMA activities done by NCAs but also by reference to variations in the cost of living index underlying the coefficient, and to associated factors (e.g. exchange rate variability for Member States that are not part of the Eurozone).

In the case of cost of fee incentives being shared between EMA and the NCA, this would reduce the amount remunerated to those NCAs, relative to their costs, for activities where incentives apply. This would negatively impact financial predictability[65], in particular for those NCAs undertaking less intensive EMA work, because the amount remunerated would not only vary according to the work completed but it would also be dependent on whether the fee payer was entitled to incentives. In addition, sharing the cost of incentives would imply that NCAs would have to fund any shortfall through national budgets. Therefore, this would have an impact on the overall budget of those NCAs.

While sharing of the incentives with EMA would have a positive impact on the Agency's budget, EMA noted, in their feedback, that should such distribution result in lack of proper financing of the NCAs activities, then this measure would be very detrimental to the NCA remuneration and thus for the Agency and the operation of the regulatory network in their turn.

This measure would not impact payers as the amount of the incentives remains unchanged.

Sharing the cost of incentives with NCAs would thus reduce financial predictability for NCAs, particularly those NCAs undertaking modest amounts of EMA work, because the amount they would be remunerated would vary not only according to the work they did but also to whether the ultimate payer for that work was entitled to incentives.

[65] Financial predictability: for NCAs it concerns visibility of annual revenues from EMA remuneration; for payers, it concerns visibility of annual expenditure of EMA fees.

1.12.7.3. Predictability for payers of their payments to EMA

The ability of payers to predict fees payable to EMA is effectively determined by how easy payers find it to forecast the frequency of fees charged and understand the range of different fees associated with regulatory procedures, in order to estimate their annual costs for EMA fees. The current fees are published on the EMA website and this should be the case in future. However, the current fee system contains a very large number of fees and incentives. Some payers, particularly companies and enterprises that have SME status assigned by EMA, and who interact with EMA less frequently, can access additional support to help them understand the amounts they will pay[66].

While EFPIA and Medicines for Europe considered that Option 3 allowed the best predictability compared to Options 1 and 2, EFPIA specifically identified Option 3 '*light*' as having the best predictability, while providing an equitable fee structure that significantly reduces the administrative fee-processing burden. Options 1 and 2 perform as 'Low' as they are at the same level of predictability as the current fee system, i.e. a granular approach reliant on fluctuating procedural fees, without any simplification that would not shift the system towards greater reliance on annual fees, which are more stable. Options 3 and 3 '*light*' will create a simpler and more predictable fee structure than Options 1 and 2, with Option 3 performing the highest, as major post-authorisation procedures no longer give rise to a fee, while 3 '*light*' performs as Medium to reflect its relatively higher reliance on less predictable procedural fee revenue than option 3.

	Option 1	**Option 2**	**Option 3**	**Option 3 '*light*'**
Indicator 8c: predictability for payers	Low	Low	High	Medium

The horizontal measures for general reductions and/or specific incentives applied to veterinary medicine fees have no impact on comprehension and predictability for payers. The measures to introduce country coefficients and incentive sharing both concern remuneration of NCAs and do not affect the fees faced by payers, so there is no difference between the horizontal measures for this indicator.

1.13. Administrative burden

1.13.1. 6.2.1. Administrative burden on EMA and NCAs

EMA indicated that simplification through a reduced number of different fees in the fee grid, in particular fewer levels of procedural fees for scientific advice, initial marketing authorisation, scientific services, and inspections, would be the most effective way to reduce their administrative burden. Option 3 therefore performs best on this indicator for EMA, as it has the fewest number of fees in the associated fee grid. As compared to the 'do minimum' baseline, Option 3 '*light*' performs better than Options 1 and 2, but is not as effective as Option 3 in this regard.

[66] EMA SME office: https://www.ema.europa.eu/en/human-regulatory/overview/support-smes

While NCAs do not operate the fee system and thus are only marginally affected by the administrative costs of running or using the fee system, two of the seven NCAs interviewed indicated a slight preference for reducing the number of different fees, although they did not consider it a significant concern. Responses from HMA and one individual NCA indicated that administrative burden was not a problem in the fee system. Nor did the other NCAs interviewed identify any differences between the options in respect of administrative burden. Therefore it is considered that for NCAs the options perform against this indicator as they do for EMA.

Thus, for this indicator, Options 1 and 2 are both scored at Low because they imply no difference from the 'do minimum' baseline in the administrative burden they place on EMA and the NCAs. Option 3 is scored High as the least burdensome option and Option 3 '*light*', being slightly less good than 3, at Medium.

	Option 1	**Option 2**	**Option 3**	**Option 3 '*light*'**
Indicator 9a: Reducing administrative burden on EMA and NCAs	Low	Low	High	Medium

With respect to horizontal measures, if EMA shared the cost of incentives with NCAs this would slightly increase the administrative burden on EMA and NCAs, compared to the 'do minimum' baseline.

Specific incentives for veterinary medicines would also be slightly more burdensome for EMA than general fee reductions, compared to 'do minimum' baseline.

Applying country coefficients when determining NCA remuneration would also slightly add to the administrative burden on EMA, compared to 'do minimum' baseline.

1.13.2. 6.2.2. Administrative burden on fee payers

The administrative burden on payers is not significantly different between Options 1 and 2 because the structure of the fee system and the number of fees payable remains largely the same. Organisations representing fee payers that responded to the survey, including representatives of the European biotech and SME sectors, did not differentiate significantly between Options 1 and 2 in terms of their administrative burden and associated costs to deal with the EMA fee system.

Fewer levels of fees mean that Options 3 '*light*' and 3 are increasingly simplified as compared to Options 2, 1 and 'do minimum' baseline. Therefore, Options 3 '*light*' and 3 perform better on this indicator. In their response to the survey and in a post-survey interview, EFPIA identified Option 3 '*light*' as performing better in terms of administrative burden.

Options 1 and 2 both perform 'Low' because they imply no change in administrative burden relative to the 'do minimum' baseline. Options 3 '*light*' and 3 are scored better, with option 3 considered to perform better relatively to 3 '*light*' due to a lower number if unitary fees to process.

	Option 1	**Option 2**	**Option 3**	**Option 3**

				'light'
Indicator 9b: Reducing administrative burden on fee payers	Low	Low	High	Medium

Applying specific incentives to veterinary medicine fees implies a slightly greater complexity and consequently slight increase in administrative burden for payers compared to applying general fee reductions across all veterinary medicine fees.

Whether country coefficients are applied when determining NCA remuneration, and whether NCAs share the cost of incentives does not affect the administrative processes of payers.

1.13.3. 6.2.3. Administrative burden for SMEs relative to other payers

SME payers are not negatively affected by the administrative burden of different options, when compared to other payers. Representatives of SME payers responding to the survey did not indicate that the administrative burden was higher for any option relative to that on other payers.

	Option 1	**Option 2**	**Option 3**	**Option 3** *'light'*
Indicator 9c: Relative administrative burden on SMEs compared to other payers	Medium	Medium	Medium	Medium

The administrative burden would not differ significantly under the horizontal measures for veterinary medicine general fee reductions and/or specific incentives. On the contrary, SMEs can avail of support from the EMA's SME office, including through free briefing meetings that are not available to other payers[67]. This support provides a platform for SMEs to discuss their planned regulatory strategy, thereby supporting the administrative process and clarifying the available fee reductions or payment deferrals.

In addition, the horizontal measures concerning country coefficients and sharing the cost of incentives with NCAs do not affect the fees paid and so do not impact on this indicator.

1.14. Position of SMEs

SMEs and microenterprises (hereafter 'SMEs') are eligible for fee incentives from EMA, namely fee reductions, exemptions and/or deferrals, as applicable, under Articles 5 to 9 of Regulation (EC) No 2049/2005, specific SME provisions in Regulation 658/2014 and other ad-hoc reduction introduced via implementing rules.[68]

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[67] Support to SMEs | European Medicines Agency (europa.eu)

[68] These are listed on pp42/43 in: Explanatory note on general fees payable to the European Medicines Agency EMA/341156/2021 available at: https://www.ema.europa.eu/en/documents/regulatory-procedural-guideline/explanatory-note-general-fees-payable-european-medicines-agency-28-january-2022_en.pdf and on page 8 in: Explanatory note on pharmacovigilance fees payable to the European Medicines Agency

Incentive rates for SMEs as laid out in the above provisions are either 40% or 90% depending on the type of activities (the former mainly for post-authorisation activities, the latter for pre-authorisation). For microenterprises on the other hand fees are always 100% waived. Incentives for SMEs and micro enterprises are retained in all of the policy options.

The EMA's website notes that "SMEs developed nearly 20% of all human medicines recommended for authorisation in 2020".[69] Other EMA data shows that 16% of marketing authorisation holders (MAHs) paying annual fees to EMA in that same year were SMEs and that 25% of requests to EMA for scientific advice were from SMEs.[70]

The impact on SMEs of setting fees on a cost-based principle would depend on whether the fees for the activities they could apply were higher or lower than in the current system.

Table 9 shows the effect the new cost-based fees amount would have on SMEs under each option for the reference year 2024 based on applicable fee incentive rates for SMEs.

2024 *€'000*	Do minimum	Option 1	Option 2	Option 3	Option 3 '*light*'
Tot payment by SMEs p/y					
Human medicines	9,600	9,600	13,100	13,500	13,200
Veterinary medicines	308	1,300	1,000	1,200	1,100
Inspections, Parallel Dist., Certificates	54	54	90	90	90
Tot SMEs payment	**9,962**	**10,954**	**14,190**	**14,790**	**14,390**

Table 9

The financial modelling confirms that by calculating fees on a cost-based principle, there is an increase in fees expected to be paid annually by SMEs compared to the 'do minimum' baseline scenario, ranging from roughly €1 million more for Option 1 (as changes affect only veterinary medicines) up to over €4 million more for Option 2, 3 and 3 '*light*'. No responses were received specifically from SMEs as part of the stakeholder consultations based on the fee amounts presented.

Option 1 imposes comparatively less of a financial burden on SMEs than Options 2, 3 and 3 '*light*'; however, considering further flexibility that can be provided within the fee system (additional ad-hoc reductions, as granted currently by the implementing rules of the EMA fee regulation) under any option, in order to comply with horizontal policies to support SMEs, performance in that respect is assessed as Medium across all options, to reflect that further reductions may be granted in this particular case than those calculated in the cost-based model. This is related to the transposition in the future fee legislation of the current provisions contained in the main fee regulation to the effect that:

- without prejudice to more specific provisions of Union law, in exceptional circumstances and for imperative reasons of public or animal health, fee reductions may be granted on a

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available at: https://www.ema.europa.eu/en/documents/other/explanatory-note-pharmacovigilance-fees-payable-european-medicines-agency-1-november-2020_en.pdf

[69] https://www.ema.europa.eu/en/human-regulatory/overview/support-smes

[70] EMA Annual Activity Report 2020

case by case basis by the Agency's Executive Director, stating the reasons on which it is based.

- total or partial exemption from payment of the fees laid down in the regulation may be granted through the rules for implementation of the regulation. Consistency of the future criteria for granting additional reductions with the specific provisions for EMA fee reductions for SMEs laid down in the EMA SME regulation (Commission Regulation (EC) No 2049/2005) should be ensured. In addition, it will be possible to use the experience thus gained in order to review, at a further stage, Commission Regulation (EC) No 2049/2005.

Compared to larger producers of veterinary medicines, SMEs are neither significantly advantaged nor significantly disadvantaged by any of the horizontal measures for general fee reductions and/or specific incentives for veterinary medicines, taking into account the applicable fee incentives[71].

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 10: Position of SMEs	Medium	Medium	Medium	Medium

The horizontal measures concerning country coefficients for NCA remuneration and those for sharing the cost of incentives with NCAs do not affect the fees faced by payers, and hence do not affect the payments made by SMEs relative to other payers.

1.15. Research and innovation

EMA fees account for only a very small percentage of the total costs of researching and developing a new medicine. While estimates of the R&D cost of a new medicine vary widely, a recent review of such estimates for human medicines published in 2021 found that the estimates range from USD[72] 0.16-4.54 billion.[73] Another 2021 study estimates that R&D costs per new medicine (accounting for the cost of failures) ranged from USD 0.94 billion-2.83 billion (adjusted to 2019 prices)[74]. With respect to veterinary medicines, the global veterinary medicine market is estimated at USD 29.2 billion in 2020 and is expected to expand at a CAGR[75] of 7.4% from 2021 to 2028[76]. It is reported that Animal health

[71] Support to SMEs will continue via the specific fee incentives in accordance with Commission Regulation (EC) No 2049/2005 (the SME regulation) and the horizontal support provided by the EMA SME Office. SME-related provisions in Regulation 658/2014 and further reductions laid down in the Rules for implementation of Regulation 297/95 for post-authorisation procedures are equally taken into account across the options for a revised fee system.
[72] Yearly Average Exchange Rate for 2021: 1 USD = 0.846 EUR
[73] Schlander et al. How much does it cost to research and develop a new drug? A systematic review and assessment. PharmacoEconomics; 2021; 39:1243-1269
[74] Simoens S, Huys I. R&D Costs of New Medicines: A Landscape Analysis. Front Med (Lausanne). 2021 Oct 26;8:760762. doi: 10.3389/fmed.2021.760762. PMID: 34765624; PMCID: PMC8576181.
[75] The compound annual growth rate (CAGR) is the annualised average rate of revenue growth between two given years.
[76] Veterinary Medicine Market Size & Growth Report, 2021-2028 (grandviewresearch.com)

manufacturers invest an average of 8.5% of sales in R&D[77]. At 29% of global sales (2021), Europe is the second largest animal medicines market in the world[78]. For 2021, the total European sales of the originator veterinary industry are estimated at €7.4 billion[79]. The EU animal medicines industry invests over €500 million in research and development every year[80]. At the same time, the market value of the European veterinary medicines industry remains only 3% of the human one[81].

EMA fees for an application for initial marketing authorisation are measured in hundreds of thousands of EUR, rather than hundreds of millions. The overall effect of alignment with a cost-based approach on the fee payers will be an increase of between € 31 million and € 35 million, i.e. some 10%-increase (projection for 2024) as indicated under Table 6 in section 6.1. This includes the post-consultation re-calculation of NCA remuneration, which accounts for ca. 85% of that increase. Changes in EMA fee levels across policy options and horizontal measures considered in this impact assessment are therefore unlikely to affect research and innovation overall[82].

Consistent with this, and supposing the application of the revised cost-based calculations described in section 6.2.1, responses to the survey and interviews revealed no differences between the policy options or horizontal measures in their impacts on the overall propensity of firms to seek authorisation for human medicines (Annex 2).

EMA, HMA and two of the six NCAs interviewed who have responsibility for veterinary medicines, as well as the industry in their survey responses, noted that all the options imply large increases in veterinary medicine fees relative to the current position, and that this might deter prospective applicants from seeking authorisation in the EU for their veterinary medicinal products, therefore impacting their availability on the EU/EEA market. However, most of the respondents were uncertain whether this situation would materialise in practice. Also, this possibility applies similarly across Options 1, 2, 3 and 3 '*light*' as all would have cost-based fees for veterinary medicines, which is what causes the large increase from the do minimum, i.e. current, levels of those fees. Therefore, there is no difference in how this indicator performs across the options.

	Option 1	**Option 2**	**Option 3**	**Option 3 '*light*'**
Indicator 11: Impact on research and innovation	Medium	Medium	Medium	Medium

[77] The Animal Health Industry - ANIMAL HEALTH INSTITUTE (ahi.org)
[78] The European animal medicines industry in figures, AnimalHealthEurope
[79] Annual report 2021, AnimalHealthEurope, 2021
[80] *Ibid*.
[81] The European animal medicines industry in figures, AnimalHealthEurope
[82] Fee incentives for the academic sector are currently included in the PRIME scheme of EMA which foresees specific fee exemptions for scientific advice for academia. Such possibility would continue also under the fee proposal. The review of the basic pharmaceutical legislation under the Pharmaceutical strategy may look into possible codification of the PRIME approach in the underlying pharmaceutical legislation. Regarding ATMPs (advanced therapy medicinal products) specifically, the specific reduction rates provided for in the ATMP regulation (Regulation (EC) No 1394/2007 of the European Parliament and of the Council of 13 November 2007 on advanced therapy medicinal products) will also be carried on under the new fee system (until any possible revision of that ATMP regulation).

Effect of horizontal measures

With respect to the various horizontal measures, the greater the fee reductions and specific incentives applied to veterinary medicines fees, the less of a potential deterrent to launch new veterinary medicines across the EU/EEA they will be. On this basis, the horizontal measure that applies both general fee reductions and specific incentives performs best for this indicator.

The horizontal measures concerning application of country coefficients to NCA remuneration and to sharing with NCAs the cost of incentives do not affect fees to payers and so do not influence this indicator.

1.16. Functioning of internal market and competition

None of the policy options and horizontal measures being considered are likely to have a significant impact on the functioning of the internal market and competition. With respect to whether the fee system under each option allows for a level playing field between categories of payers, it could be argued that the more cost-based fees are the more level the playing field is. The indicator of cost-reflectivity is discussed in section 6.2.1.1. It follows that option 1 performs the lowest, as it is the least reflective of a cost-based approach.

Among the other policy options, Option 3 puts most weight on annual fees relative to procedural fees (65:35) and is preferred by the EU generics sector due to discontinuation of all variation fees. Option 3 '*light*' is, however, preferred by the innovators sector with the argument that minor variations (i.e. the only ones included in the annual fee under option 3 '*light*') numerically comprise the majority of submissions made to EMA that attract a fee and, therefore, Option 3 '*light*' would offer predictable and equitable fee structure which significantly reduces the administrative fee processing burden, while supporting the appropriate level of regulatory oversight. Industry stakeholders agree in general that Option 2 is not satisfactory due to insufficient optimisation of the fee structure.

	Option 1	Option 2	Option 3	Option 3 '*light*'
Indicator 12a Functioning of internal market and competition: generic medicines	Low	Low	High	Medium
Indicator 12b: Functioning of internal market and competition: innovators	Low	Low	Medium	High

Effect of horizontal measures

The horizontal measures do not in their design affect the relative competitiveness of generic and new medicines.

The veterinary sector, against the background of innovative and generic medicines, also comprises two sub-sectors - farmed animals and companion animals - each driven by different marketing rationales. It operates under different market conditions from the human sector, notably in the general absence of public reimbursement schemes, has different drivers of investment and price-setting mechanisms resulting in considerably lower prices, and is rather fragmented due to the various species to which it caters and their relative geographical and market importance. Therefore the horizontal measure that most

reduces the veterinary fees, i.e. the application of both general fee reductions and specific incentives, clearly does most to reduce the relative burden on producers of veterinary medicines. The other horizontal measures concern remuneration of NCAs and do not affect the balance of fees between those paid by veterinary medicine producers and those paid by producers of human medicines.

1.17. Discussion of information gaps and uncertainties

Every effort was made to ensure that the survey for the consultation was known to all interested stakeholders. The sample of interviewees and survey respondents spanned all types of NCAs (human, veterinary, large, small, and a range of Member States), and included consultation with HMA. A larger number of survey responses would have provided greater depth to the qualitative analysis but the coverage of stakeholder interests was good, with no obvious gaps. EMA provided a survey response and participated in two interviews. Representatives of the pharmaceutical industry provided feedback. However, the responses from particular sectors was limited, including from academia/research organisations and SMEs despite multiple requests to complete the survey.

The quantitative part of the impact assessment reported here benefited from the provision of detailed data by EMA about activities, costs, fees and remuneration of NCAs. The financial model on which the quantitative analysis is based was originally constructed for the Evaluation of the EMA Fees system completed in 2018.[83] Time data for activities not included in the previous evaluation study and for which data were not collected in the MBDG exercise have been estimated based on assumptions: using time data for EMA and NCAs (as appropriate) from a 'comparator activity' that was expected to take a similar amount of effort and for which time data were already available. It should be noted that the MBDG data for the veterinary sector was based on a much smaller number of procedures compared to the human one, which might have an effect on their representativeness.

The main limitation of the method was that the time data per activity and the costs of NCA staff time per hour, non-staff inputs and of overheads, on which the costing and hence the cost-based fees parts of the model depend, are five years old. The time data per activity originate from the EMA Management Board Data Gathering exercise of 2016, and the NCA cost data were collected by RAND Europe for the year 2016 during the evaluation study. Furthermore, the departure of the UK from the EU and the EMA fee system, the relocation of EMA from London to Amsterdam, and effects of the COVID-19 pandemic, have combined to make that cost basis dated. Efforts have been made to account for events since 2016 with use of data from EMA about the cost consequences of the location change and assumptions agreed about how the workload that would have been taken by UK NCAs is reallocated to other NCAs, and allowance for general cost inflation over the years since 2016. A more recent time inputs and cost data collection exercise would have given the modelling a more up to date basis. However, in view of the history of such data collection and the technical time involved, this was deemed unfeasible.

[83] Commission Staff Working Document – Evaluation of the European Medicines Agency's fee system. 2019.

A major update of cost estimations of NCAs' costs was performed after the consultation of this impact assessment. It is related to the methodology for estimating the cost for eligible additional activities of NCAs which impact on the calculation of the annual fee remuneration. This is discussed in section 6.1 *Public authorities and budgets (including governance and good administration)*.

That said, these limitations affect similarly all options for the fee system that are being considered and do not impart a bias to the comparison between the options.

7. How do the options compare?

1.18. Overview of impacts

Section 6 presented for each impact indicator the relative strengths and weaknesses of the policy options. Table 10 summarises the qualitative assessment of the relative performance of each option against the indicators.

		Do-minimum (baseline)	Option 1	Option 2	Option 3	Option 3L
Nr	**Indicator**	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**
1	**Fee system covers relevant aggregate costs**	***Low***	***Low***	***High***	***High***	***High***
2	Alignment of fees with costs of individual activities	*Low*	*Low*	*High*	*Medium*	*High*
3	Alignment of NCA remuneration with NCA costs for EMA activities	*Low*	*Low*	*High*	*Medium*	*High*
4	Capacity of fee system to adjust to cost changes	*High*	*High*	*High*	*Low*	*Medium*
5	Balance between simplicity (less fee levels) and granular cost-based approach (more fee levels)	*Low*	*Low*	*Low*	*Medium*	*High*
6	Capacity of fee system to adjust to ensure financing if incentives	*Medium*	*Medium*	*Medium*	*Medium*	*Medium*
7	Adaptability to exceptional circumstances	*Medium*	*Medium*	*Medium*	*Medium*	*Medium*
8a, 8b, 8c	Predictability for EMA, NCAs, fee payers	*Low*	*Low*	*Low*	*High*	*Medium*
9a, 9b	Reducing administrative burden - EMA, NCAs, all fee payers	*Low*	*Low*	*Low*	*High*	*Medium*
9c	Reducing administrative burden on SMEs relative to other fee payers	*Medium*	*Medium*	*Medium*	*Medium*	*Medium*

10	Position of SMEs	*Medium*	*Medium*	*Medium*	*Medium*	*Medium*
11	Impact on research and innovation	*Medium*	*Medium*	*Medium*	*Medium*	*Medium*
12a	Functioning of internal market and competition: generic medicines	*Low*	*Low*	*Low*	*High*	*Medium*
12b	Functioning of internal market and competition: innovative medicines	*Low*	*Low*	*Low*	*Medium*	*High*

Table 10

It should be noted that from the indicators presented, those most reflective of a cost-based approach carry the most relative weight in the analysis. This is due to the clear requirement in the legislation that any review of fees should be based on cost estimations. This approach was clearly confirmed by the feedback to consultations from all types of stakeholders, where the emphasis was on a cost-based approach.

Second in importance in that analysis comes the indicators related to the simplification of the fee system. Indeed, the need for simplification was clearly identified during the evaluation and in the consultations. The minimisation of administrative burden is a horizontal principle of EU legislation. Nevertheless, since a cost-based approach is clearly mentioned in the legislation, it is recognised that this should be the major criterion[84].

Option 1 performs noticeably less well that the other options. This is the result of Option 1 doing especially poorly with respect to delivering a cost-based approach, assessed through several indicators (1, 2, 3) on both an aggregate and granular level.

Comparing Option 3 with Option 3 '*light*' in Table 10 there is a distinction drawn between them in terms of alignment to granular costs (2, 3), predictability (8a,8b,8c), administrative burden (9a, 9b), as well as balance achieved between the two major criteria, i.e. simplicity and cost-based approach (5). Option 3 '*light*' scores relatively better overall than Option 3 bearing in mind that a cost-based approach is a major indicator and taking into account the better balance achieved.

The differences between Options 2 and 3 are less pronounced than the difference between 3 and 3 '*light*' (in favour of 3 '*light*'). Option 2 achieves a higher score than 3 and 3 '*light*' notably in terms of alignment to individual (granular) costs (2,3), but lower in terms of predictability (8a,b,c), administrative burden (9a,b) and balance achieved between simplicity and cost-based approach (5).

The choice between options 3 and 3 '*light*' is finely balanced. In the final analysis, we suggest that Option 3 '*light*' is preferable because it has the merit of achieving some

[84] Some level of simplification will also be achieved through merging the two current EMA fees regulation into one legal instrument.

improvements in simplicity compared to the current fee system, while at the same time introducing cost-based fees for all activities at quite a granular level.

In the following sections, we summarise the differences between the horizontal measures as they might be applied to this option.

1.19. Appraisal of horizontal measures

1.19.1. 7.2.1. Veterinary medicines incentives

Three horizontal measures have been considered for veterinary medicines for combinations of general fee reductions and specific incentives:

A	Cost-based fees for veterinary medicines with a 50% general fee reduction for all veterinary fees.
B	Cost-based fees for veterinary medicines with a 50% general fee reduction and targeted fee incentives.
C	Cost-based fees for veterinary medicines with targeted fee incentives. This may include a selection of procedural fees and the annual fee as well (C1 is the same as C with a 25%-reduction of the annual fee in addition).

The analysis of these horizontal measures in Section 6 shows that the choice between them depends on four of the indicators:

- How closely fees reflect costs of individual activities – the greater the value of the incentives and reductions, the worse this indicator performs as the more payments will diverge from costs;
- Administrative burden on payers – specific incentives are slightly more burdensome for payers to administer than general fee reductions;
- Administrative burden on EMA and NCAs – specific incentives are slightly more burdensome for payers to administer than general fee reductions;
- How well the horizontal measure delivers on the objectives of the VMP regulation and how adequate the fee levels are to the specificities of the veterinary medicines sector.

Clearly, the greater the fee reductions or specific incentives applied, the more favourable the fee system is to the veterinary medicines sector. This effect would be greatest in horizontal measure B, where both a 50% general fee reduction and specific incentives are applied. However, this is also where the veterinary fees diverge most from the cost of doing the work and C1 is expected to deliver better balance in this respect. Due to the small share of the veterinary sector compared to the human one, under the current fee system, such incentives have not had and are not expected to have any appreciable negative effect on the overall sustainability of the fee system.

Specific incentives seem slightly more administratively burdensome for all parties than general fee reductions, but the difference is minimal. In any case, those incentives are

expected to help deliver on the objectives of the VMP Regulation and the EU's fight against antimicrobial resistance by incentivising products targeting limited markets and alternatives to antimicrobials, such as immunological VMPs[85].

Horizontal measure/Indicator	*A*	*B*	*C*	*C1*
Indicator 2: alignment of fees with costs of individual activities	Low	Low	Medium	High
Indicators 5a and 5b: administrative burden on EMA and NCAs	High	Medium	High	Medium
Indicator 5c: administrative burden on payers	High	Medium	High	Medium
New indicator on how veterinary incentives in the horizontal measures align with VMP goals	Medium	Medium	Medium	Medium

Horizontal measure C1 delivers the optimal balance between specific incentives (specific targeted fee reductions), overall support for the veterinary sector (reduction of the annual fee) and a cost-based approach (no horizontal reduction).

1.19.2. 7.2.2. Country coefficients for NCA remuneration

Country coefficients were considered to address the problem of misalignment between NCA costs and remuneration. In particular, different NCAs completing the same procedural activities would receive varying levels of remuneration, to more accurately reflect their respective costs.

The analysis in Section 6 shows that, while country coefficients would link an individual NCA's remuneration more closely to their own organisation's costs, they are likely to worsen the predictability for the actors involved.

If the coefficients were to be applied to the fees amount, this would impact predictability for payers, as the amount to be paid would vary depending on which NCAs were appointed as rapporteurs.

If coefficients were to be applied to the NCAs remuneration (i.e. industry would always pay the same amount for a given procedure), this would impact the predictability for EMA as the agency would no longer be able to predict the amount for remunerations until rapporteurs are appointed. Furthermore, this could potentially affect the ability of the agency to balance its budget, leading to strong fluctuations in the budget.

EMA, HMA and some individual NCAs indicated that country coefficients were likely to undermine scientific capability as the most important criterion for allocating work to

[85] Immunological VMPs i.e. vaccines, toxins, serums, and allergens.

NCAs. Scientific excellence and desire to contribute were considered by EMA and NCAs to be the factors determining which NCAs do EMA work, not comparative cost. In addition, adding country coefficients could represent an impediment to sub-contracting some activities to experts who do not belong administratively to the NCA and whose labour costs, therefore, are not correlated with the level of costs that the country coefficient tries to capture.

No NCA consulted supported the introduction of country coefficients, including NCAs that could potentially gain financially from their application (See Annex 2). Not applying country coefficients is in line with the approach of calculating average cost-based fees, i.e. fee levels do not depend on the actual NCA performing the assessment. It also avoids significant increase in administrative costs for EMA in calculating the remuneration to be paid to NCAs. Nonetheless, in order to address the problem of misalignment of remuneration and costs for some NCAs, the remuneration amounts are already calculated on the basis of weighted averages, taking into account the costs of the NCAs more frequently involved in assessment work. The application of country coefficients in addition would therefore duplicate the effort and further unbalance the remunerations rather than adjust them. The assessment therefore concludes that this measure should not be retained.

1.19.3. 7.2.3. Incentive sharing

Applying incentives to cost-based fees before remuneration to NCAs would mean that, unlike the current arrangements, part of the cost of those incentives (i.e. the loss of revenue) would be financed by national budgets instead of EMA budget. Currently, the EMA budget bears the cost of incentives. The horizontal measure of sharing the cost of incentives with NCAs would require NCAs to fund that part of their EMA work from national sources. As reported in Annex 2 and shown by the analysis in Section 6, the measure of sharing the cost of incentives with NCAs performs least well in relation to all indicators, and should therefore not be retained[86].

1.20. Effectiveness

Effectiveness is measured by the extent to which the policy options and horizontal measures achieve the objectives described in Section 4, namely to:

- Provide a sound financial basis for EMA and its activities, including fair remuneration for the services provided by NCAs;
- Ensure a level-playing field for industry in terms of access to EMA's services, and thus to promote competitiveness;
- Facilitate the development and marketing of safe and effective medicines; and
- Limit the administrative burden generated by the fee system.

[86] The benefits from being part of a centralised system have not been quantified in this study.

In Section 6 we analysed impact indicators of how the options and horizontal measures compare in these terms (all indicators relate to effectiveness). Our analysis identifies, as described in sections 7.1 and 7.2, Option 3 '*light*' as overall the most effective option, in combination with: targeted fee reductions for veterinary fees (C1); no application of country coefficients to NCA remuneration; and EMA not sharing with NCAs the cost of fee incentives.

1.21. Efficiency (balance of benefits and costs)

A classical efficiency analysis, which seeks maximum benefit for minimum cost, cannot be applied to the main options assessed for the revision of the EMA fee system, since the legislation requires that the fees themselves should reflect the costs incurred as closely as possible. The only scope for improving efficiency, then, is in the administrative costs generated by the implementation of the system itself, and not in the amounts of fees charged.

As reported in Section 6 and Annex 3, the administrative costs of the fee system vary only very slightly between the options. From this perspective, "efficiency" becomes pragmatically the same as "effectiveness", as there is little difference in administrative cost between options; the most effective option is also the most efficient. From another analytical angle, looking at the benefit/cost ratio, an approach that more closely reflected a cost-based approach embodied in a more granular fee system might be seen as increasing both the benefit (payment better aligned closer to cost) but also the administrative cost (more payments to process), thus neutralising the effect on the efficiency ratio.

The application of country coefficients to NCA remuneration may be seen as adding additional administrative burden to calculate and pay remuneration (increasing the cost component of the efficiency ratio) while, on the benefit side, taking better into account the relative difference in costs of different NCAs. However, country coefficients also have disadvantages, for example preventing smaller NCAs from having recourse to external expertise, as well as possible negative impacts on the fee system as a whole (in the extreme scenario, fluctuation of fee levels depending on the attribution of the rapporteurs); therefore, their effect may equally be either neutral or negative.

Over time, continued reflection of a cost-based approach depends on monitoring and adjustment mechanisms that keep fees aligned to costs, within the budgetary rules of EMA. Such a mechanism is discussed in Section 9.

1.22. Coherence with other EU policy objectives

Overall, a cost-based and flexible EMA fees system supports the contribution of EMA to the main policy objectives of the EU pharmaceutical legislation. Such objectives include providing the right regulatory environment for safe and effective medicines of the highest quality to be made available to EU citizens.

1.23. **Preferred option – Option 3 '*light*'**

The analysis shows that the relative effectiveness, and likewise the efficiency, of Options 2, 3 and 3 '*light*' are finely balanced in comparison with one another, but all are superior to Option 1. The differences between Options 2 and 3 are in essence that: Option 2 aligns fees with costs at a more disaggregated level and hence more precisely, whereas Option 3 offers simplification by reducing the number of distinct fees charged to payers. Option 3 '*light*' offers a compromise part way between Options 2 and 3 and performs the highest. Therefore, it is the preferred option.

With respect to the horizontal measures, the better performing variants appear to be; targeted fee reductions for veterinary fees combined with a reduced annual fee (C1); no application of country coefficients to NCA remuneration; and not sharing with NCAs the cost of incentives.

The monitoring framework discussed in Section 9 is consistent with the preferred option.

Further simplification will be achieved by merging the relevant provisions of the two existing EMA Fee Regulations into one legal instrument.

1.24. **REFIT (simplification and improved efficiency)**

Policy options 3 and 3 'light' allow a reduction of the existing administrative burden related to the calculation and invoicing of fees to industry and consequent remuneration to NCAs. Option 3, with post-authorisation activities included in flat annual fees, thus reducing accordingly the number of procedural fees, results in the greatest simplification of the system structure and therefore greatest reduction in administrative burden. However, it was considered such an over-simplification of the system could lead to a lack of sufficient flexibility and a cost-based approach, thus making the fee system difficult to adapt to a fast changing technical, scientific and regulatory context, with possible impacts on its future sustainability. Option 3 '*light'* was considered to provide the greatest balance between simplification and flexibility of the fee system.

1.25. **Application of the 'one in, one out' approach**

This principle ensures that any newly introduced administrative burdens are offset by removing equivalent burdens in the same policy area. Administrative costs are covered by the 'one in, one out' approach but regulatory fees are not. This initiative is not in the Commission Work Programme and there are no significant administrative costs added or removed, therefore the initiative is not in the scope of the 'one in, one out' (OI-OO) approach. Nevertheless, the quantification of the administrative costs demonstrate that no significant administrative costs have been added or removed through this initiative, i.e. the estimated effect is a limited saving in administrative net cost in the range of €54,960 to €112,350, which is negligible in the context of the entire system (see Annex 3).

8. How will actual impacts be monitored and evaluated?

The Commission will need access to evidence to monitor the revised fee system and assess to what extent it achieves its objectives in an efficient way.

Stakeholder consultation elicited inputs on feasible monitoring arrangements. The proposal for monitoring and evaluation is divided into two timescales:

1. Annual routine monitoring to provide the basis for considering adjustments to EMA fees and thereby provide some of the flexibility to adjust the fee system to changing circumstances;
2. Less frequent, periodic (i.e. no more than every five years) data collection to support periodic evaluations and, if necessary, consequent changes to the fee legislation.

Data collected and monitored annually to permit consideration of adjustment of fees would also provide much of the indicators needed for periodic evaluations of the fee system. However, data collected and monitored annually (e.g. general cost inflation across the EU, or trends in the number of assessment hours or the number of authorised products / chargeable units for which annual fees would be payable) could not necessarily be sufficient for periodic evaluations. Certain information is burdensome to generate and collect annually (e.g. data on NCA and EMA time input for the full set of EMA activities, such as were collected in the 2016 MBDG exercise) or exists outside the EMA-NCA network (e.g. administrative burdens on payers associated with the fee system).

Additional data could possibly be collected, as relevant, through primary research or regular contacts with stakeholders. In general terms, there is a trade-off: the more comprehensive and sophisticated the annual monitoring mechanism, the lower the incremental effort required for periodic evaluations and the greater the potential for more sophisticated analysis in the evaluation.

Annual monitoring and adjustment

The annual collection and monitoring of data related to EMA and NCA costs and activity levels can be used to fulfil two functions:

- To consider adjusting fee levels and / or NCA remuneration, in response to confirmed trends in general cost inflation and EMA activity costs. Such adjustment already occurs to some extent through the annual inflation factor applied to adjust EMA fees and remuneration each year.

- Beyond adjustment reflecting general cost inflation, to evidence when exceptional circumstances lead to significant and permanent changes in workload-related costs, so that such changes could be recognised and reflected in a corresponding change to fees and remuneration. A mechanism to cope with exceptional circumstances exists *de facto* in the current system, as evidenced by the response to the Covid-19 pandemic, which introduced the possibility to charge part of the fee and pay part of the remuneration upfront for rolling review of pandemic-related products. Further, the fee legislation empowers EMA's Executive Director to grant fee reductions in exceptional circumstances[87], with the assumption that this is absorbed by the EMA

[87] Article 9 of Council Regulation (EC) No 297/95

budget. Finally, increased NCA's remuneration for pandemic-related assessments, beyond the regular fee-related remuneration, was introduced, thanks to a legal possibility beyond the fee legislation, i.e. in EMA's founding regulation, with funding included in the EU budget contribution envelope for the Regulation on a reinforced role for EMA.

Some level of collection of non-inflation indicators for annual monitoring was already created by Article 15 of Regulation (EU) No 658/2014[88]. It stipulates indicators that are required to be collected and published annually by EMA to monitor the fees payable for the conduct of pharmacovigilance activities in respect of medicines for human use only. Article 15 also requires EMA to report annually to the Court of Auditors, the Commission, the European Parliament and the Council the information "that may have a bearing on the costs to be covered by the fees provided for" pharmacovigilance of products for human use.

Annex V to the abovementioned regulation provides a list of indicators that are required to be collected and reported annually. In summary they cover: numbers of (pharmacovigilance) procedures; number of EMA staff working on these procedures and activities covered by the annual fee; EMA staff costs and non-staff costs of these activities; numbers of times each kind of incentive is applied (for SMEs, etc.); how many times each NCA is rapporteur or co-rapporteur; and working hours spent by the rapporteur/co-rapporteur per procedure. The last of these indicators is provided by the relevant NCAs to EMA. EMA provides the other indicators and reports on all indicators annually to the Commission and the EMA Management Board.

A possible list of annually collected non-inflation monitoring indicators could include those listed in Table 11. The activity-specific data on workload could, initially at least, be limited to major procedures for which the corresponding fees and remuneration amounts are the highest, with data on other procedures monitored less regularly[89]. Inflation data could be used for unitary cost-related monitoring, while workload data could be used for complexity-related monitoring.

The Agency could collate and perform annual analysis presented to the Management Board (together with the raw data available). Following Management Board deliberations, if the Agency finds that there is sufficient evidence to consider triggering a change to fees and / or remuneration amounts, the analysis of indicator values over time, with justification or discussion of the limitations of the reliability, would be the evidence on which any rationale for updates (upward or downward) would need to be based and submitted to the Commission. In addition, the Commission would have the option to trigger a review of fees if there are other compelling elements, such as new tasks given to EMA or unforeseen circumstances, taking into account the balancing nature of the EU budget contribution agreed under the relevant Multi annual financial framework, in accordance with EMA's

[88] Regulation (EU) No 658/2014 of the European Parliament and of the Council of 15 May 2014 on fees payable to the European Medicines Agency for the conduct of pharmacovigilance activities in respect of medicinal products for human use.
[89] Given the study finding that some NCAs would struggle to provide time and cost data annually.

founding regulation. To respond to the need for flexibility, the legal instrument of such adjustments could be a delegated act, based on objective triggers as discussed above.

Objective	Indicator	Source
Alignment of fees and remuneration with the costs of activities	EMA income by fee	EMA accounts
	EMA workload and costs by activity grouped by fee and homogeneous groups of fees	EMA accounts
	Number of EMA activities, per fee (procedures)	EMA records
	EMA budget outturn	EMA budget reporting
	Allocations of activities by NCA, per activity	EMA records
	EMA net remuneration payments to NCAs, by fee	EMA accounts
	Total NCA income and expenditure balances (for both EMA-related and non-EMA-related activity)	Budget reporting of each NCA
	NCA workload by activity grouped by fee	NCAs (similar to current reporting on pharmacovigilance procedures)

Table 11: Possible indicators for annual monitoring

Periodic evaluations and data collection

It is envisaged that the fee system would be periodically evaluated (every five years or more) with the first evaluation taking place not earlier than 5 years after the entry into application of the new regulation.

EMA and NCAs described the collection of time input data per activity, as was done for the 2016 MBDG exercise, as burdensome and especially to those NCAs that do not currently have management information systems that record staff time by activity. Collecting other financial data from NCAs to enable estimation of their costs per EMA activity they undertake (as was done for the evaluation of the EMA fees system in 2018) was not considered to be as burdensome as collecting time input data but would also not be straightforward – due to the same NCA having both national activities and EMA work. Independent audit, e.g. at the time of evaluation, of the time and cost data provided would safeguard the robustness and objectivity of those data.

To support periodic evaluations of the EMA fees system, EMA and NCAs could collect some additional data to supplement the annual monitoring data collected over preceding years, taking into account any fee changes made as a result in the meantime. Such more burdensome provision of monitoring data could take place every five years or more.

Collection of time-per-activity data could become automated across all NCAs as well as EMA, to ensure possibly a greater efficiency of the process.

Table 12 sets out the proposed indicators to be collected periodically to supplement the annual indicator data listed in Table 11.

Objective	Indicator	Source
Alignment of fees and remuneration with the costs of activities	Analysis of fee revenue and relevant cost elements, over a longer period of time (could be based on annual monitoring data)	Data sets based on annual monitoring data and further data sources
Regulatory burden	Payer, EMA and NCA experiences of the administrative burden of the fee and remuneration system	Survey lead by EMA including stakeholder relations divisions
Support to SMEs	Specific SME reporting focused on fees and fee-system administrative burden issues and specific financial and other support provided	EMA SME office

Table 12: Additional indicators for periodic (every five or more years) monitoring and evaluation

Together, these two sets of data can be input into the financial model to generate the corresponding revised estimates of all fees. Those modelled fees can be compared with the then current fee grid to determine for which fees there are significant divergences and hence which if any fees need to be revised, always bearing in mind the objective of a balanced budget and the EU budget contribution.

ANNEX 1: PROCEDURAL INFORMATION

1. Lead DG, D*e*cide Planning/CWP references

The Directorate for Health and Food Safety (DG SANTE) is the lead DG on the initiative on the revision of the EMA Fee System. The initiative has received the validation in the Agenda Planning on 30 January 2019 (reference PLAN/2018/4193) and the Inception Impact assessment was published on 18 September 2019.

2. Organisation and timing

The Impact Assessment project started in Feb 2020. The Inter-service Steering Group (ISSG) was composed of the following DGs: SANTE, RTD, SG, LS, BUDG and GROW. For the follow up of the external study supporting the Impact Assessment the Group was consulted in twice in 2020 (kick-off and inception report), twice in 2021 (targeted consultation material and interim report) and in 2022 (28/03-04/04 2022).

The draft Impact Assessment report and all supporting documents were submitted to the Regulatory Scrutiny Board (RSB) on 13 April 2022, in view of a meeting on 11 May 2022. The RSB issued a positive opinion with reservations on 13 May 2022.

3. Consultation of the RSB

The Impact Assessment report was reviewed by the Regulatory Scrutiny Board. Following the meeting, the RSB issued a positive opinion with the following high-level reservations to be addressed:

> (1) The report does not sufficiently explain how this initiative interlinks with the revision of the EMA founding regulation and how synergies and complementarities will be ensured.
>
> (2) The definition of what a 'cost-based system' is unclear. The report does not clarify to what extent the current system and its key elements is cost-based and what the potential for cost-efficiency enhancing measures is.
>
> (3) The report does not sufficiently analyse how the proposed changes impact fee payers.

The table below lists the changes made in response to the specific recommendations provided by the RSB:

Recommendations of the RSB	**Modifications in the impact assessment report in response to the Board's recommendations**
(1) The report should explain in more detail the interlinkages and coherence with the upcoming revision of the EMA founding regulation. The report should clearly	The introduction of the report has been amended and expanded to better clarify the scope of this initiative and how it interlinks with the general revision of the

describe how the proposed fee system will be able to account for and adapt to changes in the founding regulation and how synergies and complementarities will be maximised.	pharmaceutical framework. It was explained that whilst this revision cannot pre-empt the outcomes of the work on the pharmaceutical strategy, the legal draft for the new fee system will propose measures to ensure adequate levels of flexibility in updating and adjusting the text (e.g.: delegation of powers to Commission and/or EMA MB), in order to ensure the smooth alignment of the fee system to any future provisions.
(2) When presenting the problem, the report should give a more precise picture of what 'cost-based' entails. It should define the concepts of 'cost-based' and 'cost-reflectivity' and should better outline whether the current fees and remunerations are sufficiently 'cost-based'. For instance, it should assess to what extent the industry annual fees are charged on the principle of service actually provided to fee payers. The report should also better present the background of the cost alignment objective, and it should explain the trade-offs and the basis for the relative weight between cost alignment, simplicity and the flexibility objectives.	The introduction of the report has been amended and expanded to better clarify the principle of 'cost-based' and the legal basis from where the objective of cost alignment stems from. The level of cost reflectivity of the current framework has been better explained, showing that whilst the current system manages to balance the EMA budget and can be considered overall cost based, at granular procedural level there are discrepancies between the fees and remunerations amounts and the respective costs of EMA and NCAs to undertake the necessary work. The trade-off between costs alignment and simplicity have been better outlined and put in perspective with what the initiative tries to achieve.
(3) The report should better explain the overall functioning and efficiency of the current system. It should better present how the NCAs are assigned to their tasks and what kind of process will be followed to ensure excellence in service and cost-efficiency. It should explain why internal efficiency improvement measures (possibly in interaction with the changes to the founding regulation) have not been considered to tackle the financial sustainability challenge. In this context, the report should clarify to what extent the current EMA and NCA services provision can be considered as overall performing well and cost-efficient.	The functioning of the current regulatory framework has been better explained in the Annex on Context, with clarification on the procedure for assignment of rapporteurs from NCAs. The report has also been amended to better outline measures to guarantee efficiency of the current system (as periodical reviews and Commission reporting on the functioning of the system). Nonetheless, it has been clarified that this initiative is limited to revising the EMA fee system based on the current EU pharmaceutical legal framework and that .further possibilities for efficacy and efficiency gains, including aspects on governance, are being discussed separately as part of general revision of the pharmaceutical framework. Setting the new fee system with the appropriate level of

	flexibility will allow to smoothly take into account any governance improvements and efficiency gains introduced in future and update fees and remuneration amounts accordingly.
(4) The report should better substantiate why country coefficients for NCAs would lead to significant administrative burden and clarify whether the burden outweighs the benefits. It should assess the risk that the current NCA remuneration system overall may result in delivering the NCA services at the cost of the most cost expensive national authorities.	The subsection dealing with appraisal on horizontal measures has been expanded to better clarify the various elements that contributed to the exclusion of country coefficient as a viable way to address differences in costs across the NCAs. Beyond the aspect of administrative burden, the application of coefficient would negatively impact predictability either for payers or for NCAs and would ultimately put at risk the ability of the EMA to balance its budget.
(5) The report should better describe why the baseline is not a viable way forward, in particular given the apparent lack of stakeholder support for the options presented. The report should outline the drivers behind the negative financial balance and explain why it is not possible to balance incomes and expenditures in the baseline scenario.	The subsection on option discarded has been amended to better present the arguments in support of discarding the baseline as a viable option. Due to the new legal provisions put in place by the new VMP Regulation and the extended mandate of the EMA, the current fee system cannot be adjusted by non-legislative action to the extend needed to accommodate appropriate funding for these additional costs and it would ultimately result in a negative financial balance for the EMA.
(6) The report should clarify the impacts on fee payers. It should explain better how the recalculation results in higher total industry fees. It should assess the consequences of the raising the costs for fees payers, such as impacts on innovation or on the number of new applications. In particular, the report should specifically account for consequences on fee payers from the veterinary medicine sector. It should also better reflect the views of fee payers from the various consultation activities.	The financial effect of the changes on payers has been further clarified and expanded. It was stressed that an 8-9% increase in total industry fees cannot be accounted as a barrier to innovation, especially when seeing it in the context of total R&D costs.
(7) The report should better reflect the overall impact of this initiative on the development and availability of safe,	It has been clarified that the general objective of the initiative is to provide a sound financial basis for EMA and its

effective, and quality medicines. It should also indicate if there are any significant social, environmental or fundamental rights impacts.	activities. The legal basis section was expanded to explain that the initiative aims to support the goal of setting high standards of quality and safety of medicinal products by ensuring the availability of sufficient financial resources to perform the activities that are necessary to guarantee that high standards are applied for the authorisation of pharmaceutical products and maintenance of those authorisations. It has been clarified that given the nature and scope of the initiative no significant social, environmental or fundamental rights impacts have been identified and that only impacts of an economic nature were assessed.

4. Evidence, sources and quality

A targeted consultation was conducted with NCAs, EMA and Industry from June until August 2021. In total, 10 interviews were conducted with EMA (2 interviews) and HMA/NCAs (8 interviews) in the period between September 2021 and October 2021 in order to supplement some survey responses.

ANNEX 2: STAKEHOLDER CONSULTATION (SYNOPSIS REPORT)

- **Introduction**

In accordance with the Better Regulation Guidelines, this document provides a synopsis or summary of all the consultation activities in support of the *Study supporting the Impact Assessment of the Revision of the EMA fee system*. This Synopsis Report accompanies the Final Report of the study supporting the impact assessment, Section 2 of this Annex presents the approach to the consultations and Section 3 of this Annex provides an overview of the results. Stakeholders were not re-consulted following the recalculations which were undertaken to address the issues they had rised.

- **Approach to the consultation**

The objective of the consultations was to collect information to support the qualitative analysis. They were used to obtain views on the impacts of the policy options and horizontal measures and to validate the list of procedural activities covered by the model.

Stakeholder selection

Six key stakeholder groups (EMA, national ministries and National Competent Authorities (hereinafter, NCAs), pharmaceutical industry for human medicines, pharmaceutical industry for veterinary medicines, industry representative organisations and academia) were identified in the Terms of Reference of this study. In addition to these groups, wider stakeholder associations were consulted (via an invitation to respond to the targeted survey). A list of specific organisations and companies within each group was defined based on the stakeholder mapping in the 2018 RAND study (Smith et al. 2018)[90]. The list was updated, the contacted stakeholder list can be found in Annex 2.1. An overview of the stakeholders invited to participate in the targeted surveys is shown in Table 2.1 below.

Table 2.1 Summary of stakeholder contacted for the targeted survey

Type of organisation	Number of organisations
National Competent Authority and Ministries	86

[90] Smith, E., Dunkerley, F., Altenhofer, M., Cochrane, G., Harte, E., Barberi, M., & Sussex, J. (2018). Study for the Evaluation of the EMA Fee System - SANTE/2016/B5/021. https://www.rand.org/pubs/external_publications/EP67970.html

Other national institutions	45
Patient and Consumer Association	6
Research Associations	13
EU level Healthcare Professional's Associations	28
Industry organisations and the associations representing them	31
Other (EMA and HMA)	2
TOTAL	211

The sample of NCAs interviewed covered a range of organisation sizes and geographies, human medicines only organisations, veterinary medicines only organisations, and organisations responsible for both.

Table 2.2. provides an overview of the targeted consultation activities and the main stakeholder groups that were engaged. Stakeholders were selected to be as comprehensive and representative as possible and all relevant groups (see Annex 2.1 to this note for a full list of stakeholders contacted) were given the opportunity to provide their views and potential impacts concern the revision of the EMA fee system.

Table 2.2 Targeted consultation strategy activities per stakeholder group

Stakeholder group	Consultation Activity/ Tool	Answer received / Interviews carried out
NCAs	Targeted surveys and interviews	24 survey responses/standalone position papers contributions and 7 interviews conducted
Fee payers	Targeted surveys	6 survey responses, one position paper and 1 interview conducted
EMA	Targeted survey and interview	1 survey response and 2 interviews conducted
HMA	Targeted survey and interview	1 position paper and 1 interview conducted

Note: ICF and RAND Europe analysis of the stakeholder consultations.

Targeted surveys

The analysis of the targeted surveys included cross-tabulations of closed answer questions and a qualitative analysis of additional textual feedback provided by respondents in open answer questions and through position papers. Manual qualitative analysis was used to provide insight into the themes being discussed.

The different themes were pre-identified as key areas covered in the impact assessment exercise. In order to understand which questions respond to the covered themes, each survey question was connected to an indicator under each theme. Questions solicited views on the general impacts of the policy options and horizontal measures as well as the more specific impacts estimated with the financial model.

The questions asked in each of the survey covered the following themes: good administration, regulatory burdens on industry, public health and animal health, research and innovation, functioning of the internal market and competition, impacts on SMEs, monitoring and evaluation of the fee system.

No duplicates were identified among the replies. However, several NCAs supported and shared the comments submitted by the HMA that represents them.

ICF launched the targeted surveys on 17 June 2021 via Qualtrics and they remained open until 23 August 2021, a period of nine and a half weeks.

Interviews

Targeted interviews were undertaken in September and October 2021, following the targeted surveys. Interviews were conducted with EMA (two), HMA (one), individual NCAs (seven: AT, BE, CZ, FR, NL, PT, SE) and one pan-European payer organisation.

These interviews built on the replies to the targeted survey, giving interviewees the opportunity to emphasise issues of particular importance in their view, and to provide further background to, and explanations of, their survey responses. The topics covered in the interviews were:

a. consequences (including financial) of involvement in the centralised, EMA-level activities;

b. sustainability of the fee system: flexibility to adjust to significant changes (e.g., new activities, new legislation, innovation, increasing complexity) and related indicators, predictability of income;

c. administrative burden;

d. coherence of the fee system (external and internal);

e. impact on fee payers and innovation. e.g. fairness, competitiveness;

f. how the policy options compare;

g. monitoring and evaluation in a future fee system.

Limitations

The online surveys yielded fewer replies than anticipated, despite a dissemination campaign and reminder emails. This may be due to the topic being highly technical and that the consultation period was during the European summer months. Some stakeholders group invited refused to respond to the targeted surveys because of the technical nature of the subject matter. A larger number of survey responses would have provided greater depth to the qualitative analysis but the coverage of stakeholder interests was good, with no obvious gaps.

All but one of the organisations approached for interviews responded positively and were interviewed. One NCA did not respond, despite reminders. Nevertheless, the desired spread of NCA perspectives was covered by the seven NCAs that were interviewed, as detailed in Section 3 of this Annex, below.

- **Overview of contributions**

Six key stakeholder groups were identified in the terms of reference: the European Commission, EMA, national ministries and NCAs, pharmaceutical industry for human medicines, pharmaceutical industry for veterinary medicines, industry representative organisations and academia. Responses were received from stakeholders from every group except academia.

Targeted survey

The targeted survey elicited 31 responses, of which 14 included a position paper as an attachment. Table 3 presents an overview of the contributions to the targeted survey by key stakeholder group (as self-identified by the respondents). Of the 31 replies, 24 were from NCAs, 6 of which had an interest only in human health, 6 had an interest only in animal health and 12 had an interest in both human and veterinary health. Two responses were received from a ministry of health and another government institution (along with their NCAs), two additional NCAs provided their feedback as standalone documents to the consultation, and six responses were received from organisations representing fee payers.

Survey responses were received from NCAs located in 17 Member States (BE, BG, HR, CY, CZ, DK, FI, FR, DE, IE, IT, MT, NL, PT, SI, ES, SE) and two EEA countries (IS, NO). Separately, responses from the HMA and two NCAs were received as standalone contributions (AT, FR) Authorities located in the remaining 9 Member States (EE, EL, HU, LV, LT, LU, PL, RO, SK) did not respond. The HMA is an umbrella body representing the NCAs, in this consultation the HMA provided feedback presenting these NCAs, some of these NCAs also responded individually to the consultation. Organisations representing fee payers were all pan-European and based in Belgium.

Table 2.3 Number of survey contributions by stakeholder group

	Total	Human	Veterinary	Human and Veterinary

	Total	Human	Veterinary	Human and Veterinary
National Competent Authorities (incl. ministries and other government institutions)	24	6	6	12
Organisations representing fee payers and their associations	6	4	1	1
EMA	1			1
Total	31	10	7	14

Note: ICF analysis of consultation replies.

Interviews

Two interviews were undertaken with EMA representatives. The first took a strategic perspective and the second was focused on technicalities of the options and their implementation.

One interview was undertaken with senior representatives of the Heads of Medicines Agencies (HMA). Four senior NCA managers were present, representing human and veterinary medicines and both smaller and larger NCAs. With the assistance of the HMA eight NCAs were identified to interview so as to cover a spread of NCA types and locations. One NCA did not respond to requests for an interview. The seven NCAs collectively covered:

- NCAs undertaking: human medicine activities only (n=1); human and veterinary medicine activities (n=4); and veterinary medicine activities only (n=2);
- A geographical distribution of NCAs across the EU, covering NCAs in Northern and Southern Europe as well as in newer and older Member States;
- NCAs with different degrees of involvement with EMA;
- NCAs with different costs and different country coefficients associated with their activities.

The final interview was with three senior representatives of European Federation of Pharmaceutical Industries and Associations (EFPIA)[91].

- **Analysis of the replies**

The categories of impact that were analysed for each of the policy options and horizontal measures for the different responses received from the consultation activities were:

- Governance and good administration (including financial sustainability)
- Regulation burdens on business, EMA and NCAs
- Public health and animal health in the face of emerging risks
- Research and innovation
- Impact on SMEs.

The analysis also considered the monitoring and adjustment mechanism.

The following subsections summarise the evidence collected and analysed in the consultation activities for the categories above.

Governance and good administration (including financial sustainability)

Over half of the survey consultees found that all options would negatively affect the **financial stability and sustainability of the operation of EMA and NCAs as a regulatory network**. The general opinion among countries responding to the survey questions was that Options 2 and 3 would worsen the current situation. Veterinary NCAs believed that Option 1 could bring positive impacts and rejected Options 2 and 3. EMA and some NCAs favoured the system's simplification. Moreover, EMA noted that Options 2 and 3 would balance the EMA budget; however it noted that they could mean less remuneration for NCAs and this could put at risk the **stability of the network**. In the NCAs' view (especially NCAs undertaking both human medicine and animal medicine activities) Option 1 would not guarantee that the costs they incur contributing to network activities will be covered. The HMA stated that there are already some difficulties in meeting demand for rapporteurs and co-rapporteurs to carry out assessment activities and any option that reduced remuneration of NCAs would worsen this difficulty.

The HMA emphasized the importance of the future fee system fairly remunerating all activities undertaken by NCAs, not just procedural activities. In the opinion of the HMA, supported by individual NCAs, reimbursement should be calculated to include other costs; if other costs (e.g., Committees, Working Groups, additional EMA related activities) are added to the totals, the remuneration paid by EMA to NCAs for undertaking procedural activities for human and veterinary will leave a shortfall.

[91] EFPIA: The federation representing the biopharmaceutical industry operating in Europe. Direct membership of national associations, pharmaceutical companies and a growing number of small and medium-sized enterprises (SMEs).

Four features of the cost methodology were identified by NCAs and the HMA as leading to the cost-based fee options (2, 3 and 3 '*light*') yielding, in aggregate, insufficient funding for NCAs:

- Not all NCAs activities for EMA are remunerated;
- Not all capacity-related costs are remunerated;
- The nature of the work undertaken by NCAs means that they use proportionately more senior scientific staff than EMA;
- The cost basis for the financial model is out of date.

The first and main theme raised in all ten of the interviews conducted to follow up the survey (two with EMA, one with HMA and seven with a range of individual NCAs), was the need for any option for the fees and remuneration system to provide sufficient funds to NCAs, as well as EMA, to enable them to continue to play a full role in the EMA system.

EMA and HMA supported by all seven NCAs interviewed stressed that options that reduced funding to NCAs in total – Options 2, 3 and 3 '*light*' – would mean that the EMA system would not be sustainable. On these grounds alone, Option 1 was preferred over the others because it would yield the highest amount of remuneration of NCAs. However, this has to be interpreted not as a preference for the design of the option but rather as a strong concern that remuneration should not be reduced in any option implemented in a future proposal.

Over half of NCAs and one ministry of health responding to the targeted survey indicated that Option 1 would have no impact on their ability to undertake activities. Some NCAs tasked with veterinary activities expected some positive impact if Option 1 is implemented. NCAs overall expected that the implementation of Options 2 and 3 would have a negative impact on their ability to undertake EMA activities; only a few NCAs believed Option 2 could have some positive impact. NCAs believed that Options 2 and 3 could have negative impacts, mainly because a cost-based approach method used will result in a decrease in overall reimbursement and reduce the network's ability to cross-subsidise NCA activities. The proposal to move to cost-based fees was also rejected by the HMA as it results in a reduction of income in relation to human medicines.

Financial predictability

The general opinion among the NCAs and one ministry of health responding to this consultation was that none of the options would improve the outlook or could have negative impacts in the financial predictability of their organisations. In their view, the least impactful options would be Options 1 and 2. Similarly, none of the organisations representing fee payers and its associations believed that these policy option would impact their financial predictability. Half of the veterinary NCAs had the same beliefs about Options 1 and 2.

Almost all NCAs and one ministry of health interested on both human and animal medicines believed that Option 3 would bring negative impact to financial predictability. This option was rated more negatively than the other options. To a lesser extent the same NCAs and one ministry of health believed that Options 1 and 2 would have negative

impacts. Option 2 was believed to have no impacts or negative impacts (here the opinion of NCAs was divided).

Many NCAs indicated that the proposed fixed amounts/fees in Option 1 provide a level of predictability and would be helpful for forecasting veterinary activities. However, for veterinary medicines, potential fee increases make predicting future income very challenging, as NCAs noted that it is hard to predict how companies will approach new authorisation applications fees for veterinary medicines under the VMP regulation rules in the first place. Option 1 was liked by NCAs expecting an increase in their income or those undertaking veterinary medicines' activities, therefore Option 3 was less liked. NCAs rejecting Options 2 and 3 noted disagreement with the changes on the variation activities being included in an annual fee.

HMA supported by individual contributions of NCAs believed that Option 3 (full version) would have a negative impact on financial predictability. The HMA supported by many NCAs explained that moving to a cost-based fee system with the proposed methodological approach showing in their views that for human medicines fees, as in Options 2, 3 and 3 '*light*' would reduce the fee income of NCAs. The problem was expected to be most severe for those NCAs undertaking the most human-medicine activities. However, moving to cost-based fees was expected to increase income for NCAs undertaking veterinary activities.

HMA supported by individual contributions of NCAs believed that Option 3 (full version) would have a negative impact on financial predictability. Veterinary NCAs considered that this option would mean that NCAs receive less remuneration and would not recover the full costs. They also considered that this policy option may work in favour of EMA and its future financial position, but not for all NCAs.

EMA believed that Option 1 would not impact its financial predictability and Options 2 and 3 would see financial predictability deteriorate for EMA. It stated that with these two options, the proportion of revenue from less predictable procedures would rise from 11% (today) to 22%.

Monitoring and adjustment mechanism

Survey respondents were asked to provide their opinion on what indicators should be monitored in respect of each objective of the EMA fee system, in view of future amendments to the fee system. Around half of the NCAs responding to these questions did not know what indicators to choose under each system objective. Most of the respondents (EMA and NCAs) considered that the indicators should be monitored on a yearly basis.

NCAs with responsibility for animal medicines tended to see the list of procedures in the fee grid as incomplete or were unsure whether the list of procedures in the fee grid captured all EMA procedures and that there will be further activities in future that need to be recognised beyond DARWIN EU.

Horizontal measures: country coefficients, reduction of 50% for veterinary fees, cost incentives shared between EMA and NCAs

Country coefficients:

The consultation activities revealed strong, but not unanimous, opposition to using country coefficients. Only a few NCAs showed positive support. EMA and HMA along with four of the seven NCAs interviewed (including two NCAs that would gain financially from the introduction of coefficients and two that would lose out) opposed the use of country coefficients when determining NCA remuneration. Objections were based mainly on two positions: Solidarity among NCAs and between EMA and NCAs; and the principle that scientific excellence and desire to contribute should be the sole criteria determining which NCAs do which work, not costs. This lack of support contrasts with the general acceptance of the principle that fees and remuneration should reflect costs.

Reduction of 50% for veterinary fees:

Some NCAs and EMA called for fee reductions to be set at levels different to what they are today. EMA explained that a 50% general fee reduction is not sustainable under the different scenarios and would generate a significant negative budget deficit in 2024 as well as significantly reduced remuneration for the NCAs. Some NCAs noted that, if fee increases for veterinary medicines caused by either of the options would deter some veterinary medicine companies from using the EMA system (particularly for medicines with small markets) then a general 50% reduction would reduce the likelihood of that happening.

Cost of incentives shared between EMA and NCAs:

None of EMA, HMA or the individually interviewed NCAs expressed support for the cost of incentives to be shared with NCAs. The HMA and some NCAs, and EMA argued that EMA could be recompensed through the financial contribution it receives from the EU budget.

Regulation burdens on business, EMA and NCAs

All organisations representing fee payers thought Option 2 had the highest potential for negative impacts. Half of the organisations found Option 3 to be the most attractive option. The administrative burden of the fee system - currently and under any of the options under consideration - was not a major worry for the HMA or individual NCAs. EMA considered that Options 1 and 2 would have a somewhat negative impact, as in its view, new fees would generate additional administrative work that would not be compensated by the simplification of the fee structure. On the other hand, even though Options 3 and 3 '*light*' could generate additional administrative work, EMA believed these options have the potential to compensate the work generated by some simplification of the new proposed fee structure or a reduced number of financial procedures.

Public health and animal health in the face of emerging risks

Most respondents to the consultation activities did not expect Option 1 to change the likelihood of new medicines being authorised in the EU. Most organisations representing fee payers preferred policy Option 3 (with the exception of an organisation representing fee payers of animal health products). EMA found that all three policy options could put innovation and public health at risk and the EU could become slower in approving new medicines compared to other region.

It was also noted – by EMA, HMA and two of the NCAs – that all the options imply large increases in veterinary medicine fees relative to the current position, and that this might deter some organisations from seeking authorisation for their veterinary products.

Research and innovation

An organisation representing European bio-industries noted that removal of fee incentives for orphan/paediatric would not be coherent with the objective of the Pharmaceutical Strategy for Europe to foster European innovation. EMA found that Options 2 and 3 could put innovation and public health at risk.

Impact on SMEs

The HMA noted that producers of veterinary medicines may be sensitive to fee changes. One veterinary-only NCA and the HMA noted that fees for new products under all three options may have an unintended consequence that would affect certain animals (e.g. chickens) where the economic value of the treated organism is comparatively small.

Feedback on the consultation process

Furthermore, HMA and the NCAs consulted, noted that in their view the cost exercise presented in the consultation activities is flawed as it is based on pre-Brexit data (this comment does not address the methodological explanations provided on tackling the effect of Brexit in the MBDG data set), pre-Covid-19 time data from 2016, and does not reflect the emergence of more complex procedures from the regulatory and scientific points of view (however, no supporting data was presented). Therefore, in their opinion, the methodology did not reflect the current situation, including new tasks of NCAs stemming from the legal proposal for an extension of the EMA mandate (this comment does not take into account the fact that additional remuneration for these new activities has already been introduced under the current system and that the regulation on EMA's reinforced role will continue to apply regardless of a revision of the fee legislation, with the respective increase in the EU budget contribution). In general, although more specific comments and input were invited, including during interviews of NCAs, no further data or substantiation has been provided for use by the study model.

A significant number of stakeholders did not respond to the survey. Reasons given include the technical nature of the subject matter and that the consultation period was during the European summer months. The medical device industry did not provide a reply to the survey.

Issues with the fee grids were notified by some respondents, these were addressed by the study team and all participating stakeholders were informed of the undated questionnaires and fee grids. They were given an extension to provide their replies.

Annex 2.1 Targeted survey – list of stakeholders contacted

This annex contains the six lists of stakeholders invited to participate in the targeted surveys. In addition to the stakeholders listed below, EMA and HMA were also contacted.

Table 2.1.1 National Competent Authorities and Ministries

Institution name	Area of Interest (Human health/ Animal health /both)	Country
Austrian Agency for Health and Food Safety (AGES)	Both	Austria
Austrian Ministry of Health (BMG)	Both	Austria
Federal Ministry of Labour, Social Affairs, Health and Consumer Protection-Health and Women's Affairs (BMEIA)	Animal	Austria
Federal Ministry of Social Affairs, Health, Care and Consumer Protection, Austria (Sozialministerium)	Human	Austria
Federal Office for Safety in Health Care, Austria (BASG)	Both	Austria
Federal Agency for Medicines and Health Products	Animal	Belgium
Federal Agency for Medicines and Health Products (FAGG-AFMPS)	Both	Belgium
Bulgaria Drug Agency (BDA)	Human	Bulgaria
Bulgarian Food Safety Agency (BFSA)	Animal	Bulgaria
Ministry of Agriculture, Food and Forestry	Animal	Bulgaria
Ministry of Health of Bulgaria	Human	Bulgaria
Agency for Medicinal Products and Medical Devices of Croatia (HALMED)	Human	Croatia
Ministry of Agriculture, Veterinary and Food Safety Directorate	Animal	Croatia
Ministry of Health of Croatia (MIZ)	Human	Croatia
Veterinary Services, Ministry of Agriculture, Natural	Animal	Cyprus

Institution name	Area of Interest (Human health/ Animal health /both)	Country
Resources and Environment (MOA)		
Ministry of Health of Cyprus	Human	Cyprus
Institute for State Control of Veterinary Biologicals and Medicines (ÚSKVBL)	Animal	Czechia
Ministry of Health, Czechia (MZCR)	Human	Czechia
State Institute for Drug Control, Czechia (SUKL)	Human	Czechia
Ministry of Food, Agriculture and Fisheries	Animal	Denmark
The Danish Medicines Agency (DKMA)	Both	Denmark
Health Board of Estonia	Both	Estonia
State Agency of Medicines	Both	Estonia
Finnish Medicines Agency (FIMEA)	Both	Finland
Finnish Ministry of Social Affairs and Health (STM)	Human	Finland
Ministry of Agriculture and Forestry	Animal	Finland
Agency for Food, Environmental and Occupational Health & Safety (ANSES)	Veterinary	France
French Agency for the Safety of Health Products (ANSM)	Human	France
French Ministry of Solidarity and Health	Human	France
Ministry of Agriculture	Animal	France
Federal Institute for Drugs and Medical Devices	Human	Germany
Federal Ministry of Food and Agriculture	Animal	Germany
Federal Ministry of Health, Germany (BMG)	Human	Germany
Federal Office of Consumer Protection and Food Safety (BVL)	Animal	Germany
Ministry of Social Affairs, Health and Integration Baden-Wurttember, Germany	Human	Germany
Paul-Ehrlich-Institute (PEI)	Human	Germany

Institution name	Area of Interest (Human health/ Animal health /both)	Country
National Organization for Medicines (EOF)	Both	Greece
Ministry of Rural Development and Food	Animal	Greece
Hungarian National Institute of Pharmacy and Food Health (OGYEI)	Human	Hungary
National Food Chain Safety Office, Directorate of Veterinary Medicinal Products	Animal	Hungary
lyfjastofnun (Icelandic Medicines Agency)	Both	Iceland
Ministry of Health, Iceland (HRN)	Human	Iceland
Department of Agriculture, Food and the Marine	Animal	Ireland
Department of Health, Ireland	Human	Ireland
Health Products Regulatory Authority, Ireland (HPRA)	Both	Ireland
Italian Medicines Agency (Aifa)	Human	Italy
Ministry of Health, Directorate General for Animal Health and Veterinary Medicines	Animal	Italy
Food and Veterinary Service (PVD)	Animal	Latvia
Ministry of Agriculture	Animal	Latvia
Ministry of Health of Latvia	Human	Latvia
State Agency of Medicines	Human	Latvia
State administration of Liechtenstein - Office of Public Health	Human	Liechtenstein
Ministry of Health of Lithuania (SAM)	Human	Lithuania
State Accreditation Service for Health Care Activities under the Ministry of Health	Both	Lithuania
State Food and Veterinary Service	Animal	Lithuania
States Medicine Control Agency	Human	Lithuania
Ministry of Health of Luxembourg	Human	Luxemburg

Institution name	Area of Interest (Human health/ Animal health /both)	Country
Ministry for the Environment, Sustainable Development and Climate Change	Animal	Malta
Ministry of Health of Malta, Medicines Authority	Human	Malta
Veterinary and Phytosanitary Regulation Department (VMANS)	Animal	Malta
Ministry of Health and Care Services	Human	Norway
The Norwegian Medicines Agency	Human	Norway
Chief Pharmaceutical Inspectorate of Poland	Human	Poland
Ministry of Health of Poland	Human	Poland
Office for Registration of Medicinal Products	Human	Poland
Office for Registration of Medicinal Products, Medical Devices and Biocidal Products	Poland	Poland
Medical University of Warsaw	Human	Poland
National Medicines and Health products Authority, Portugal (Infarmed)	Human	Portugal
Portuguese General Directorate of Food and Veterinary (DGAV)	Animal	Portugal
Institute for Control of Biological Products and Veterinary Medicines	Animal	Romania
National Agency for Medicines and Medical Devices of Romania	Human	Romania
National Sanitary Veterinary authority and Food Safety Authority	Animal	Romania
Institute for State Control of Veterinary Biologicals and Medicaments (USKVBL)	Animal	Slovakia
Ministry of Health of Slovakia	Both	Slovakia
State Institute For Drug Control (SUKL)	Human	Slovakia

Institution name	Area of Interest (Human health/ Animal health /both)	Country
State Veterinary and Food Administration of the Slovak Republic	Animal	Slovakia
Agency for Medicinal Products and Medical Devices of Slovenia (JAZMP)	Both	Slovenia
Ministry of Health of Slovenia	Human	Slovenia
National Laboratory for Health, Environment and Food, Slovenia	Human	Slovenia
Ministry of Health of Spain	Both	Spain
Spanish Medicines Agency (AEMPS)	Both	Spain
Swedish Medical Products Agency (MPA)	Human	Sweden
Medicines Evaluation Board (CBG-MEB)	Both	Netherlands
Ministry of Agriculture, Nature and Food Quality	Animal	Netherlands
Ministry of Economic Affairs and Climate Policy	Animal	Netherlands
Ministry of Health, Welfare and Sport of the Netherlands	Human	Netherlands

Table 2.1.2 Other Member States' institutions

Institution name	Country
Ministry of Foreign Affairs and European Affairs of Slovakia	Slovakia
Representative of Federal Council of Germany	Germany
Secrétariat Général des Affaires Européennes	France
Foreign Affairs, Foreign Trade and Development Cooperation of Belgium	Belgium
Finnish Ministry of Foreign Affairs (FORMIN)	Finland
Ministry of Foreign Affairs of the Republic of Croatia (MVEP)	Croatia
Ministry of Foreign Affairs, Czechia (MZV)	Czechia

Ministry of Foreign and European Affairs of Luxembourg	Luxembourg
Hungarian Ministry of Human Resources (EMMI)	Hungary
Department of Foreign Affairs (DFA)	Ireland
Ministry of Foreign Affairs of the Netherlands	The Netherlands
Ministry of Economic Affairs and Climate Policy	The Netherlands
Romanian Permanent Representation to the EU	Romania
Federal Foreign Office	Germany
Swedish Ministry of Foreign Affairs	Sweden
Ministry of Enterprise and Innovation	Sweden
Ministry of Foreign Affairs of Latvia	Latvia
Hungarian Ministry of Foreign Affairs and Trade (MFA)	Hungary
Federal Ministry for European and International Affairs (BMEIA)	Austria
Spanish Ministry of Foreign Affairs	Spain
Bulgarian Permanent Representation to the EU	Bulgaria
Belgian Permanent Representation to the EU	Belgium
Czech Permanent Representation to the EU	Czechia
Danish Permanent Representation to the EU	Denmark
German Permanent Representation to the EU	Germany
Estonian Permanent Representation to the EU	Estonia
Irish Permanent Representation to the EU	Ireland
Greek Permanent Representation to the EU	Greece
Spanish Permanent Representation to the EU	Spain
French Permanent Representation to the EU	France
Croatian Permanent Representation to the EU	Croatia
Cypriote Permanent Representation to the EU	Cyprus
Latvian Permanent Representation to the EU	Latvia
Lithuanian Permanent Representation to the EU	Italy
Luxembourgish Permanent Representation to the EU	Luxembourg
Hungarian Permanent Representation to the EU	Hungary

Maltese Permanent Representation to the EU	Malta
Dutch Permanent Representation to the EU	The Netherlands
Austrian Permanent Representation to the EU	Austria
Polish Permanent Representation to the EU	Poland
Portuguese Permanent Representation to the EU	Portugal
Slovak Permanent Representation to the EU	Slovakia
Finnish Permanent Representation to the EU	Finland
Swedish Permanent Representation to the EU	Sweden
Italian Permanent Representation to the EU	Italy

Table 2.1.3 Industry stakeholders and organisations representing them

Organisations/Association name
Vaccines Europe
Medicines for Europe
Alliance for Regenerative Medicine (ARM)
Affordable Medicines Europe
Active Pharmaceutical Ingredients Committee (APIC)
Plasma Protein Therapeutics Association (PPTA)
Association of the European Self-Medication Industry
European Paediatric Formulation Initiative (EuPFI)
European Federation of Pharmaceutical Industries and Associations (EFPIA)
European Biopharmaceuticals Enterprises (EBE)
European Alliance for Personalised Medicines (EAPM)
European Coalition on Homeopathic and Anthroposophic Medicinal Products (ECHAMP)
Association of Clinical Research Organization (ACRO)
European CRO Federation (EUCROF)
European Healthcare Distribution Association (GIRP)
Parenteral Drug Association (PDA)
European Federation of Statisticians in the Pharmaceutical Industry (EFSPI)

Confédération Européenne des Syndicats
IndustriAll
European Group for Generic Veterinary Products (EGGVP)
AnimalhealthEurope
Animal Cell Technology Industrial Platform (ACTIP)
European Network of Centres for Pharmaco-epidemiology and Pharmacovigilance (ENCePP)
The European Association for Bioindustries (EuropaBio)
Europharm SMC
European Confederation of Pharmaceutical Entrepreneurs (EUCOPE)
European Federation for Exploratory Medicines Development (EUFEMED)
European Quality Assurance Confederation (EQAC)
Medtech
COCIR (European Coordination Committee of the Radiological, Electromedical and Healthcare IT Industry)
Team NB (The European Association for Medical devices of Notified bodies)

Table 2.1.4 Patient and consumer associations and organisations representing them

Organisation name
European Patients' Forum (EFP)
The European Consumer Organisation (BEUC)
European Hospital and Healthcare Federation (HOPE)
International Association of Mutual Benefit Societies (AIM)
European Social Insurance Platform (ESIP)
European Renal Association/European Dialysis and Transplantation Association/European Renal Best Practice

Table 2.1.5 Research Associations

Organisation name
European Federation for Pharmaceutical Sciences (EuFEPS)

Federation of European Academies of Medicine (FEAM)
Science Europe
European Academy of Allergy and Clinical Immunology (EAACI)
ELIXIR
Infrastructure for Systems Biology (ISBE)
ECRIN-ERIC (European Clinical Research Infrastructure Network)
EATRIS-ERIC (European Infrastructure for Translational Medicine)
BBMRI-ERIC (European research infrastructure for biobanking)
European Society of Endocrinology (ESE)
INFRAFRONTIER
Network of Coordinating Centres for Clinical Trials (KKS Netzwerk)
European Renal Association (ERA-EDTA)

Table 2.1.6 EU level Healthcare Professionals' Associations

Organisation name
Federation of Veterinarians of Europe (FVE)
Pharmaceutical Group of the European Union (PGEU)
European Association for Clinical Pharmacology and Therapeutics (EACPT)
European Respiratory Society
Comité Permanent des Médecins Européens/ Standing Committee of European Doctors (CPME)
European Union Geriatric Medicine Society
European Academy of Paediatrics (EAP)
European College of Neuropsychopharmacology (ECNP)
European League Against Rheumatism (EULAR)
European Society for Medical Oncology (ESMO)
European Society of Cardiology
European Society of Endocrinology

European Society of Radiology (ESR)
European Specialists Nurses Organisations
European Union of General Practitioners
European working group on Gaucher Disease
Health Care Without Harm Europe
International League Against Epilepsy
United European Gastroenterology (UEG)
European Academy of Neurology (EAN)
European Federation of Internal Medicines (EFIM)
European Association for the Study of Diabetes (EASD)
European Association of Hospital Pharmacists (EAHP)
European Association of Urology (EAU)
European Forum for Primary Care (EFPC)
European Hematology Association (EHA)
European Society for Blood and Marrow Transplantation (EBMT)
International Society for Cellular Therapy Society (ISCT)

ANNEX 3: WHO IS AFFECTED AND HOW?

1. Practical implications of the initiative

Payers of fees and charges collected by EMA are mainly marketing authorisation holders and applicants. They will have the legal obligation to pay the applicable amount when a submission is sent to EMA (e.g. request for a new authorisation or for a variation of the terms of an existing authorisation) or when EMA requests the payment of an annual fee for an existing authorisation. Such obligation is currently equally in place. In all cases, an invoice is sent by EMA. An invoice may group several fees. The aggregate annual administrative cost for fee payers associated with the EMA fee system depends on the unitary cost to process a payment and on the frequency of such payments.

Based on data provided by EMA, taking account of all fee types and charges foreseen, based on 2021 figures, the 'do-minimum' baseline scenario triggered 32,967 payable services (number of unitary fees charged), cumulated in 18,420 invoices to payers of fees, i.e. an average of 1.7 unitary fees on one invoice.

Under the preferred option 3 '*light*' sub option (C1), procedures corresponding to minor ("Type I") variations and renewals will no longer attract a fee per procedure.[92] The estimated effect of that would **be that the number of payable unitary fees would drop from 32,967 to 29,757 and the number of invoices would drop from 18,420 to 17,504 (decrease of ca. 5%).**

An additional simplification is related to the fact that fees for initial applications will no longer be increased for additional strength, pharmaceutical forms or presentation, which will reduce complexity and will increase predictability about the amount that will be charged.

The proposed measures will not influence, in a substantial way, the safety, efficacy and quality of medicines and, therefore, the measures will not have an effect on the UN Sustainable Development Goals.

2. Summary of costs and benefits

[92] This is true for the human sector, while the equivalent procedures will be discontinued in the veterinary sector; in parallel, pharmacovigilance fees for veterinary products are introduced in addition to the existing system. For these veterinary pharmacovigilance fees, the number of payable services and invoice cannot be estimated at the moment. Nevertheless, it is assumed that the frequency of new payments will compensate the frequency of discontinued payments and thus the effect of this particular change on the administrative cost related to paying EMA fees will be neutral. This assumption cannot be verified, however, due to the fact that for veterinary pharmacovigilance fees, the number of payable services and invoices cannot be estimated at the moment.

Based on a benchmark approach[93], it can be estimated that an EU-average value for administrative cost per invoice is 60€ (or 35€ per fee). On that basis, the initiative does not result in any new additional administrative costs whilst it leads to some minor benefits for fee payers (mainly industry), as follows:

Overview of costs – Preferred option(s)			
		Businesses (payers of EMA fees)	
		One-off	Recurrent
Payment of EMA invoices	Aggregate administrative costs	n.a.	No additional costs

Overview of Savings (total for all provisions) – Preferred Option(s)			
		Businesses (payers of EMA fees)	
		One-off	Recurrent
Payment of EMA invoices	Aggregate administrative costs	n.a.	Range from €54,960 to €112,350[idem] (depending on whether yearly administrative cost is estimated based on frequency of invoices or of unitary fees)

The weight of payments processed by SMEs is estimated, based on historic EMA data, at 13% of all payments. This means that 13% of the estimated on administrative costs and respective savings affect payers of EMA fees that are SMEs .

Overall, based on the estimated overview of benefits in the table above (i.e. reduced administrative cost related to the preferred option) it can be concluded that the effect of the proposal on administrative costs of businesses is neutral (or slightly positive).

[93] EMA administrative invoicing costs scaled to an average estimated level used as a benchmark for EU administrative invoice processing cost for the EU. The EMA administrative invoicing costs stem from EMA own calculations.

ANNEX 4: ANALYTICAL METHODS

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1. Introduction

This note provides a modelling methodology note for the 'Study supporting the Impact Assessment of the Revision of the EMA Fee System'. It provides information about the financial modelling undertaken as part of the study. The financial modelling used in the impact assessment builds on a model (hereafter, the '2016 model') developed for the 'Study for the Evaluation of the Fee System' conducted on behalf of the European Commission, Directorate General for Health and Food Safety (DG SANTE).[94] The fee and remuneration rules of the current Fee and remuneration system are summarised in Annex 4, Addendum 1 to this note.

The financial model is designed to convert data on EMA and associated NCA activities and costs into cost-based fees, and thereby to quantify the impact of different options and horizontal measures for the revision of the EMA fee system on the revenues of EMA and NCAs and the payments made by fee payers. The model is also used to conduct sensitivity analyses of the effects on fees and financial flows of a number of different possible future states of the world with respect to key variables including EMA activity levels, and time taken per procedure. Impacts are calculated for each option over a five-year projection period from 2022 to 2026 inclusive and compared to the baseline (a 'do-minimum' scenario), which represents a continuation of the existing fee system over the same period. The accuracy of the model in projecting future fees and hence payments by fee payers and the revenues received by EMA and NCAs, depends on how accurate the data and assumptions input into the model turn out to be in the future. This is a limitation of any model.

The model is constructed (in MS Excel) in such a way that future, not currently foreseen, changes to the fee system (including legislative changes) can be readily built into it, for example by the addition of rows in input and output tables that relate to new (or newly defined) activities.

This document provides:

- An overview of the approach to the financial modelling and how the model is used in the impact assessment;
- An explanation of the financial model, including adjustments made to the 2016 model to support the impact assessment;
- Details regarding implementation of the do-minimum and the policy options in the model; and
- Appendices setting out additional detail concerning updates to the model for the purposes of the impact assessment.

The results of the financial modelling presented in the final report are based on the data, assumptions and implementation of the policy options outlined in this document.

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[94] Further information is available in the detailed methodology note for the 2016 model that was provided as a formal deliverable alongside the final report. Available at: https://ec.europa.eu/health/sites/default/files/files/fees/evaluation_ema_fee_methodology_en.pdf

1. Model overview

1.1. Financial model

The financial model is designed to calculate cost-based fees, revenues to EMA and remuneration to NCAs, and to quantify the impact of different options for the revision of the fee system on these financial variables. The model is not intended to replicate the financial accounting systems of stakeholders. It also does not, and cannot, take account of the impact of the timing of payments on stakeholders. In practice, this means that the model considers that for all EMA procedures started in a given year the fee is levied by EMA and the remuneration to NCAs is paid, as relevant, during the same year. This approach is appropriate for the impact assessment as none of the policy options or horizontal measures affects the timings of payments.

The financial model has two parts:

a) A **cost** model of the costs for NCAs to undertake EMA activities that are eligible for remuneration and for EMA to undertake its activities (NCA costs for national and non-eligible activities are not included):

   - A **costing methodology** was developed to calculate costs for all procedural activities undertaken by EMA and NCAs using information from EMA and NCAs on staff costs, overhead costs and direct non-staff costs, time spent on individual activities and the numbers of activities undertaken. In this approach costs are allocated to one 'average scientific staff type' and one 'average administrative staff type' in each organisation in order to match the type of data available from the evaluation on which this exercise builds.

   - Other costs are included in the model as inputs. Costs for horizontal activities undertaken by EMA are provided by EMA. Costs for additional activities undertaken by NCAs eligible for remuneration by EMA have been calculated separately and are detailed in Annex 4, Addendum 2 to this note.

b) A **revenue** model of the remuneration income that NCAs receive from EMA for procedural activities and the additional eligible EMA scientific activities they undertake, and the share of total net fee revenue that EMA retains (i.e. EMA fee income), as well as the European Union (EU) / European Economic Area (EEA) budget contributions to the EMA budget:[95]

   - The fees paid by the pharmaceutical industry and other fee payers enter the model as the total fee revenue that is received by EMA. This revenue is net of incentives that are applied in order to reduce the level of fees due for some activities (e.g. related to orphan medicinal products) and/or organisations (e.g. SMEs).[96]

[95] In addition, in any year EMA may receive miscellaneous revenue from outstanding invoices, staffing changes and minor corrections. As this revenue is small (circa €370 p.a.) and difficult to forecast, it does not impact on the integrity of the model and has not been included in the model.
[96] Incentives are targeted reductions applied to unitary fees.

- NCA income in this model consists of the payments for procedural activities and scientific work they receive from EMA.[97] (NCA income from other sources, such as national fees or national budget contributions, is not included as it is not related to EMA).
- EMA fee income consists of the fee revenue it receives, net of incentives, less the payments NCAs receive from EMA (remuneration).

Two rules are implemented in the financial model:

a) A **fee rule** that establishes the unitary EMA fees. Such fees are calculated by the model under each option, taking into account the estimated costs of EMA and NCAs and the number of procedures undertaken. The model takes into account the EU budget contribution and implements the budgetary principle that all revenues taken together cover all costs for EMA. EMA fee revenue depends on the fee rules and the incentives that are applied to the fees. For the 'do minimum' baseline, the unitary fees are those currently applying and are therefore inputs to the model rather than calculated by the model, and are updated by inflation for future years, as in all other options.

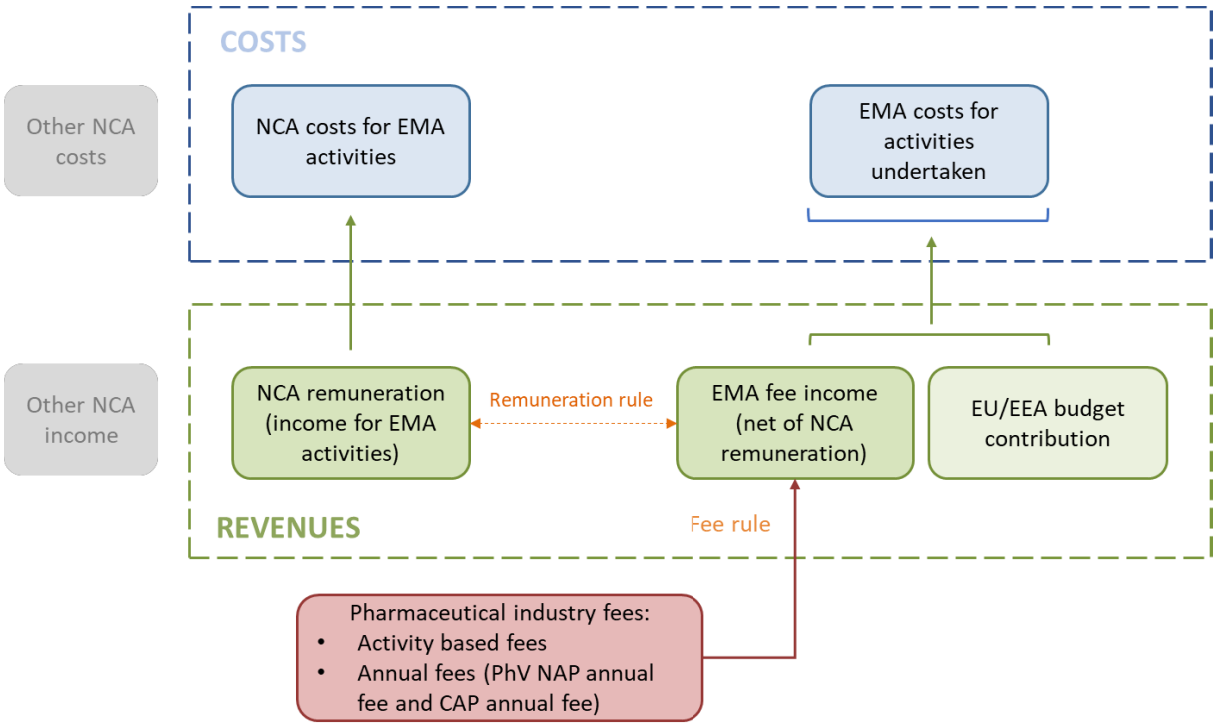
b) An **NCA remuneration rule** that establishes NCA unitary remuneration for EMA activities. Such remuneration is calculated by the model under each option, taking into account the estimated NCA costs for such activities. For the do minimum baseline scenario, remuneration is based on the existing fee system.[98] NCA income depends on the remuneration rule. EMA net fee income after making payments to NCAs also depends on the remuneration rule, as this rule determines the EMA costs for remuneration to NCAs for scientific services.

The model is illustrated in Figure 4.1. Costs and income not included in the model have been greyed out. Under the centralised system, NCAs receive their remuneration for EMA activities from EMA because they contribute to an EMA output: the payment is treated within the model as a transfer of income and is therefore included in the revenue model as a reduction in the EMA's share of fee revenue from industry, rather than as a cost to EMA. The same approach to NCA remuneration applies to all the options considered in the impact assessment.

[97] Reimbursement of travel and hotel costs, the travel allowance in case of arrival/departure outside of the meeting days and the daily allowance for each day of the meeting are not included as these are separate transfers from EMA to NCAs to reimburse expenses not related to specific scientific services (and would be included in both the cost and revenue sides of the model for NCAs which neutralises their effect in the model).

[98] See Annex 4, Addendum 1 to this Annex for more explanation of the existing system.

Figure 4.1: Schematic presentation of the cost and revenue model



There is no *a priori* reason for the fee and remuneration rules to be connected. However, legislation states that revisions of the fees levied by EMA should be based on an evaluation of both the costs of EMA and the costs of the tasks carried out by the NCAs. In the existing fee system, NCA remuneration is linked to the fees charged to industry, as NCA remuneration is a fixed percentage of the fee EMA charges industry and a fixed amount in the case of pharmacovigilance activities. Hence the remuneration rule *de facto* is currently linked to the fee rule. This approach is applied in the 'do-minimum' baseline scenario. In the policy options, the remuneration rule depends on the costs of carrying out the procedures and, for the annual fee, the costs of eligible additional activities, and this then determines the fee rule.

1.2. Model scope

The financial model for the current study extends the 2016 evaluation model[99] in a number of ways to support the impact assessment of options for the revision of the legislation governing the EMA fee system.

Firstly, the model takes account of changes to the existing fee system that have been implemented since the 2016 model (e.g. scientific services related to medical devices) and changes in legislation, in particular the Veterinary Medicines Product (VMP) Regulation that comes into force from January 2022 and the changes to the EMA Founding Regulation. The model also takes account of the financial statement of the Regulation of the European Parliament and of the Council on a reinforced role for EMA in crisis preparedness and management for medicinal products and medical devices (hereinafter called proposal for EMA reinforced role). The financial statement of that proposal includes three objectives, of

[99] Available at: Evaluation of the European Medicines Agency's (EMA) fee system (europa.eu)

which objective 3 has a future impact on EMA fees (relating to EMA as a node in the European Health Data Space, i.e. DARWIN EU[100]).

The financial model is used to quantify the impacts of four policy options and a set of horizontal measures on EMA, NCAs and industry stakeholders. Three of the policy options were first described in the Inception Impact Assessment. The fourth was added subsequently by DG SANTE. The options as implemented in the model for the present study are described in the Final Report. Additional detail of the options' implementation is provided later in this modelling methodology note. The options introduce different possibilities for changes to the current EMA fee and remuneration system. The ways in which fees are charged and fees and NCA remuneration are calculated are explained below.

The impact of the changes related to the Veterinary Medicines Regulation, the EU budget contribution and the proposal for EMA reinforced role are modelled in the 'do minimum' baseline scenario, separately from the impact of the policy options. This 'do minimum' scenario represents a continuation of the current system but with the inclusion of new legislation impacting on EMA tasks only, through non-legislative amendments of EMA fees, and, to the extent possible, the proposal for EMA reinforced role and updated EU budget contribution. The impacts of the policy options is thus assessed after taking into account the impact of these 'do minimum' changes.

Secondly, the list of procedural activities included in the 2016 model has been extended so that procedural fees can be calculated for all procedural activities undertaken by EMA and NCAs, where applicable, as well as annual fees. New or amended activities introduced as a result of the VMP Regulation and the proposal for EMA reinforced role in relation to EHDS/DARWIN EU, have also been included. These apply in the 'do-minimum' scenario and all policy options.[101] The full list of activities included is presented in the fee grid provided for each option, supplied as Excel files as a supplementary Annex to this note. Activities for which procedures are not expected to be undertaken every year and where the volume is low are designated 'infrequent' activities. This means that unitary fees and remuneration are calculated for these 'infrequent' activities but as their impacts are *de minimis* they are not included in the yearly cost and income calculations for EMA and NCAs (see section 2.3).

In addition, some changes to activities for which procedural fees can be charged are proposed as part of the options. These changes are explained later in this note.

A number of costs to NCAs are excluded from the model, namely:

- costs to NCAs for undertaking roles for procedural activities that are unremunerated under the existing system, such as peer review;[102]
- costs of time spent in committee meetings and working groups by NCA representatives when they are not appointed as rapporteur or co-rapporteur; and

[100] See Annex 4, Addendum 2.

[9] Charges for activities are also permitted under changes to the EMA Founding Regulation but no charges were put forward for implementation in the modelling exercise.

[102] This does not apply to rapporteur or co-rapporteur roles for paediatric or orphan medicine procedural activities, for which costs are included in the model.

- some of the additional activities declared by NCAs as EMA-related activities, which do not meet the criteria for remuneration. These are discussed in Annex 4, Addendum 2.

Finally, the model has been extended to cover the period 2022 to 2026 inclusive. This five-year period was selected because: (i) the VMP Regulation starts to apply in January 2022; (ii) EMA EHDS node activities under the proposal for EMA reinforced role are expected to be funded through fee income as of 2024; and (iii) it balances the need to consider impacts over the Multiannual Financial Framework (MFF) budget period against the robustness and reliability of the forecast activity for EMA and NCAs.

The existing system was also modelled using updated EMA data for 2020, which is before any changes resulting from the VMP Regulation, the EMA Founding Regulation and the proposal for EMA reinforced role are introduced. EMA provided aggregate cost data for 2020, including staff costs, direct costs, overhead costs and costs of reimbursing NCAs for attending meetings. Payments made to NCAs are not included in these costs and are calculated according to the existing system remuneration rules.

1.3. Model outputs

The financial impacts are calculated as yearly totals for each year over a five-year period from 2022 to 2026, for the 'do minimum' baseline and for each of the options. For each year, the model generates the EMA costs and NCA costs for EMA activities undertaken. These costs are independent of the fee and NCA remuneration rules and are the same for both the 'do-minimum' scenario and the policy options tested.

The model also generates the following yearly outputs, which depend on the fee and NCA remuneration rule applied in the 'do minimum' baseline and the options:

Total yearly fees paid to EMA by fee payers.

EMA yearly fee income, which is the yearly fees paid to EMA net of remuneration paid to NCAs. This is used to identify whether EMA's costs are balanced in the budget by all sources of revenue including the agreed EU/EEA budget contributions.

Total NCA yearly remuneration by EMA (for NCAs undertaking human medicine activities only, veterinary medicine activities only, and both human and veterinary medicine activities).

In addition to the yearly totals that are used to determine the financial impacts on stakeholders, the model also generates:

- EMA unitary fees: that is, fees before any incentives are applied. These fees are generated for each procedural activity included in the fee grids that are provided as an output to this study, including centrally authorised products (CAP) and (Pharmacovigilance) Pharmacovigilance annual fees. For the cost-based options, indicative fees are additionally generated for procedural activities for which fees are not currently levied under the existing fee system.
- NCA unitary remuneration (payments from EMA) for EMA procedural activities undertaken and yearly remuneration for additional eligible activities.

These outputs depend on the fee and remuneration rules and are presented in detailed fee grids together with the corresponding incentives.

2. Key elements of the financial model

2.1. Cost model

The cost model includes the costs for EMA to undertake its activities and costs for NCAs to undertake EMA activities.

2.1.1. EMA costs

EMA costs are for the scientific and administrative work that EMA staff undertake as part of fee- and non-fee-generating services EMA provides to industry and horizontal activities.

Costs of fee- and non-fee-generating services

An activity-based costing methodology was used to determine costs for the EMA's procedural activities (i.e. costs for the scientific and administrative work EMA undertakes as part of fee- and non-fee-generating services they provide to industry), including those for paediatric and orphan medicines activities. This approach allocates overhead costs (i.e. costs related to the operation of an organisation – e.g. overall corporate management, accounts, HR ('human resources') functions, building rents and maintenance costs – but not directly due to any one individual activity) as well as non-staff direct costs and staff direct costs to individual activities, thus enabling cost-based fees to be calculated for individual activities in the modelling.

The costing methodology consisted of two steps:

- Step 1: Determine the full cost per hour of an activity. Salary costs per hour for each of two staff types (scientific and administrative) were calculated from total EMA salary costs divided by total annual number of hours worked (number of full time equivalents (FTEs) x annual hours per FTE) for each staff type. Overhead and non-staff direct costs were then allocated to each of these staff types in proportion to staff numbers, because overheads and non-staff direct costs are likely to be aligned with staff numbers.
- Step 2: Multiply full cost per hour by hours spent on an activity. The total time spent on an activity by each staff type was determined from the time taken to carry out a procedure for the given activity and the number of procedures undertaken. Total costs were calculated by multiplying the time taken by the costs per hour for each staff type and activity.

The following data sources and assumptions were used.

EMA staff were categorised as one of two staff types: scientific or administrative staff. These definitions are consistent with those used by EMA in the 2016 MBDG exercise, which provides the data on time inputs per activity. This categorisation was made by EMA and is consistent with the overall EMA budget reporting provided to, and checked by, the study team as part of this study.

The annual number of hours worked per FTE is based on 41 working weeks per year (after allowing for holidays, sick leave etc.) of 40 hours per week for both staff types. This is based on data provided by EMA for the 2016 model.

The hourly cost of each staff type was assumed to be independent of the type of activity they undertake (e.g. the average salary cost per hour of scientific staff time is the same for all

activities). Costs of each staff type not directly involved in scientific activities were included as overhead costs. All reported EMA costs are allocated to either procedural activity or horizontal activity costs. This includes EMA staff time related to committees or working groups, which are not reported separately by EMA or included as a separate category in the model.

Hourly cost data for EMA staff have been derived from EMA budget data provided to the study team by EMA for 2020 and EMA's forecast budget data over the period 2022 to 2026.[103] The projected costs increase by 5% per annum for labour costs and 2% per annum for non-labour costs in accordance with EMA forecasts. FTEs data for scientific and administrative staff types from the 2016 model were updated based on the forecast cost increases.

The full list of procedural activities for which costs are calculated are presented in the fee grids. In the fee grids, inspection activities and other EMA fee generating services to industry that do not involve NCAs are presented together with human medicine activities for convenience, although they may cover both human and veterinary medicines. Costs that were allocated to CAP annual fees and NAP Pharmacovigilance annual fees in the budget data provided to the study team form part of the EMA horizontal activity costs[104]. The projected numbers of procedures for each activity for each year from 2022 to 2026 have been provided by EMA based on historic data and projections. These are disaggregated by incentive type.

The MBDG exercise carried out from 2015 to 2017 by the EMA Management Board is the main source of data on time taken to undertake procedural activities. For those activities where data is not available from the MDBG, including new and amended activities as a result of the VMP regulation, suitable 'comparator' activities were agreed with EMA and the time taken for those comparator activities was used to proxy the time taken. This approach ensures that a consistent estimate of the time taken is used for EMA and NCAs for activities where both are involved.

Meeting cost data were provided for each year at an aggregate activity level (e.g. scientific advice, marketing authorisations). These reflect the cost to EMA of reimbursing NCA representatives for attending meetings. The meeting costs are then allocated to disaggregated activities in proportion to the number of procedures and added to the procedural activity costs. To avoid calculating excessive fees for veterinary activities, meeting costs have been combined and distributed equally across human and veterinary activities where appropriate.

A scaling factor (of 0.92) was used to match the procedural costs calculated in the model to costs provided by EMA at the aggregate activity level for 2020. The latter, 2020, costs are based on data from EMA's financial accounting system, which has a more detailed cost specification than the model used in this study. This calibration takes account of differences in actual time spent and the type of EMA staff working on different activities.

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[11] These forecasts may not fully align with financial budget forecasts as the full costs of procedures are assumed to be covered in a single year in the model, while in reality some costs are distributed over a longer period.

[104] Costs were allocated to CAP and NAP Pharmacovigilance annual fees in the EMA budget data in the study for the evaluation of the fees system. The study team understands that these are costs the annual fees are intended to cover in the existing system. However, as EMA does not undertake work directly related to annual fees, these costs are considered horizontal.

The costs to EMA of remunerating NCAs for their contribution to EMA activities depend on the remuneration rule applied. The NCA remuneration is a cost reported in EMA budget reporting and can be considered as a transfer of fee income from EMA to NCAs, subject to an administration cost.

Costs of EMA horizontal activities

Horizontal activities of EMA and their costs are shown in

Table **4.1**, as provided to the study team by EMA. Horizontal activities include product maintenance activities and pharmacovigilance (CAPs) costs and general Pharmacovigilance (data management and databases) (NAPs) costs (human only) that annual CAP and Pharmacovigilance fees, respectively, are intended to cover under the existing system. For the future years, there are expected to be additional horizontal activities resulting from the VMP and the proposal for EMA reinforced role, and hence there is a further allocation of horizontal costs to human and veterinary medicines activities for these in the forecast data provided by EMA. The approach to covering the costs of EMA horizontal activities under the do-minimum and the policy options is explained further in the discussion of the revenue model in Section 3.2 of this note and in Section 4.

Costs associated with the proposal for EMA reinforced roleare covered by a corresponding increase of the EU budget contribution (see **Table 4.3** in Section 3.2), except for EHDS/DARWIN EU operating expenditure (maintenance phase), as of 2024, as per the financial statement of the proposal. For 2022 and 2023, the project phase costs will be fully covered by the EU/EEA budget contributions. From 2024 onwards, fee revenue should cover the costs of the maintenance phase. It is understood that use of EHDS/DARWIN EU will be proportional to the number of products on the EU market and is therefore likely to support more NAPs than CAPs. Therefore, for all the policy options, maintenance costs of EHDS/DARWIN EU (i.e. objective 3 of the financial statement of the proposal for a reinforced role of EMA) are allocated to the human Pharmacovigilance annual fee and human CAP annual fee in proportion to the number of NAPs (75%) and CAPs (25%). More information regarding EHDS node reuse data/DARWIN EU activities is presented in Annex 4 to this note.

Table 4.1: Yearly cost (€) for EMA horizontal activities

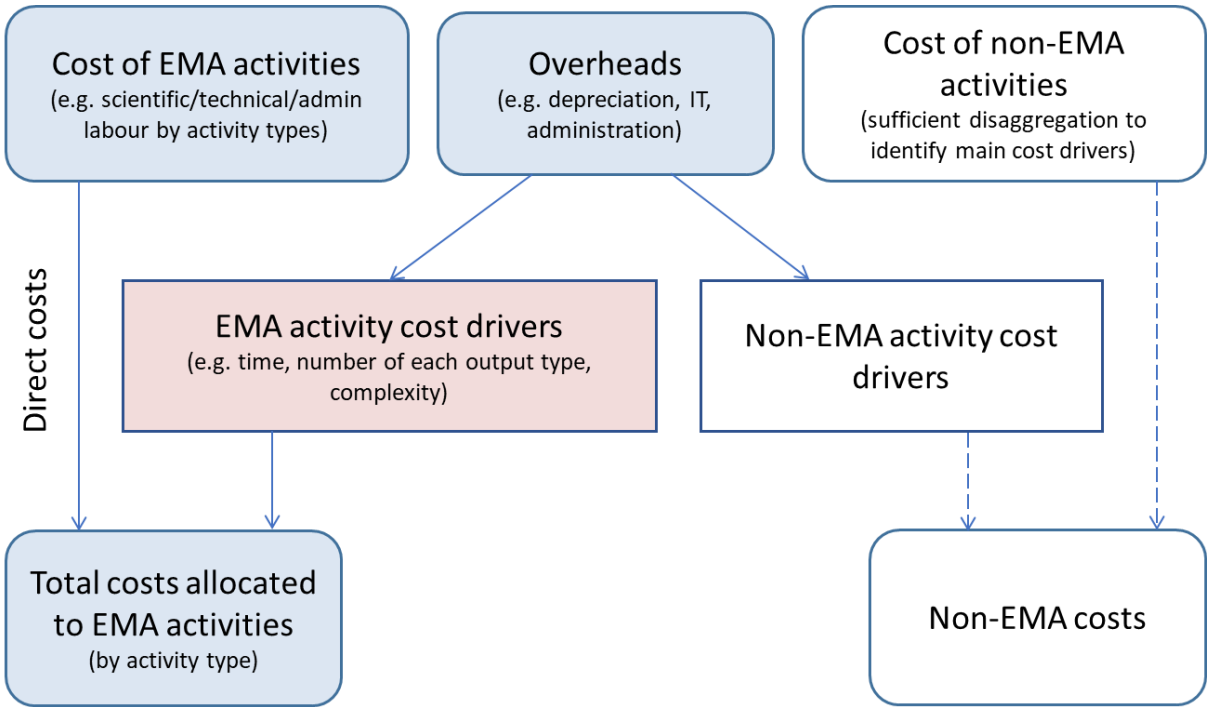
	EMA activity list	Total (€)					
		Typical budget (2020)	2022	2023	2024	2025	2026
1.	*Product maintenance activities and Pharmacovigilance (CAPs) - human*	5,902,000	6,577,000	6,873,000	7,182,000	7,682,000	8,202,000
2.	Signal detection (CAPs)	5,667,000	5,979,000	6,318,600	6,673,616	7,052,545	7,447,301
3.	*General Pharmacovigilance (data management and databases) (NAPs) - (PHARMACOVIGILANCE) - human*	11,745,000	12,487,000	12,839,000	13,204,000	13,743,000	14,223,000
4.	Literature monitoring (Pharmacovigilance)	1,980,000	2,081,000	2,130,000	2,179,000	2,238,000	2,293,000
5.	DARWIN EU (investment and maintenance expenditure)		8,000,000	8,000,000	16,000,000	16,000,000	16,000,000
6.	Expenditure related to proposal on extended mandate (objectives 1 & 2)		14,090,000	14,700,000	15,300,000	15,300,000	15,300,000
7.	*Product maintenance activities and Pharmacovigilance (CAPs) - Vet*	1,923,000	2,501,000	2,586,000	2,675,000	2,900,000	3,136,000
8.	Vet public health -product availability/MUMS (CAPs)	285,000	306,000	317,000	330,000	346,077	362,746
9.	Signal management (vet) (CAPs)		440,000	466,400	494,384	522,455	551,699
10.	Vet public health - AMR - Total expenditure	626,000	1,163,000	1,214,000	1,268,000	1,340,884	1,416,902
11.	Vet databases (Pharmacovigilance)	2,500,000	2,652,250	2,731,818	2,813,772	2,908,910	2,996,302
12.	Databases for use outside EMA: EudraVigilance,	28,524,000	30,125,750	30,904,183	31,701,228	32,773,090	33,757,698

	EMA activity list	Total (€)					
		Typical budget (2020)	2022	2023	2024	2025	2026
	EudraPharm - Corporate						
13.	Guidelines for good practice (including working parties)	10,745,000	11,587,000	11,983,000	12,396,000	12,902,000	13,362,000
14.	(Non-Guideline) Published information for healthcare professionals, patients and general public	7,487,000	8,230,000	8,597,000	8,981,000	9,314,000	9,640,000
15.	EU Network Training Centre	490,000	528,000	546,000	565,000	588,000	609,000
16.	Public Health activities: AntiMicrobialResistance, Stakeholders, PRIME(Priority Medicines), Health Technology Assessment, and SME etc.	13,272,000	14,500,000	15,252,000	15,909,000	16,590,443	17,288,889
17.	Vet public health - EU Co-Operation Costs	527,000	571,000	595,000	620,000	652,596	686,464
18.	Projects which create costs – Innovation Medicines Initiatives (IMI), GRIP, European Network of Centres for Pharmacoepidemiology and Pharmacovigilance (ENCePP)	5,829,000	6,383,000	6,658,000	6,945,000	7,276,000	7,511,000
19.	Transparency on non-fee generating areas e.g. Access to documents and publication of clinical trials	6,848,000	7,716,000	8,150,000	8,601,000	9,071,000	9,565,000
20.	International Activities	4,466,000	4,842,000	5,025,000	5,218,000	5,458,000	5,672,000
21.	Coordination Group (Cmd) Human & Vet	2,774,000	2,934,000	3,009,000	3,085,000	3,159,000	3,243,000

2.1.2. NCA COSTS

NCA costs can be considered to consist of three types: costs for EMA activities, costs for other (non-EMA) activities that NCAs undertake, and overhead costs. The current study is concerned only with costs for EMA activities by NCAs and the proportion of NCA overheads that can be attributed to NCA work for these EMA activities. Costs associated with all other, non-EMA, activities undertaken by NCAs are excluded from the model. This is illustrated in **Figure 4.2**.

Figure 4.2: Cost allocation for NCAs



NCA costs for undertaking EMA activities cover procedural activities for EMA-level procedures and eligible additional activities (see Annex 4, Addendum 2 to this note).

Costs for scientific and administrative work on procedural activities

An activity based costing methodology was also used for NCAs. The following steps were applied to each NCA separately:

1. Determine hourly costs of NCA scientific and administrative staff conducting EMA activities.
2. Determine the annual cost of EMA-related activities by activity type. This includes not only staff costs but also non-staff costs and an allocation of overhead costs, as illustrated in Figure 4.2.

The following data and assumptions were used.

Hourly cost data for each NCA have been derived from aggregate organisational cost data collected for the 2016 model. Twenty-nine NCAs provided data to that model. The original respondents included the two UK NCAs. The UK bodies' time inputs contribute to the estimates of average time taken, due to limited sample sizes in the MBDG exercise. But as UK NCAs no longer contribute to the EMA system, the hourly costs of UK NCA staff have now been removed from the dataset, and the time previously spent by UK NCAs has been replaced by the same time being allocated to the NCAs that have taken over that work. The projection of how EMA activities allocated away from the UK NCAs would be distributed across other NCAs was provided by EMA. Thus, the estimates of average NCA costs per activity in the financial model no longer take into account the UK organisations' staff costs per hour but only the staff costs per hour of the NCAs that conduct the work in future. For the remaining 27 NCAs, cost information is based on that which was provided by the NCAs for the calendar year 2016 for the evaluation exercise. The information included salary, overhead and non-staff costs, FTEs and annual hours worked for the two scientific and administrative staff types.

For the NCAs that provided data, overheads and non-staff costs were added to the annual salary costs to determine the annual costs of undertaking EMA activities for two different staff types: administrative and scientific. The cost per hour of EMA activities for each staff type was calculated by dividing the annual costs by the annual hours worked. The cost per hour was then multiplied by a factor of 1.2 to allow for FTEs working on EMA activities being more senior than the average level of staff in the NCAs and spending some time on non-assessment activities (such as administrative tasks).

For NCAs that did not provide data to the 2016 model,[105] the average cost/hour of NCAs that did provide data has been applied. This average cost/hour was also used to calculate cost-based fees for infrequent activities.

To determine hourly costs for the period 2022 to 2026, the 2016 cost data of all NCAs (both those who have provided data and those who have not) have been increased in the same way as EMA costs: by an assumed 5% per annum for labour costs and 2% per annum for non-labour costs since 2016. This applies to both procedural cost and additional costs. These are the same rates of cost increase that were applied to EMA costs (see section 3.1.1). They have also been used for NCAs for consistency as no new cost data was collected from NCAs in this study. In addition to this adjustment for inflation, projected NCA staff costs have been multiplied by a further factor of 1.2, to allow for NCAs on average allocating more senior, and hence more costly, staff to EMA activities (based on NCA responses to the targeted consultation exercise).

Beyond the above updates, the 2016 cost data of all NCAs (both those who have provided data and those who have not) have been increased in the same way as EMA costs: by an assumed 5% per annum for labour costs and 2% per annum for non-labour costs since 2016.

The term 'procedural role' is used for each instance that an NCA undertakes a particular assessment activity within a procedure. NCAs undertake two types of procedural roles that are remunerated under the existing system. These are rapporteur or equivalent lead role and co-

[105] Study for the evaluation of the EMA fee system – Methodology note. SANTE/2016/B5/021, December 2018, available at: https://op.europa.eu/en/publication-detail/-/publication/15cbe704-d9d0-11e9-9c4e-01aa75ed71a1/language-en

rapporteur or equivalent role. For any given type of procedure, a number of NCAs may carry out different procedural roles. For example, for five procedures of the activity 'Type II variation – level I', NCA X could undertake three rapporteur roles, NCA Y two rapporteur roles and NCA Z five co-rapporteur roles. Some activities only have rapporteurs and some always have both rapporteurs and co-rapporteurs. This was confirmed by EMA for each activity and is reflected in the fee grid produced by the model for each option.

For a given type of procedural activity and role, the total cost of a given NCA in a year is calculated based on the average time taken of the procedural activity multiplied by the number of procedures undertaken in the year. These costs are summed across the different roles (rapporteur, co-rapporteur and equivalents) and activities to provide the total yearly procedural activity cost of a given NCA. The procedural activity costs include rapporteur and co-rapporteur roles, as well as peer review roles, in line with MBDG data. Other activities that are undertaken in addition to the remunerated roles for a given activity are not included in the procedural activity costs (however, please see below the eligible additional activities costs). The total yearly activity costs are presented separately for human and veterinary medicines in the model's output tables. A weighted yearly average cost per procedure for each type of procedural activity is calculated from the total yearly cost divided by the number of procedures.

As different NCAs have different costs for the same procedure, the distribution of procedures across NCAs affects the total cost of NCAs work on EMA activities in a year. (Note that post-Brexit, no EMA activity in 2022-2026 is projected to be undertaken by UK NCAs). The distribution of rapporteur and co-rapporteur roles across NCAs is derived from 'purchase order' data (i.e. data on actually recorded procedures) provided by EMA, supplemented by information reported in the survey of NCAs for the 2016 model for those activities, such as paediatric and orphan medicines activities, for which NCAs undertake rapporteur or co-rapporteur roles but these are unremunerated under the current system.[106] This distribution is scaled to the forecast total number of procedures for each activity provided by EMA according to available information.

The 2016 MBDG exercise is the main source of time input data for procedural activities for NCAs. The MBDG exercise was a major undertaking, providing time input data at a granular level, and has not been repeated. Hence the 2016 MBDG data are the best time input data currently available. For the 2016 model, data from the MBDG exercise was used to calculate an NCA average time for rapporteurs and co-rapporteurs separately for a given activity that was used as the default for each NCA in the model.[107] As discussed for EMA, time data from comparator activities for both EMA and NCAs have been used where appropriate. More detailed information on the time data for activities included in the 2016 model and used in this study can be found in the Methodology Note published with the EMA Fee System Evaluation in 2018.[108]

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[106] Purchase orders (POs) are a commitment for future payment to NCAs by EMA. Under the existing fee system, one purchase order is sent out for each rapporteur, co-rapporteur or equivalent remunerable role undertaken by NCAs for a given procedure.

[107] The MBDG time input data include data from the UK NCAs, MHRA and VMD, and this has not been excluded from the time data used due to the limited sample size.

[108] RAND Europe, 2018, Study for the evaluation of the EMA fee system: Methodology note (SANTE/2016/B5/021).

NCA costs for additional activities eligible for EMA remuneration

In addition to procedural activities, the evaluation study estimated overall costs (for all NCAs taken together) for two other groups of activities:

- time spent by NCA representatives in committees and working groups of EMA, without being in charge of an assessment procedure (cost estimated based on respective MDBG time collected); and

- a range of 'additional activities' reported by NCAs as related to the EMA fees system in the evaluation study (cost estimated as a remainder of an overall cost related to EMA reported by NCAs).

These costs have been increased for inflation in the same way as the costs for procedural activities. The additional EMA activities of NCAs that are considered eligible for remuneration from EMA fee revenue[109] are allocated across NCAs in proportion to the rapporteur and co-rapporteur 'purchase orders' for CAP annual fees for human and veterinary products and are reflected in the annual remuneration presented in the fee grids that are produced as outputs by the model. The rationale for this allocation is based on the observation during the evaluation study that the level of additional activities increases in proportion to the level of involvement in procedural activities.

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For NCAs responsible for veterinary medicines, the introduction of the VMP regulation rules is expected to result in changes in pharmacovigilance-related costs with, on one hand, an increase for updates by NCAs to the EU pharmacovigilance database and, on the other hand, a decrease due to the discontinuation of Periodic Safety Update Reports for CAPs (PSUR) activities. The total yearly PSUR costs that NCAs incur under the existing system have been used as a proxy for the additional costs and are allocated across NCAs in proportion to the co-rapporteur 'purchase orders' for CAP annual fees for veterinary products and are reflected accordingly in the respective annual remuneration presented in the fee grids produced as model outputs.

As is more fully explained in Section 6.2.1 of the Final Report, the analysis of the stakeholder opinion gathered during the consultation process for the impact assessment indicated a broad consensus that the cost of additional NCA activities eligible for remuneration by EMA, and therefore included in the annual fee calculation, was underestimated in the interim fee grids presented for the consultation. The approach to determining what portion of additional activities would be eligible for remuneration through EMA fees was reviewed by DG SANTE taking into account the feedback to the consultations. As a result, a revised approach was applied, which preserves the approximately 1/4 ratio of NCA remuneration from annual fees to NCA total remuneration that exists in the 'do minimum' baseline. This implies increasing annual fees and de facto maintains NCA remuneration in aggregate at the level it would be in the 'do minimum' scenario. The resulting adjusted annual remuneration of NCAs as estimated by the financial model still falls within the overall maximum cost envelope originally estimated for all additional activities (see Table 4.2.1 in Annex 4).

[109] See Annex 4, Addendum 1.

2.2. Revenue model

The revenue model includes:

- EMA fee income, which is the share of total fee revenue that EMA retains after remunerating NCAs for the EMA activities they undertake and after fee reductions due to incentives; and
- EU/EEA budget contributions.[110]

NCAs' income is also calculated as the remuneration they receive from EMA for their EMA activities[111].

There are three stages to the revenue model, as detailed below.

First, EMA receives fees from undertakings for the services it provides. The total fees paid by industry depend on the **fee rule**, the **fee reductions**, referred to as 'incentives', and the number of procedures for a given activity. The fee rule determines the full fee, which is the maximum fee that could be paid. Incentives (discounts or waivers) are applied to the full fees depending on the nature of the product and of the organisation paying the fee (e.g. whether it is an SME), as well as for other reasons. For a given activity, the model calculates the unit full fee, which is the full fee per procedure before any incentive, (i.e. discount or waiver), as well as the total fees paid by industry in a year. Three types of fees may be covered by the fee rule. These are procedural activity based fees for CAPs charged per procedure, annual fees for CAPs charged per authorisation and annual Pharmacovigilance fees for nationally authorised products (NAPs) charged per chargeable unit as defined in Article 2(1) of Regulation (EU) No 658/2014.

Second, NCA income takes the form of a payment from EMA to provide remuneration to each NCA for the EMA activities it has undertaken. The amount of this payment is determined by the **remuneration rule**.[112] EMA's net fee income is calculated as the total fee revenue minus the NCA remuneration minus fee incentives applied. For EMA and each NCA, fee income from annual fees and procedural-activity based fees are provided separately for both human and veterinary medicines.[113]

In addition to revenue from its share of industry fee income, EMA receives EU and EEA budget contributions (hereafter 'EU budget contribution'). The EU budget contributions foreseen for the upcoming period (as provided by DG SANTE) are shown in Table 4.3.

EMA fee income is calculated from the unit fee, the number of procedures (or number of products for the annual fees) and the incentive rates. The EU budget contributions include a

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[110] Miscellaneous revenue to EMA is not included in the model because it is *de minimis*.
[111] In line with EMA budgetary reporting, this is considered as equivalent to EMA expenditure for NCA remuneration.
[112] NCA delegates are additionally also reimbursed by EMA for travel and subsistence costs for attending meetings. This is included in the costs to EMA but is not included in the NCA income or costs in the model (as the income would exactly balance the cost in each instance and so has no effect on any of the options whose impact is being assessed).
[113] The exception is inspections, for which human and veterinary procedures are not distinguished at the aggregate level.

specific component for DARWIN EU[114] in 2022 and 2023 to offset the costs incurred by EMA for that purpose (project phase). This is replaced by fee income as of 2024.

Table 4.3: EU/EEA yearly budget contributions (€) to EMA

EU/EEA budget contributions	2022	2023	2024	2025	2026
Initial MFF proposal non-orphan	22,500	22,500	18,700	18,700	18,700
Initial MFF proposal - orphan medicines contribution	14,000	14,000	14,000	14,000	14,000
EMA Reinforced Role proposal (objectives 1&2)	22,090	22,700	15,300	15,300	15,300
EMA Reinforeced Role proposal, specifically for Node reuse data* (specific objective 3, DARWIN EU)	8,000	8,000	0	0	0
TOTAL	44,590	45,200	34,000	34,000	34,000

Finally, in the financial model for EMA, revenues are compared to costs to determine whether the budget is balanced, so that EMA total revenue matches its costs. Under the 'do minimum' baseline, and given the EU budget contributions presented in Table 4.3, no additional mechanisms beyond reducing costs are available to balance the EMA budget, and costs are assumed fixed for the purposes of the study. A budget excess or deficit may therefore occur for a projection year in the 'do minimum' baseline. However, under the policy options, annual CAP fees are calculated to balance the EMA budget after taking into account cost-based procedural and pharmacovigilance fees and EU budget contributions.

The EMA fee income, NCA remuneration (total for all NCAs contributing to EMA activities) and EU budget contributions that are used in the revenue model are yearly totals. To compare the policy options against the 'do minimum' baseline, an approach was developed to compare the impact of introducing cost-based fees and remuneration over the five-year projection period (2022-2026), updated annually by inflation. The revenue model was used to balance the EMA budget for the central year of the forecast period (2024) only. The cost-based fees and remuneration amounts calculated by the model for the central year, adjusted by inflation, were then used to determine the impact over the five-year period (2022-2026) for the different stakeholders, given the outputs of the model for each year.

The details of the fee and remuneration calculations and the role of fee reductions for the cost-based options are provided in the following sections. The existing fee system rules are presented in Annex 1 to this note.

[114] Data Analytics and Real World Interrogation Network: allow timely access and analysis of EU-wide health data to support better decision-making throughout the product lifecycle on medicines with valid and reliable real world evidence

EMA fees

In the model, under the current fee system, there is a single basic fee for each activity that is updated for inflation each year.[115] For the assessment of the impact of each policy option, a single fee is likewise determined. To do this the fees that balance the EMA budget for 2024 (the central estimate for the study model) are calculated.[116] These are then adjusted for inflation and used to calculate the stakeholder impacts for each year modelled.[117] As a further step, based on the analysis of these impacts and feedback from the targeted consultation, single fees may be replaced by fee bands for some activities, provided that the legal instrument can accommodate such a choice.

Under the current fee system some fees can be varied depending on the number of different presentations and dosage strengths of the medicine to be marketed. In the model, however, we just calculate a single basic fee. No variations to the basic fee are calculated by the model for the cost-based options as no data are available on the different time inputs needed for different presentations and dosage strengths. There are a number of activities for which different fee levels apply under the existing system and similarly there are three different levels of annual fees for human medicines and two levels of annual fees for veterinary medicines. For these activities, the ratios between the different levels of each fee in the current fee system have been used to derive corresponding fee levels in the model.[118]

Under the cost-based options (i.e. Options 2, 3 and 3 '*light*'), rules are also implemented to allocate EMA horizontal costs to human and veterinary medicines (specifically to CAP and Pharmacovigilance annual fees) based on which products the type of activity is addressed to. The allocation is shown in Table 4.4. The remaining horizontal costs (as per Table 4.2) are allocated to human and vet CAP annual fees in the ratio 85% to 15% based on the relative number of CAPs and NAPs.[119]

Table 4.4: Allocation of horizontal costs to CAP and Pharmacovigilance annual fees

	CAP	Pharmacovigilance
Product maintenance activities and Pharmacovigilance (CAPs) - human	100%	
Signal detection (CAPs)	100%	
Genral Pharmacovigilance (data management and databases) (NAPs) - (PHARMACOVIGILANCE) - human		100%

[115] The fee may be increased for additional strengths and presentations for some activities or number of active substances. The fee grids presented under each option represent the detailed fee grid that would be implemented under the legislation for that option.
[116] For option 1, only part of the EMA budget deficit that is allocated to veterinary medicines based on their share of additional EMA activities is balanced, as the existing system still applies for human medicines under this option.
[117] Inflation rates are based on ECB staff macroeconomic projections for the euro area, March 2021 (europa.eu) with the 2024 forecast of 1.4% per annum assumed to apply also to 2025 to 2026.
[118] Scientific services – PMF, scientific services traditional herbal, scientific services certification for advanced therapies, pharmacovigilance referrals and annual CAP fees.
[119] Objectives 1 & 2 expenditure is offset by EU/EEA budget contributions.

Literature monitoring (Pharmacovigilance)		100%
DARWIN EU (as of 2024)	25%	75%
Product maintenance activities and Pharmacovigilance (CAPs) - Vet	100%	
Vet public health -product availability / MUMS (CAPs)	100%	
Signal management (vet) (CAPs)	100%	
Vet public health - AMR - Total expenditure	75%	25%
Vet databases (Pharmacovigilance)		100%

Fee reductions

Reduction rates from the current fee system are applied to the 'do minimum' baseline and all options for human medicines. For veterinary medicines, the existing system applies in the 'do minimum' baseline but changes to these incentives are applied in the policy options in connection to the overhaul of the veterinary sector stemming from the VMP regulation. This is because a number of horizontal measures with different combinations of specific and general reductions are implemented in Option 1. As the impact of the incentive and general reduction horizontal measures could be assessed using the model results from Option 1, only SME incentives are carried forward to Options 2, 3 and 3 '*light*' in the model. The changes implemented in Options 2, 3 and 3 '*light'* can then be compared with Option 1 with a common set of incentives.

Under the current fee system nearly all incentives are borne by the EMA budget (NCA remuneration is not reduced by incentives), except for pharmacovigilance fees. In the cost-based options, two approaches are implemented for all fees: the main option, in which the cost of incentives is borne by EMA budget alone, and a horizontal measure, in which the cost of incentives is shared with NCAs, i.e. NCA remuneration is reduced in the same proportion as the fee reduction and the burden of the fee reduction is thereby shared proportionately between EMA and NCAs. In the fee grids, the fee and remuneration amounts before any incentives are applied are presented in a separate row for each procedural activity. The incentives that should be applied to the fees are provided in subsequent columns. These incentives are applied to the fees in all cases. They are only applied to the NCA remuneration for the horizontal measure where the cost of incentives is shared between EMA and NCAs.

The incentives in the 'do minimum' baseline and the policy options are presented in the corresponding fee grids output by the model.

NCA remuneration

EMA makes payments to NCAs to remunerate them for the provision of scientific services. Under the existing system these payments are covered by specific rules as outlined in Annex 4, Addendum 1. These are implemented in the model for the 'do minimum' baseline scenario. These remuneration amounts are adjusted for inflation each year.

For the cost-based options, NCA remuneration for a given activity is determined from a weighted average of NCAs' costs that typically undertake the activity, and the time taken to undertake it. The remuneration differs between activities because these take different amounts of time to complete and because NCAs have different costs. As discussed in Section 3.1.2, purchase order data are used to determine the distribution of rapporteur and co-rapporteur roles across NCAs for a given activity that are used in this calculation in the model. For infrequent activities, a simple average cost is used.

Purchase order data are not available for activities for which NCAs are not remunerated under the current system. For these activities remuneration is calculated under the cost-based options. Self-reported data from the NCA survey collected during the 'Study for the Evaluation of the Fee System' (being the most recent data available from NCAs overall) are used to provide a distribution of roles across NCAs for this purpose. This distribution is then scaled to match the total number of procedures for the activity provided by EMA. The data are then used in the same way as the purchase orders data to calculate the weighted average costs that determine the remuneration amounts and to allocate the remuneration across NCAs.

In line with the approach to the fee calculations, a corresponding NCA remuneration amount is first identified for each relevant procedural activity under each policy option; this is the cost-based unit remuneration for 2024. These figures are adjusted for inflation and used to calculate the impacts for each of the other years modelled. The assumed inflation rate is 1.2% per annum up to 2024 and 1.4% per annum after that. A specific inflation update was used for 2020 and 2021 closer to the finalisation of this Staff Working Document, based on actual the inflation rate used for the update of EMA fee regulation in 2022, which was higher than the initial estimations.

Under the policy options, when cost-based remuneration is introduced, the calculated remuneration for rapporteur and co-rapporteur roles may be different if they do not, on average, spend the same amount of time on an activity, as revealed by the MBDG exercise. Remuneration for co-rapporteur roles is constrained to always be less than or equal to remuneration for rapporteur roles. All NCAs continue to receive the same level of payment as one another for each of these roles. An alternative approach is tested in the horizontal measures where country coefficients are applied (see below).

Remuneration is then allocated across NCAs in the same way as under the existing system for procedural activities, i.e. to the NCA of the rapporteur/co-rapporteur (where relevant) or similar role (e.g. lead role in scientific advice). The allocation is based on the distribution of purchase orders or self-reported survey data used in the cost calculations. Remuneration for eligible additional costs is covered by the annual CAP fees remuneration and is allocated in proportion to the corresponding rapporteur and co-rapporteur activity levels (based on purchase order data). In Options 3 and 3 *' light'*, the annual remuneration also covers the costs of some procedural activities that are no longer remunerated directly in those options.

For veterinary medicines, given the overhaul of the pharmacovigilance system, the remuneration also covers pharmacovigilance-related costs that are proxied by the PSUR costs incurred by NCAs under the current system. In addition, the veterinary annual fee covers relevant eligible additional activities.

NCA unitary remuneration for rapporteur and co-rapporteur (or equivalent) roles is presented in the fee grids for the policy options.

Two possible adjustments to NCA remuneration are considered as part of the horizontal measures:

- NCAs share the cost of incentives applied to fee income with EMA, so that NCA remuneration is reduced accordingly.

- Each NCA's remuneration is scaled by a country-specific coefficient so that different NCAs receive a different level of remuneration for the same activity. Country coefficients similar to those used by the European Chemicals Agency (ECHA), based on the country correction coefficients used by the European Commission, have been adopted for this study as these cover almost all NCAs. The coefficients are presented in Table 4.5.[120]

These adjustments to NCA remuneration affect fees because they change the EMA budget deficit in the model that has to be balanced. In the results presented in the Final Report, only the annual CAP fees are used to balance the EMA budget and therefore only these fees change; procedural fees remain as calculated under the cost-based principle as explained above.

As far as possible, under the cost-based options, the annual CAP fees for human and veterinary activities are used to cover the costs for human and veterinary activities, respectively. In each case, a share of the EU budget contribution is added to the revenue from fees for procedural activities to cover the cost of incentives and EMA horizontal activities. As shown in Table 4.4, some horizontal activity costs are designated as human or veterinary related. In the model it is assumed that, from the EU budget contribution, all the orphan designation contribution and 85% of the remaining EU budget contribution are added to the human procedural fees, and 85% of the horizontal activity costs, not pre-assigned to human or veterinary activities, are considered to be human activity costs. The remaining 15% of the EU budget contribution and 15% of the horizontal costs are allocated to the veterinary activities in the same way. This allocation was agreed with EMA and reflects the relative size of the human and veterinary workloads.

Table 4.5: Country-specific scaling coefficients

Country	Coefficient
Austria	105
Belgium	100
Bulgaria	51
Croatia	74
Cyprus	74
Czech Republic	73
Denmark	133
Estonia	78
Finland	119

[120] ECHA Country coefficients. Available at: https://echa.europa.eu/documents/10162/2792271/FINAL_MB_36_2017_Transfer_of_Fees_revised_decision_signed_at_MB48_en.pdf/235fdafe-6652-6c44-dc60-2412e504903c. For Liechtenstein, a value of 100 was assumed.

France	114
Germany	96
Greece	79
Hungary	70
Ireland	118
Italy	98
Latvia	73
Lithuania	70
Luxembourg	100
Malta	86
Netherlands	108
Poland	67
Portugal	81
Romania	64
Slovakia	76
Slovenia	81
Spain	88
Sweden	127
Norway	136
Iceland	134

ECHA Country coefficients. Available at: https://echa.europa.eu/documents/10162/2792271/FINAL_MB_36_2017_Transfer_of_Fees_revised_decision_signed_at_MB48_en.pdf/235fdafe-6652-6c44-dc60-2412e504903c. For Liechtenstein, a value of 100 was assumed.

3. Detailed implementation of the 'do minimum' baseline scenario and the policy options

This section presents details of the implementation of the 'do minimum' baseline scenario and the policy options. This implements the options that were outlined in the Inception Impact Assessment (IIA),[121] taking account of feedback received on that exercise (Annex 4, Addendum 3).

'Do minimum' scenario

The 'do-minimum'baseline scenario represents the fee system in the forecast years when no legal action is undertaken in relation to the fee system, while taking into account current policy commitments, i.e. the VMP regulation and the effect on fees the Regulation on a reinforced role for EMA, i.e. objective 3 of the respective financial statement relating to EHDS/DARWIN EU. It provides the reference against which the impacts of the cost-based policy options can be assessed. Under the 'do minimum' scenario, changes are limited to ensuring that the fee system aligns with the 2018 VMP Regulation and the revised EMA Founding Regulation (although no charges enabled under the latter legislation were proposed for inclusion in the modelling). The costs and EU budget contributions associated with the proposal for EMA reinforced roleare also included as they affect fees from 2024 onwards

[121] https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/2091-Revision-of-EMA-fees

(EHDS node). The structure of the fee system is otherwise unchanged from the current system.

The main changes to procedural activities for veterinary medicines from 2022 triggered as a result of the VMP Regulation are:

- Classification of initial market authorisations (MA), both in terms of the new legal basis and further sub-classifications for fee levels;
- Classification of variations requiring assessment and not requiring assessment, covering line extensions, Type IA, Type IB and Type II variations;
- Classification of referrals;
- Procedural activities in relation to renewals and PSURs are no longer undertaken.[122]

The Pharmacovigliance database and the Union Product database are introduced and a small change is made to the supplier database (EUDRA GMP) by adding veterinary wholesalers. The additional costs of these to EMA are included in

[122] The costs for renewals that may need to be undertaken for products approved prior to 2022 under the existing legislation are already included in EMA horizontal costs.

Table 4.1. The mechanism of remuneration to NCAs, as well as fees for human and veterinary medicines procedures and the incentives applied to fees remain unchanged from the existing system.

For new and amended procedural activities under the VMP Regulation, the fee from the closest matching existing procedural activity is applied (no cost-based fees are implemented because the 'do minimum' scenario is a continuation of the current system).

Costs to EMA resulting from the veterinary databases implemented under the VMP Regulation and from the proposal for an EMA reinforced role are included in the EMA horizontal costs (

Table **4.1**).

Information about EHDS node reuse data activities under objective 3 of the proposal to reinforce EMA's mandate (EHDS/DARWIN EU) is provided in Annex 4, Addendum 3. It is understood that the use will be proportional to the number of products on the market and therefore likely to support more NAPs than CAPs. For 2022 and 2023, the DARWIN EU phase costs will be fully covered by the EU budget contributions (Table 4.3)[123]. Thereafter, as there is no legal action under the 'do minimum' baseline, these maintenance costs will not give rise to changes in fees under the 'do minimum' baseline scenario.

In the 'do minimum' baseline, there are no further changes to annual fees or to procedural fees. The model calculates the impact on the EMA budget variance (whether income is sufficient to cover costs) of the costs to EMA, payments to NCAs and income from fees and EU budget contributions, given the forecast frequency of procedural activities, EMA horizontal activities and eligible NCA additional activities.

Option 1: Introduce cost-based fees for veterinary medicines only

Option 1 introduces the minimum legislative action required to address recent changes to EU legislation affecting EMA activities. In addition to the changes made to procedural activities under the VMP Regulation, changes are also introduced as a result of DARWIN EU. For Option 1 and the other policy options described below, DARWIN EU maintenance costs are allocated to the human Pharmacovigilance annual fee and human CAP annual fee in proportion to the number of NAPs (75%) and CAPs (25%).

The following changes to fees and remuneration are thus introduced in Option 1:

- Cost-based fees are implemented for **all** fee-paying veterinary medicines procedural activities. This includes new and amended activities under the VMP Regulation. Fee-paying procedural activity in relation to renewals and PSURs is discontinued in line with underlying VMP regulation provisions.

- An annual fee for veterinary CAPs is maintained. In addition to EMA horizontal veterinary costs (

[123] Objectives 1 and 2 of the proposal for EMA reinforced role are fully covered by the EU budget contributions for the entire period covered by the study.

- Table **4.1**), this fee will also cover the eligible NCA additional costs for veterinary activities, including eligible pharmacovigilance costs, as a result of the VMP Regulation to the extent that they contribute to the EMA mandate (04). The fee is calculated to balance the EMA budget after taking into account cost-based procedural and pharmacovigilance fees and EU budget contributions.

- In view of the EMA pharmacovigilance mandate in the VMP Regulation, a pharmacovigilance annual fee for veterinary NAPs, based on an estimated number of chargeable units,[124] is introduced to cover the cost to EMA of non-procedural veterinary pharmacovigilance activities, namely veterinary databases and veterinary public health activities in relation to product availability, MUMS, AMR and EU co-operation. (These activities are marked in grey in

[124] Defined for the purpose of the model estimations, following the same principle as for the pharmacovigilance annual fee for human NAPs.

- Table **4.1**).

- The mechanism of remuneration to NCAs for veterinary medicines remains unchanged from the 'do minimum' baseline for procedural activities. NCAs will also receive a flat annual remuneration to cover the costs of eligible NCA additional costs for veterinary activities, including eligible pharmacovigilance costs, as a result of the VMP Regulation to the extent that they contribute to the EMA mandate.

- Cost-based fees are introduced for a small number of veterinary activities for which fees are not currently charged and to which incentives are not applied, namely pre-submission and re-examination activities. Cost-based remuneration for NCAs is introduced for these activities.[125]

- For human medicines, the majority of fees and NCA remuneration remain unchanged from the 'do-minimum', i.e. they remain the same as in the current system. Only the annual fees, both CAP and pharmacovigilance, are adjusted as of 2024 to allow EMA to recover operational costs of DARWIN EU (maintenance phase).

- SME fee reductions from the existing system are first applied; there are no other specific fee incentives or general reductions on fees. Different combinations of fee incentives and general reductions to fees for veterinary medicines are then tested as further horizontal measures, as per the inception impact assessment. Specifically:

    - Horizontal measure A introduces cost-based fees for veterinary medicines with a general fee reduction. This horizontal measure is the same as Option 1, but a 50% general reduction for veterinary medicines is applied to all veterinary fees. No additional incentives are applied.

    - Horizontal measure B introduces cost-based fees for veterinary medicines with a 50% general fee reduction and incentives. This horizontal measure is similar to horizontal measure A but it also includes specific incentives that are applied for limited markets.[126]

    - Horizontal measure C introduces cost-based fees for veterinary medicines with specific incentives applied for limited markets. No general reduction is applied to veterinary medicines cost-based fees.

    - Horizontal measure C1 is the same as A(iii) but with larger incentives.

Option 2: A cost-based fee system for human and veterinary activities with the level of granularity of the current system

[125] If the respective procedural fees, included in the fee grid for information, were to be created, the remuneration amount linked to the annual fee would need to be reduced in order to avoid double charging.
[126] In addition to the MUMS incentives from the existing system, reductions of 50% are applied all other limited market applications.

In addition to the changes implemented to the fee system under Option 1, Option 2 introduces a cost-based system for both human and veterinary activities. These further changes to human and veterinary procedural activities are implemented relative to Option 1:

- Cost-based fees reflecting EMA and NCAs costs are also implemented for human medicine procedural activities.

- In addition to EMA horizontal costs including a proportion of EHDS/DARWIN EU costs, the CAP annual fee-human also covers remuneration for the eligible NCA additional costs for human activities.

- The annual pharmacovigilance NAP fee covers EMA horizontal pharmacovigilance costs and a proportion of EHDS/DARWIN EU costs.

- The annual CAP fee income is then matched to procedural fee income and the EU budget contributions to ensure that the EMA's income after cost-based payments to NCAs is sufficient to cover its costs. This leads to calculating the annual CAP fee at the appropriate level, after taking into account the cost of NCAs' eligible additional activities.

- For human medicines, relevant fee incentives continue to apply in line with existing legislation and rules (implementing rules, EMA decisions, sectorial legislation, SME regulation). For veterinary medicines, the SME incentives from Option 1 are implemented.[127]

- Cost-based fees are calculated for all procedural activities but these may be fully waived in accordance with the applicable legislation for activities such as paediatric and orphan medicines. In these cases, NCA remuneration is still maintained and is calculated as part of EMA's remuneration costs, together with EMA's respective costs.

- NCA remuneration for human and veterinary procedural activities is cost-based. NCAs also receive a flat annual remuneration, also cost-based. For human and veterinary medicines, this remuneration covers eligible additional NCA costs.[128]

- Fees for Type II variations for human medicines are re-classified to align with patterns stemming from analysis of the data collected during the MBDG data gathering exercise (only fees are concerned, not the variations themselves). Fees and remuneration are determined for Type II variations in Quality, Clinical safety, and Clinical indication, respectively.

- Cost-based fees are introduced for a small number of human and veterinary activities for which fees are not currently charged and to which incentives are not applied in addition to paediatric and orphan designation activities, namely pre-submission and

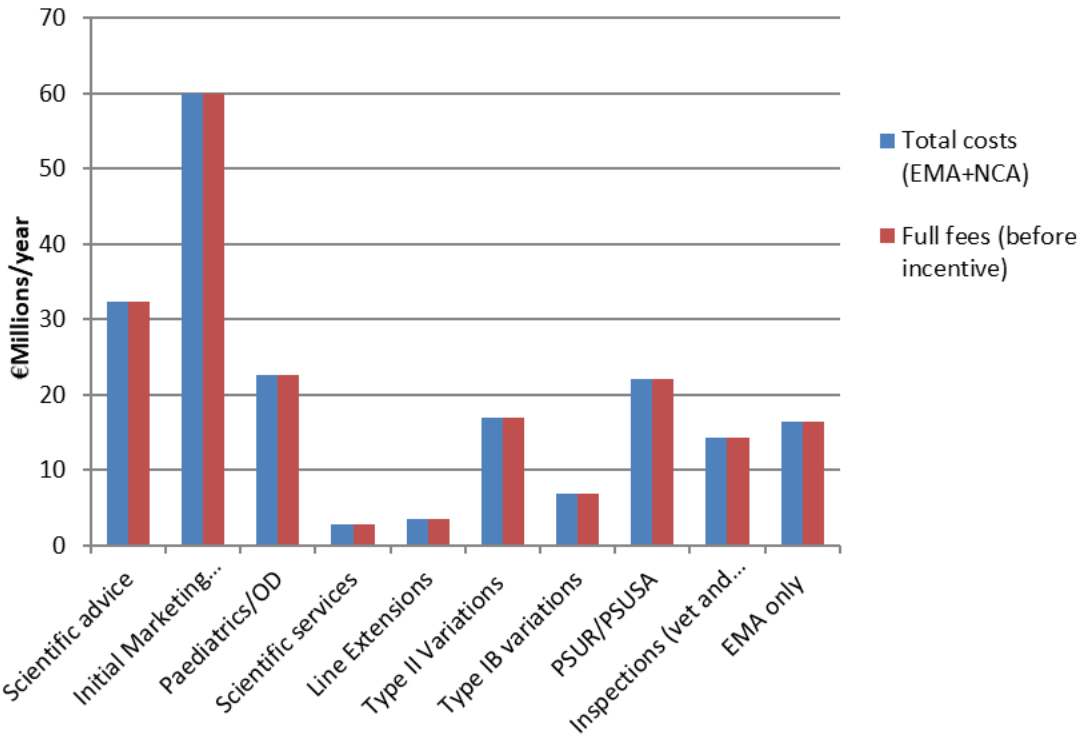
[127] These can be compared with the results for the policy option 1 sub-options.
[128] For veterinary medicines, the current PSUR assessment revenue of NCAs is used as a proxy to remunerate NCAs for relevant additional activities under the VMP regulation (updates of products under databases), for which no data are otherwise available.

re-examination activities. Cost-based remuneration for NCAs is introduced for these activities.[129] This is aimed at covering all procedural activities by a fee.

Figures 4.3, 4.4, 4.5 and 4.6 illustrate for Option 2, for the example year of 2024, how human medicine fee revenues match the costs of corresponding activities (Figure 4.3), how veterinary medicine fees match corresponding costs (Figure 4.4); and how EMA and NCAs respectively share the financial burden of incentives on human medicine fees (Figure 4.5) and veterinary medicines fees (Figure 4.6) respectively. As Option 2 is for fully cost-based fees, the revenues and costs in Figures 4.3 and 4.4 match for each category of activities. Figures 4.5 and 4.6 show that EMA bears the cost of incentives.

[The same is true for Options 3 and 3 ' *light'*, so equivalent illustrative Figures would be redundant and are not reproduced in the discussion of those options in the following paragraphs.]

Figure 4.3: Comparison of total fee revenues and total costs projected in Option 2 for 2024 (before incentives have been applied) – human medicines



[129] If the respective procedural fees, included in the fee grid for information, were to be created, the remuneration amount linked to the annual fee would need to be reduced in order to avoid double charging.

Figure 4.4: Comparison of total fee revenues and total costs projected in Option 2 for 2024 (before incentives have been applied) – veterinary medicines

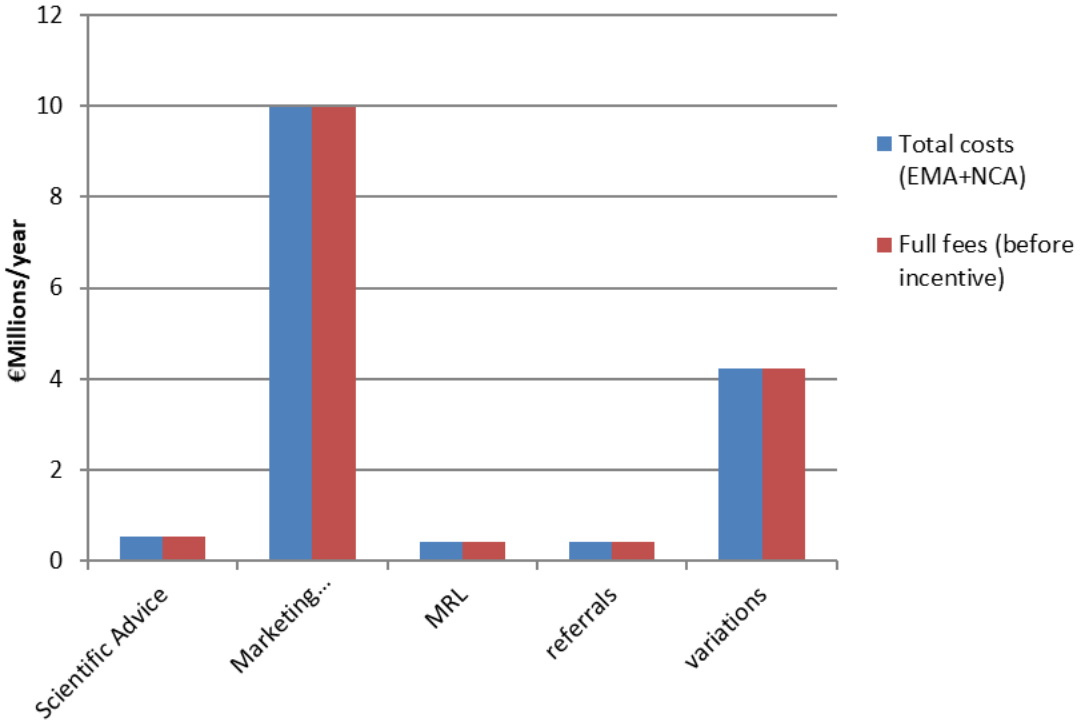


Figure 4.5: EMA and NCA shares of costs and fees projected in Option 2 for 2024 after incentives have been applied – human medicines

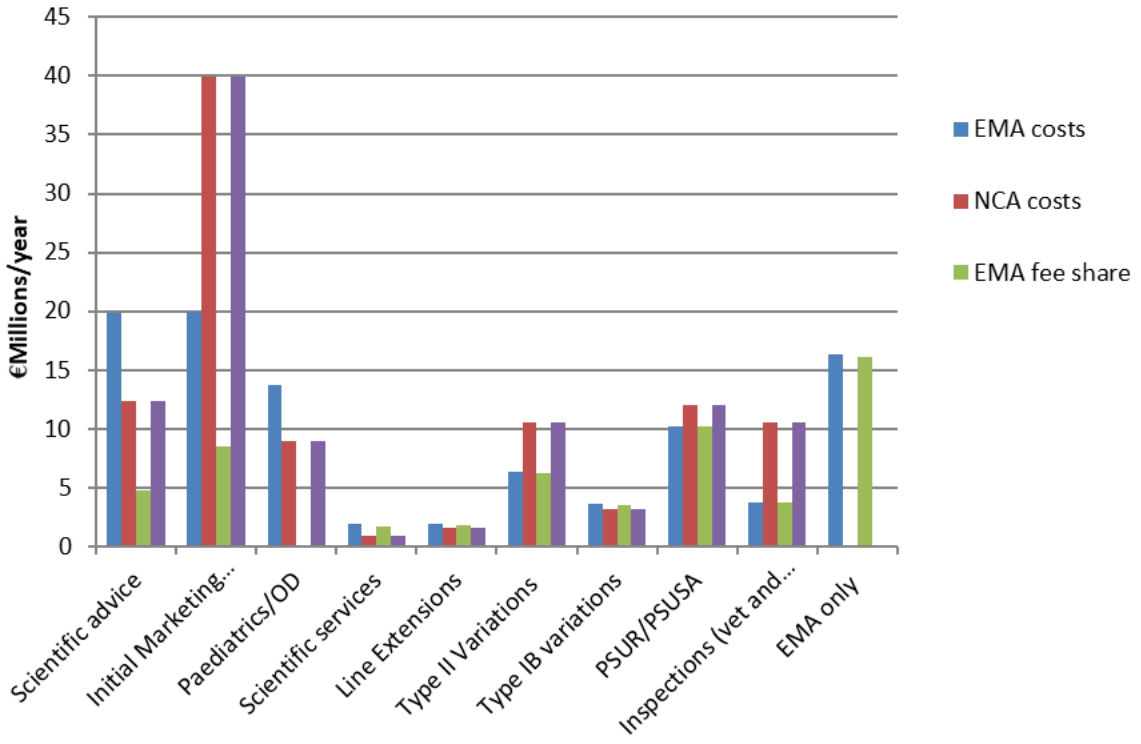
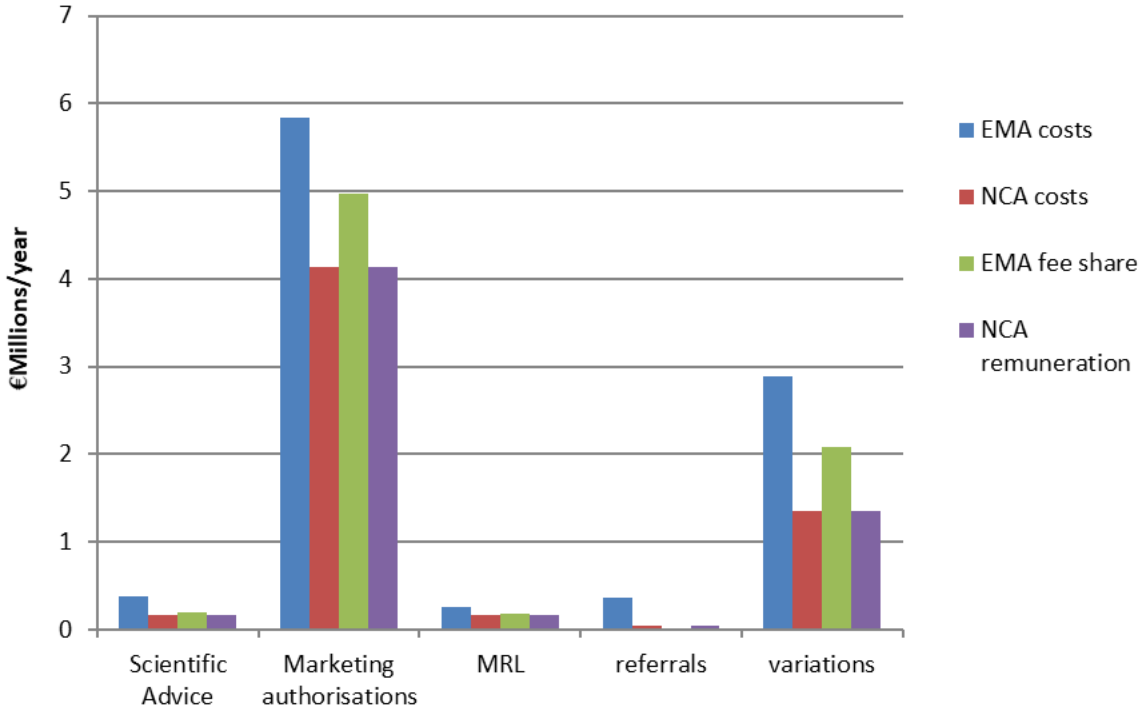


Figure 4.6: EMA and NCA shares of costs and fees projected in Option 2 for 2024 after incentives have been applied – veterinary medicines



Option 3: A cost-based fee system with a simplified structure

The purpose of this option is to simplify the cost-based fee system implemented in Option 2 for both human and veterinary medicines by applying a reduced number of procedural fees for post-authorisation activities (human and veterinary):

- A reduced number of procedural fees are applied for post-authorisation non-pharmacovigilance activities for human and veterinary medicines. Procedural fees are levied for pre-authorisation activities (human and veterinary), inspections and only some major post-authorisation activities (e.g. referrals). Due to technical complexities linked to the variety of products included in pharmacovigilance procedures and activities, pharmacovigilance procedures continue to attract procedural fees.

- The annual fee for CAPs covers a broader set of costs as compared to the current system, including those non-pharmacovigilance post-authorisation procedures that would no longer levy a procedural fee.

- The annual fees for pharmacovigilance cover costs of EMA horizontal pharmacovigilance activities in both the human and veterinary sectors (separate amounts for human and veterinary products, to match the respective estimated costs).

- NCA remuneration for procedures charged under the CAP annual fee is no-longer per-procedure and is included in the annual remuneration paid to NCAs via the CAP annual fee.

Option 3 ' ***light'*****: A cost-based fee system with a simplified structure**

Following the feedback from the IIA, a further option is considered, namely a partial simplification of the cost-based fee system relative to Option 2 but not as simplified as in Option 3. Option 3 '*light'* is based on Option 3 but a more limited set of activities are covered by annual fees (mainly minor variations) and procedural fees are retained for a larger number of activities (mainly major variations).

The lists of activities included in the annual fees in Option 3 and Option 3 '*light'* are presented in the fee grids produced as model outputs. For these activities no procedural fees are charged and these fees are therefore set to zero in the fee grids.

Presentation of the options and horizontal measures in the fee grids

In the fee grids, for each option and horizontal measure, the fee and remuneration amounts before any targeted incentives are applied are presented in a separate row for each procedural activity. These fees are subject to any general reductions (or mark-ups) that have been implemented. The incentives that should be applied to the fees are provided in subsequent columns. These incentives are applied to the fees in all cases. The remuneration amounts for NCAs are those amounts that apply when all NCAs receive the same level of remuneration for the same work and when EMA bears the cost of incentives. This is the case for all the main options and horizontal measures.

Incentives are also applied to the NCA remuneration for the particular horizontal measure where the cost of incentives is shared between EMA and NCAs. Applying incentives to the

NCA remuneration has implications for the annual CAP fees that are used to balance the EMA budget. The CAP annual fees for NCA remuneration after incentives are shown in a separate row in the fee grid.

To determine the NCA remuneration when this is scaled by country coefficients, the remuneration shown in the fee grids is scaled by the coefficient shown in Table 4.5.

The procedural activity and CAP annual fees and remuneration and pharmacovigilance annual fees are shown separately for human and veterinary activities. An additional contribution to the annual human CAP and pharmacovigilance fees to cover the cost of DARWIN EU is shown at the bottom of the fee grid. This is the same for all options.

Annex 4, Addendum 1

Fee and remuneration rules under the existing fee system

Under the current fee system, each procedural activity (or service) for which a fee can be charged has a full fee associated with it. This is the maximum fee that an organisation could be asked to pay for a given activity (i.e. if there were no discount or waiver) and has a specific legal basis. The different full fees were the main basis for the level of disaggregation of procedural activities in the NCA survey for the evaluation study and hence in the model. In addition, there are a number of procedural activities for which no fees are currently charged.

The unitary full fees used in the model were taken from published EMA values for 2019:

- A yearly inflationary adjustment is applied to the fees charged for years in the future.
- The fee charged for some procedures (full application for marketing authorisation and line extensions) contains a fixed and a variable fee, as per rules defined in currently applicable system. The variable part is linked to the requests from the applicants for additional "strength, pharmaceutical forms and presentations, so the higher the number of additional requests the higher fee charged. In these cases a single total unitary fee was calculated based on the proportion of procedures that would be expected to have additional requests and this was used in the model.

For procedural activities, detailed data on incentives was provided by EMA. From this, the study team calculated the average incentive rate for a given activity, in percentage terms, which was implemented in the model to calculate EMA and NCA incomes. Thus the modelling assumption is that the mix of activity in future will be similar to that in the past, so that the outturn average rate of incentive remains unchanged.

The rule for the remuneration of NCAs under the existing fee system is implemented in the model as follows:

1. For a rapporteur or co-rapporteur role for a non-pharmacovigilance, fee generating procedural-activity, the NCA receives 50 per cent of the full fee before incentives are applied. Where more than one NCA undertakes a remunerated role for the same procedure, the remuneration is distributed equally between them. For

pharmacovigilance activities, NCAs are remunerated a fixed amount, which is reduced in proportion to the incentive applied to the full fee.[130]

2. Rapporteurs and co-rapporteurs of eligible procedures receive 30 per cent (15 per cent each) of the CAP annual fees for human and veterinary medicines. NCAs do not receive a share of pharmacovigilance annual fees which cover activities undertaken only by EMA.

The net fee income that EMA receives from fee-generating activities is the remainder of the full fee income less NCA remuneration and the incentives applied. Hence, for procedural activities, other than pharmacovigilance activities, EMA retains:

Full fee x (100% – 50% paid to NCAs – incentive rate (%))

For pharmacovigilance activities, EMA fee income is calculated as:

(Full fee – NCA remuneration) x (100% – incentive rate (%))

EMA receives 70% of the annual fees for CAPs and 100% of the annual pharmacovigilance fees. In both cases the EMA fee income is net of incentives.

Based on the above rules, the yearly fee income for EMA and remuneration for NCAs is calculated as follows:

- The total full fee income was calculated as the product of the full fee per activity and the number of invoiced procedures for a given activity.
- Data on the actual number of CAP authorisations attracting an annual fee and NAP chargeable units attracting a Pharmacovigilance annual fee, the incentive rates and the number of purchase orders (POs) for CAP annual fees sent to individual NCAs acting as rapporteur / co-rapporteur was provided by EMA based on actual records. These data were used to determine the share of CAP annual fee income EMA received.
- EMA net fee income is the total fee income net of the NCA share and incentives.
- NCA remuneration per year was calculated for a given type of activity according to the rules outlined above. The remuneration was allocated across NCAs according to the number of rapporteur/co-rapporteur roles undertaken by each NCA (The formula is modified slightly for pharmacovigilance activities.)

  Annual remuneration of NCA X = NCA share of fee x unit full fee x (no. rap + no. co-rap NCA X) /(no. rap + no. co-rap per procedure)

[130] The combined NCA remuneration for rapporteurs and co-rapporteurs for post-authorisation safety studies (PASS) is €7280 for the draft report and a further €10920 for the final report. For PSURs and PSUSAs, it is €13100. The remuneration is scaled proportionally to the incentive rate applied to the full fee (EU Regulation 658/2014).

The remuneration is summed over all NCAs to determine the total NCA remuneration.

Annex 4, Addendum 2

NCA participation and additional activities

NCA participation in EMA committees and working parties and activities declared in addition to procedures – analysis of relevance to the EMA fee and remuneration system

The evaluation of the EMA fee system found that, overall and at an aggregate level, the remuneration paid by the Agency to NCAs exceeds the total costs calculated for undertaking procedures for human and veterinary medicines, if the two sectors are taken together.

Beyond this group of NCAs activities, i.e. procedural activities, the evaluation also considered two other groups of NCAs' activities: (1) Attending EMA's committees and working groups, outside procedures, costed based on time collected by the EMA Management Board data gathering [131] and (2) Additional activities declared by NCAs as potential EMA activities, beyond the assessment procedures and the committee and working groups non-procedural time, costed based on a remainder of an overall EMA related cost declared by NCAs during the evaluation exercise. These two groups of NCAs activities were considered in the evaluation study and their cost was estimated, but their relevance was not analysed with regard to the remuneration that EMA pays to NCAs.

NCAs' time for attending EMA committees and working parties when not in charge of a procedure

The evaluation estimated the cost of time for participating in committees and working parties outside procedures at €17.9 million/year for all NCAs in aggregate. This figure did not take into account the reimbursement of travel and subsistence costs.

This time relates to taking part in common EU-level structures and is therefore seen as part of the overall setting of the EU regulatory system, consistent with the model of the EU in general. Without a relation to a specific assessment procedure, and in common with many other sectors, this is part of the collective responsibility of all Member States within the centralised regulatory system, which is combined with their collective benefit of having medicines authorised and monitored throughout the Union via a single centralised assessment procedure and a single centralised authorisation adopted by the Commission. Therefore, being part of these EU-level structures is not consistent with the remuneration paid by EMA, as an EU decentralised agency, specifically for the work carried out by the national competent authorities of the Member States which act as rapporteurs and, where applicable, co-rapporteurs in accordance with Articles 61(6) and 62(1) of Regulation (EC) No 726/2004. Moreover, calculating a monetary equivalent of benefits associated with the EU centralised system is also not considered appropriate for the purpose of this exercise. This rationale is applied as an overarching matter of principle.

Separately, NCAs receive in principle reimbursement of travel and hotel costs, a travel allowance in case of arrival/departure outside of the meeting days, and a daily allowance for

[131] EMA committees' and working parties' time related to procedural activities has been taken into account in the procedural time.

each day of the meeting. The reimbursement in principle of travel and subsistence costs is not affected by the above considerations.

NCAs' declared activities in addition to procedures

In relation to the EMA fee system evaluation, NCAs have declared broader 'additional activities', i.e. other than procedural activities. Examples of such additional activities, as declared by NCAs, included: work related to IT and databases, participation in the EMA Management Board, surveillance of safety of medicines, giving or attending scientific training sessions, actions on AMR, providing comments to draft assessment reports when not in the role of co-/rapporteur, updating national registries and publishing information on medicinal products, national implementation of EU decisions, national inspections related to EMA requests, work related to EU presidency, work on ICH (International Conference on Harmonisation), WHO work, etc.

The evaluation study[132] estimated the overall costs of this type of activities at €52.5 million/year for all NCAs in aggregate, based on the overall cost declarations by NCAs. According to the estimations of the evaluation, €22.7 million/year are currently paid to the NCAs via a share of the annual fee in the current system.[133] However, whether and to what extent such 'additional activities' should be remunerated by EMA in a cost-based system was not analysed by the evaluation and has therefore been subject to further analysis by DG SANTE services.

Analysis of NCAs additional activities and relevant costs

Up to 88 activities were declared by NCAs, with a very high level of variation in the number of activities declared and in the level of precision of the description. This called for a pragmatic approach of the analysis. After the evaluation, NCAs were surveyed to provide further detail and to specify a relative distribution of the estimated time spent on those declared activities. The outcome allowed for a relative distribution of the overall aggregated costs estimated by the evaluation, across the various activities (see Table 4.2.1 in Annex 4).

An assessment of potential eligibility for remuneration by EMA consistent with calculating such remuneration in the level of EMA fees was carried out, based on the activities and additional explanations on content of activities provided by the NCAs respondents and a preliminary analysis of the principles established by the legislation[134]. The resulting amount of such additional activities eligible for a remuneration calculated in the annual fee was added to the overall costs used as a basis for the calculation of the CAP annual fee and respective NCA remuneration. The fee amount and the NCA remuneration amount presented in the fee grids take these costs into account. This approach to remunerating eligible additional activities of NCAs on an annual basis, through an amount calculated in the annual fee is consistent with the trend observed in the evaluation study estimations that the level of possible additional activities is proportionate to the level of procedural activities of NCAs.

The general criterion for the assessment of eligibility for remuneration by EMA which is consistent with calculating the EMA fees paid by undertakings, is whether the activity is in support of the EMA's scientific services, at central level, or, whether it is instead an activity

[132] https://ec.europa.eu/health/human-use/legal-framework/ema_fees_en

[133] The Implementing Rules of the Fee Regulation provide that NCAs of the rapporteur and co-rapporteur receive 15% each of the annual fee.

[134] Further legal scrutiny may be needed for the purpose of a legislative proposal.

that EMA fees are not called to fund, e.g. a national activity (such as implementation of EU legislation at national level).[135]

The Founding Regulation of EMA provides in general that the Agency is responsible for coordinating the existing scientific resources put at its disposal by Member States for the evaluation, supervision and pharmacovigilance of medicinal products (Article 55). Further, it stipulates (Article 67) that fees are paid by undertakings:

> (i) for obtaining and maintaining Union marketing authorisations for medicinal products for human use and for veterinary medicinal products and for other services provided by the Agency, as provided for in this Regulation and in Regulation (EU) 2019/6; and
>
> (ii) for services provided by the coordination group as regards the fulfilment of its tasks in accordance with Articles 107c, 107e, 107g, 107k and 107q of Directive 2001/83/EC

In addition, it stipulates (Article 62) that the provision of services by rapporteurs or experts shall be remunerated.

In the most recent EMA fee legislation, i.e. Regulation 658/2014, the legislator stated that any revisions of fees levied by the Agency should be based on a transparent and independent evaluation of the costs of the Agency and the costs of the tasks carried out by the national competent authorities (recital 7). It also clarified that such costs cover the work carried out by the national competent authorities of the Member States which act as rapporteurs and, where applicable, co-rapporteurs in accordance with Articles 61(6) and 62(1) of Regulation (EC) No 726/2004 (recital 6). Similar provisions exist in Regulation 297/95. Further, Regulation 2019/6 confirmed (Article 2(8) that it is without prejudice to national provisions on fees.

In light of the above, three cumulative conditions can be established to guide the assessment of the eligibility for remuneration calculated in the level of EMA fees of each of the so-called 'additional activities' considered by the evaluation: **(1)** the activity must be of scientific nature, consistent with Articles 61(6) and 62(1) of Regulation (EC) No 726/2004 **(2)** it must be part of EMA's services, consistent with Articles 67(3)(c) of Regulation (EC) No 726/2004 and **(3)** it must be a service provided to EMA consistent with Articles 61(6) and 62 of Regulation (EC) No 726/2004. In addition, for a fair and proportionate EMA fee system, any risk of double charging between the Agency's fee system and the national fee systems in Member States should be eliminated.

Examples of activities potentially eligible for remuneration under the annual fee

Activities such as for example work on the additional monitoring list, or checking national translations of safety communications on centralised procedures and annual reassessment of a marketing authorisation under exceptional circumstances may qualify for remuneration in accordance with the eligibility criteria and the analytical conditions.

Examples of activities potentially non-eligible for remuneration under the annual fee

Some activities declared are at national level or do not constitute a service to EMA and/or can be charged for at national level and, therefore, are not eligible. Examples include updates of

[135] This does not exclude a priori such activities from eligibility for financing through EU financial instruments.

national drug registries, DSURs, adverse drug reaction reporting, signal management[136], national safety communication following a pharmacovigilance procedure of a centrally authorised product, participation in IT projects relating to databases and portals, and participation in ICH/VICH meetings (which are reimbursed by the Commission).

Regarding the provision of comments to scientific reports from non-rapporteur NCAs and IT activities of NCAs, following the same reasoning as for committee and working parties time, remuneration is not consistent. These activities are part of the overall setting of the EU regulatory system, which is based on the collective responsibility of all Member States and which provides a collective benefit to all.

Examples of activities potentially non-eligible for remuneration under the annual fee but eligible under a procedural fee

Another group of activities are considered as "non-eligible" for remuneration through the annual fee not because they do not fulfil the criteria but because, instead, the proposed fee and remuneration grids (see consultation materials) comprise a procedural remuneration, calculated in a procedural fee.

The following activities (totalling €3.9 million) appear thus in the table below as "non-eligible for remuneration through EMA annual fee", because it is considered to charge instead a cost-based procedural fee. Such fee could be potentially reduced or fully exempted; however, a fee level could be calculated and a remuneration for NCAs could be included:

- Pre-submission meetings -to cover Qualification Opinion meeting, Pre-submission meetings/hearings, Eligibility requests (including Eligibility requests, PRIME requests, Letter of intent, Accelerated assessment/ review requests, ATMP certification, notification changes and withdrawals, total requests and notifications: *procedural fee Pre-submission activities* Compassionate use programme: *procedural fee for Scientific services - Compassionate use opinions (Scientific services compassionate other than MA)*
- Paediatric Investigation Plan (PIP) modifications: *procedural fee for Paediatrics - PIPs (modification)*
- Orphan designation, review of maintenance of an orphan designation at the time of the initial marketing authorisation, including assessment of significant benefit criteria: *procedural fee for Orphan medicinal product designation procedures*
- Classification MUMS/limited markets: *procedural fee for Limited market classification*
- HMPC operation and associated procedures: *procedural fee for centralised herbal application*
- Plasma Master File (PMF) – initial certification, *procedural fee for Scientific services PMF*
- PMF - annual updates, procedure aligned with *Scientific services PMF Type IA/IB*
- ATMP classification/ certification- *procedural fee for Scientific Services - Certification for Advanced Therapies (Scientific services ATMP certification)*

[136] The Council working party's discussions in relation to Regulation 658/2014 on fees for pharmacovigilance indicated that national fees may apply for this type of activities and there should be no risk of creating legal grounds for double charging as Member States would keep that possibility.

- Establishment, modification or extension of maximum residue limits (MRLs) – *procedural fee Maximum residual limit (MRL) applications (Establishment of MRL)*
- Re-examination procedure: *procedural re-examination fee*
- Art. 5(3) procedure (Regulation (EC) No 726/2004): *procedural fee for referral – Article 5(3)*
- Annual renewal of a conditional marketing authorisation – *new procedural fee.*[137]

The total estimated average cost (of NCAs) for those activities which are considered at the current stage eligible for remuneration calculated in the CAP annual fee is ca. €8.3 million, while the cost of those activities eligible for remuneration calculated in procedural fees is ca. €3.9 million.

[137] A fee has not been calculated for this activity for the consultation.

Table 4.2.1 Additional activities declared by NCAs in 2016[138]

'Additional activities' declared by NCAs	*Estimated average cost in 2016 for all NCAs (€)*
Total	52.634.924 €
Not eligible under annual fee because does not meet eligibility criteria	***33.822.704 €***
(Work related to being a) member of the EMA Management Board	730.881 €
Member of and work related to EMA-hosted boards and forums (e.g. Scientific Coordination Board (SciCoBo))	586.721 €
Member of and work related to ad-hoc working groups for organisational matters	277.537 €
Participation in multi-stakeholder meetings/forums (e.g. European Forum for Good Clinical Practice (EFGCP)) ; Stakeholder engagement (e.g. patients and healthcare professionals, industry, European and International partners)	337.080 €
Attending and presenting at Drug Information Association (DIA) events	99.151 €
Patient Registries Initiative, e.g. member of Cross-Committee Task Force and/or of one of the Cross-Committee Task Force Working groups, or participation in their workshops	243.269 €
Member of and work related to EU Telematics Management Board and Telematics Working Group (e.g. meetings for Clinical Trials Interface Working groups (Application Programming Interface), Consultative Group for Veterinary Product Data Systems (CGVPS, former TIG), Consultative Group for Veterinary Pharmacovigilance Systems (CGVPhS, former JIG));	2.197.168 €
EMA Strategic Review & Learning Meeting (SRLM)	289.628 €
PDCO Non-clinical Working Group (NcWG) and PDCO Formulation Working Group (FWG)	298.378 €
ICH or VICH (Expert) Working Group (EWG) (meetings and other related work)	391.015 €
Medical dictionary for regulatory activities (MedDRA) or Veterinary Dictionary for Drug Regulatory Activities (VeDDRA): establishment and maintenance of terminology standards	115.715 €
EudraLex - Volume 8 of the publications "The Rules Governing Medicinal Products in the European Union" ('Volume 8'), titled: 'Notice to applicants and Guideline – Veterinary medicinal products – Establishment of maximum residue limits (MRLs) for residues of veterinary medicinal products in foodstuffs or animal origin'	221.023 €
WHO collaboration, other than related to antimicrobial resistance	134.925 €
Reaction of EFSA	155.908 €

[138] The approach to the eligibility assessment was reviewed post-consultation (see under section 6, Indicator 1: fee system covers relative aggregate costs).

'Additional activities' declared by NCAs	*Estimated average cost in 2016 for all NCAs (€)*
Total	52.634.924 €
Lumpy skin disease (focus group) and FishMed	301.106 €
Transparency: access to documents (ATD) (Policy/0043)	68.722 €
Transparency: proactive publication of clinical trial data (CDP) (Policy/0070)	101.693 €
Transparency: reviewing of the contents of documents made public on the EMA website (e.g. review of the European Public Assessment Report (EPAR) for human or veterinary medicinal products and the Assessment Report Summaries for the Public (ARSPs) for herbal medicinal products)	72.138 €
Transparency: linguistic review of documents made public on the EMA website (e.g. product information or the EPAR summary for the public)	2.230.843 €
Transparency: preparation of responses to queries related to referral procedures	663.620 €
Coordination of safety communication	533.021 €
Communication	591.853 €
Attendance, organisation or giving training, presentations, webinars or workshops (outside working parties/committees) in the framework of the EU Network Training Centre (EU NTC)	1.892.036 €
Attendance, organisation or giving training, presentations, webinars or workshops (outside working parties/committees), other than EU NTC-related activities	800.922 €
Work related to EU presidency	512.557 €
Data gathering, EMA or EC surveys	600.285 €
OMCL laboratory projects, incl. taking samples from the market	1.472.747 €
GLP inspection	719.795 €
GMP/GDP inspection: national	3.832.751 €
Speeding up access to medicines	356.985 €
Assessment of invented names	212.024 €
Comments on non-(co)rap procedures (concerned comments)	3.489.140 €
Monitoring of the advertising of all medicinal products	2.098.283 €
Checking of the content of the QR (quick response) code	52.860 €
National implementation of EC decisions (e.g. after safety referrals)	932.278 €
Update of national drug registry and publishing of drug information	1.927.568 €
Work related to product defects ; Rapid Alert (RA)/Non-Urgent Information (NUI)/Incident Management Plan (IMP)	770.357 €
Medicine shortages	1.518.487 €
Parallel distribution activities	323.511 €
EMA Guidance dev rapporteur	429.653 €
Herbal legislation	28.601 €
WHO collaboration, other than related to antimicrobial resistance	134.925 €
Development Safety Update Report (DSUR)	1.075.544 €

'Additional activities' declared by NCAs	*Estimated average cost in 2016 for all NCAs (€)*
Total	52.634.924 *€*
	33.822.704 €
Eligible under annual fee	***14.819.059 €***
Post-authorisation measures (PAMs) (REC, MEA, ANX, LEG, SOB) / follow-up measures (FUM)	1.024.082 €
Annual reassessment of a marketing authorisation under exceptional circumstances	88.981 €
List of Union reference dates and frequency of submission of period safety update reports (the EU reference dates (EURD) list)	32.687 €
Pharmacovigilance audit, including (non)conformity reports	641.750 €
Signal management human medicines (this includes the following actions: 1. Signal detection (incl. review e-RMR), 2. Signal validation, 3. Signal confirmation, 4. Signal analysis and prioritisation, 5. Signal assessment, 6. Recommendation for action) ; Signal detection and surveillance veterinary medicines	1.625.948 €
Adverse drug reaction (ADR) reporting	4.900.673 €
Checking of national translations of additional risk minimization materials (educational materials etc.) and DHPC letters	2.183.163 €
Drafting, peer-review and commenting on herbal monographs and list entries	209.826 €
Modification of a herbal monograph	105.502 €
Regular revision of a herbal monograph (every five years)	116.486 €
Member of and work related to (smaller) (ad-hoc) working groups for scientific matters (e.g. for review and implementation of ICH guidelines or those related to the different annual Committee Work Plans (e.g. improving the full MA/AR-documentation process and templates))	660.040 €
CODEX	134.187 €
HTA collaboration	118.377 €
Additional monitoring list	267.950 €
Work related to addressing antimicrobial resistance (AMR), including JIACRA, AMEG, RONAFA, ESVAC, CADVVA	1.701.743 €
European Pharmacopoeia work and corresponding laboratory work	821.439 €
Post-Authorisation Efficacy Studies (PAES): PAES protocol	186.225 €
	14.819.059 €
Not eligible for annual fee because procedural fee remuneration either exists or is to be created	**3.993.161 *€***
Qualification Opinion meeting	87.763 €
Compassionate use programme	113.875 €

'Additional activities' declared by NCAs	*Estimated average cost in 2016 for all NCAs (€)*
Total	52.634.924 *€*
Paediatric work-sharing in accordance with Article 45 and 46 of Regulation (EC) No 1901/2006 (Paediatric Regulation) in case of centrally authorised products	475.691 €
Paediatric Investigation Plan (PIP) modifications	335.843 €
Orphan designation, review of maintenance of an orphan designation at the time of the initial marketing authorisation, including assessment of significant benefit criteria; orphan derogation	263.217 € + 106.242€
Classification at the request of the MAH on MUMS/limited markets	20.021 €
HMPC operation and associated procedures	62.016 €
National GCP inspection linked to EMA request (MA), including preparation of supporting documents for sanctions imposed for GCP non-compliance	502.268 €
Plasma Master File (PMF) – initial certification	72.032 €
PMF - annual updates	75.137 €
ATMP certification	23.040 €
Pre-submission meetings/hearings	532.818 €
Establishment, modification or extension of maximum residue limits (MRLs)	93.203 €
PRIME	363.965 €
Accelerated assessment, including eligibility requests	161.024 €
Eligibility assessment for the centralised procedure	9.772 €
ATMP classification	63.619 €
Re-examination procedure	477.784 €
Annual renewal of a conditional marketing authorisation	101.523 €
Art. 5(3) procedure (Regulation (EC) No 726/2004):	52.308 €
	3.993.161 *€*
TOTAL ALL	**52.634.924 *€***

Final calculations of NCAs remunerations (post-consultations)

Consultation feedback pointed out the role the annual fee remuneration has historically played as a "stabilising factor" that enabled NCAs to continue to contribute to EMA's work in accordance with the founding Regulation, and to finance the horizontal activities this contribution requires, and suggested that this had not been taken sufficiently into account.

On the basis of the feedback, the approach to determining what portion of additional activities would be eligible for remuneration through EMA fees was reviewed and NCA remuneration under the different options was recalculated accordingly. It became clear that the granular

bottom-up approach applied for the consultations, that sought to determine eligible costs activity by activity according to criteria for compatibility with the legislation, could not provide a comprehensive basis for determining the level of remuneration for those activities, due to the degree of variability involved, and the impossibility of gathering all the relevant data with sufficient precision and detail.

The great variety of activities declared as additional by NCAs includes some that are clearly national only, others that clearly contribute to EMA's work, and yet others in which these two dimensions are very difficult to disentangle, due to the level of disaggregation and precision of the description provided. A different approach was therefore required, one which could reconcile the heterogeneous and incomplete bottom-up information that was available with a broader, top-down analytical framework for determining what level of cost-based annual remuneration, in addition to the cost-based per-procedure remuneration, would enable NCAs to fund in a sustainable manner those additional activities that are eligible, i.e. which do make a contribution to EMA's activities, in accordance with the founding Regulation.

The starting point chosen for this revised approach was the estimated aggregated level of annual fee remuneration as a proportion of total fee remuneration received by NCAs from EMA. Based on a projection of the current fee system, this proportion averages around 1/3 of total NCA remuneration received from EMA on aggregate. This ratio was considered to provide a good proxy for estimating the level of annual remuneration which would be consistent with the arguments put forward in the abovementioned consultation feedback.

The cost used by the financial model to calculate the annual fee and remuneration was then adjusted in the study model so that this approximate 1/3 ratio was preserved within the study model calculations (that is at aggregate level, for the whole system). This led to an upward adjustment of unitary annual remuneration (and, therefore, of unitary annual fees) as compared to the amounts presented for consultations. The resulting higher annual remuneration of NCAs, as estimated by the study model, still falls within the overall maximum envelope of ca. EUR 53 million covering all additional activities, including both eligible and non-eligible activities. This envelope can be considered as the maximum possible amount for cost of NCAs' additional activities included in the calculation of the NCAs' annual remuneration.

It has to be noted that, because of the difficulties, explained above, in accurately quantifying the actual cost of eligible activities not compensated through the per-procedure fee, this choice implies the acceptance of some costs which, had complete quantification been possible, might ultimately not have been deemed fully eligible. At the same time, this top-down approach compensates for possible shortcomings of the methodology in updating granular level costs since the evaluation. Therefore, this methodological choice is only relevant to the estimations generated for the study supporting this particular impact assessment, in order to establish initial fees under a revised fee system. The conditions under which the annual and procedural fees will be updated in future depend upon the monitoring mechanism that will be established under the revised fee system (see section on Monitoring below). The validity of this approach (i.e. reflecting the cost of eligible additional activities in the annual fee remuneration paid to rapporteurs) is supported by the observation made during

the evaluation study that, for a given NCA, the level of engagement in additional activities is likely to be proportionate to the level of engagement in procedural activities[139].

Annex 4, Addendum 3

DARWIN EU, its interplay with the European Health Data Space (EHDS) and expected annual maintenance cost

The creation of the EHDS is one of the main priorities of the Commission in the area of health. The EHDS will enable the cross-border exchange of and access to different types of health data originating from real-world data sources such as electronic health records, administrative databases or patient registries. The EHDS will not only support healthcare delivery but also health research and innovation, public health policy-making and regulatory activities. The EHDS is an overarching initiative that covers four key strands of work:

- a governance framework and rules for the secure exchanges of health data for primary and secondary purposes;
- the deployment of the interoperable digital infrastructure for such exchanges;
- specific actions for improved quality and semantic interoperability of health data;
- capacity building activities in Member States, including on digital skills of competent authorities and health workforce.

The Commission is currently working on the preparation of a legal framework for the governance, rules and requirements for a common EHDS. A legal proposal is expected to be adopted by the end of the year of the beginning of 2022. The Commission, together with relevant stakeholders, and including EMA, is preparing a pilot that aims at demonstrating the added-value of the EHDS, among others in use cases related to EMA's regulatory activities at the level of the Union. The integration of DARWIN EU in the EHDS (as a node in the digital infrastructure for secondary use of health data) will facilitate the EMA's and national agencies' ability to launch cross-countries observational studies.

The Data Analysis and Real World Interrogation Network (DARWIN EU) is the future EMA's infrastructure that will support regulatory decision-making by:

- establishing and expanding a catalogue of observational data sources for use in medicines regulation;
- providing a source of high-quality, validated real world data on the uses, safety and efficacy of medicines;
- addressing specific questions by carrying out high-quality, non-interventional studies, including developing scientific protocols, interrogating relevant data sources and interpreting and reporting study results.

DARWIN EU will connect EMA and the European medicines regulatory network to the European Health Data Space (EHDS), an initiative to promote better exchange of and access to different types of health data. DARWIN EU will include a coordination centre for the

[139]Evaluation study report figure 13, p. 55

exchange of queries and information across European medicines agencies and EMA, and it will be integrated in the broader EHDS infrastructure network for access to real-world health data. DARWIN EU would also support FAIRification of datasets[140], which can also be made available to other re-users.

The DARWIN EU infrastructure and organisational structure are expected to be developed, deployed and operated in two phases:

- A project phase (Phase 1), which covers the development and deployment of the core components of the DARWIN EU infrastructure (2021-2023): covered through EU budget contribution
- **A maintenance phase (Phase 2), which covers the operations and further development of the DARWIN EU infrastructure (from 2024 onwards): included under EMA cost calculations for the fee model of this study as from 2024.**

Phase 1 is expected to be funded through the Union budget contribution allocated to EMA under its revised mandate. Phase 2 is expected to be covered annually by fees collected by EMA. EMA has estimated the yearly amount for Phase 2 at 16 million EUR (see Table below). This yearly amount includes the operation of the Coordination Centre and its integration in the EHDS, the operation of the associated infrastructure, and the execution of routine and complex data analysis studies.

Expected annual maintenance cost (phase 2)

Type	Category	Amount €
Analysis and Studies	Analyses and Studies	7,200,000
Operational	Governance	3,750,000
	Training and Missions	258,000
	Maintaining Data Sources	2,998,187
Infrastructure	Technology Infrastructure	1,720,713
Total expected annual maintenance cost		**15,926,900**

[140] FAIR data sets are those that meet principles of **f**indability, **a**ccessibility, **i**nteroperability and **r**eusability. FAIRification is the process through which data sets are made compliant with FAIR principles.

ANNEX 5: CONTEXT AND RELEVANT ACTORS

A medicinal product for human or veterinary use can only be placed on the market in the European Union (EU) when a marketing authorisation has been granted either by a Member State national competent authority (national procedure for access to that territory's market) or by the European Commission (centralised procedure for access to the EU market).

In addition, once a medicinal product has been authorised and placed on the market, its safety profile continues to be monitored throughout its entire lifespan (pharmacovigilance).

EMA (or 'the Agency') is the decentralised agency of the EU responsible for coordinating the existing scientific resources put at its disposal by the Member States, usually **National Competent Authorities** (NCAs), for the evaluation, supervision and pharmacovigilance of medicinal products at **centralised level**, both for human and veterinary use. EMA is governed by a Management Board, which includes members from each of the EU Member States. While authorisations to place centrally authorised medicines on the EU market are granted by the European Commission, these decisions are based on the scientific evaluation and consequent opinion issued by the Agency. The work carried out by the Agency's seven committees informs this.

EMA provides technical, scientific and administrative support for each assessment and it coordinates the work and operations of all committees and working parties/groups. EMA also provides the same technical, scientific and administrative support to the coordination groups and ensures adequate coordination between the coordination groups and the committees. In addition the Agency carries out a number of horizontal activities, such as IT developments and maintenance, international activities, stakeholder engagement, access to documents etc.

Each EEA Member State has one or more **NCAs,** with over 50 in total, dealing with the evaluation and maintenance of marketing authorisations of medicinal products for human and veterinary use in their own territory. While the NCAs have regulatory responsibilities at national level and participate in fora at international level, only NCAs centralised work is within the scope of this impact assessment. Their contribution to the work of EMA, to support the centralised system, involves the provision of the vast majority of scientific experts, carrying out the scientific work at Union level (centralised work), including through the Committees of the Agency.

– EMA structure and functioning

a. Composition of EMA MB

Members include:

- one representative of each of the EU Member States;
- two representatives of the European Commission;
- two representatives of the European Parliament;
- two representatives of patients' organisations;
- one representative of doctors' organisations;
- one representative of veterinarians' organisations.

In addition to the members, the Management Board also has one observer each from Iceland, Liechtenstein and Norway. The Board sets the Agency's budget, approves the annual work programme and is responsible for ensuring that the Agency works effectively and co-operates successfully with partner organisations across the EU and beyond. The Agency's day-to-day operations are carried out by the EMA staff, overseen by EMA's Executive Director.

b. Committees, associated Working Parties and associated groups

EMA has **seven scientific committees** (established by Union legislation) and over 40 working parties and related groups[141] which conduct scientific work of the Agency. Membership to the committees is based on the representation of each Member State (one main member and one alternate, appointed by each MS), usually experts from NCAs and other relevant experts in line with the Rules of Procedure for each committee. Membership of committee associated working parties and associated groups is based purely on expertise and presence on the list of European experts maintained by the Agency. Experts are nominated by Member States or by the Agency and are primarily made available by NCAs, with a few members from academia or hospitals. The committees are:

- the Committee for Medicinal Products for Human Use (CHMP) - opinion
- the Committee for Medicinal Products for Veterinary Use (CVMP) - opinion
- the Pharmacovigilance Risk Assessment Committee (PRAC)
- the Paediatric Committee (PDCO)
- the Committee for Orphan Medicinal Products (COMP)
- the Committee for Advanced Therapies (CAT)
- the Committee on Herbal Medicinal Products (HMPC).

During its evaluation of marketing-authorisations, the relevant committee may consult EMA's working parties, scientific advisory groups or other related groups on scientific issues relating to their particular field of expertise.

In addition to their primary role, the committees and working parties, together, support **medicines' developers** and provide clarifications with respect to medicine regulation, by providing scientific advice to companies researching and developing new medicines, by preparing scientific guidelines and regulatory guidance to help companies prepare marketing authorisation applications, and by contributing to the harmonisation of regulatory requirements both in the EU and internationally.[142]

To carry out a scientific assessment, usually a committee appoints a rapporteur from within the committee to prepare an assessment report, which the committee will consider and eventually adopt as part of a scientific opinion or recommendation. For certain procedures (the majority in the case of initial marketing authorisation procedures), a 'co-rapporteur' also

[141] This figure dates form the evaluation phase in 2019. Since then the Agency has undertaken a revision of the working parties/groups of the Agency to streamline the governance of the activities undertaken and the rules of procedures.

[142] For more information, see the individual work plans of the committees as published on EMA's website under 'Committees' (www.ema.europa.eu).

prepares an assessment independently from the rapporteur. An optional peer-review process provides additional quality assurance for certain scientific assessments, although this is not a legal requirement.

EMA committees try to reach their conclusions by consensus whenever possible, but if not the committee holds a vote.

An assessment team supports the rapporteur and co-rapporteur with necessary expertise and resources. The EMA secretariat provides technical, scientific and administrative support for each assessment. Furthermore, it coordinates the work of all committees and working parties/groups. To be noted that EMA provides the same technical, scientific and administrative support also to the coordination groups[143] and ensures adequate coordination between the coordination groups and the committees. Remuneration is paid to the respective NCAs via a cooperation agreement, in accordance with Article 62(3) of Regulation (EC) No 726/2004.

Appointment of (co)-rapporteurs[144]

All Members and alternates can act as rapporteur/co-rapporteur. The rapporteurs are supported also by a team of assessors/experts made available either from their own NCAs or from across the EEA (multinational teams).

The appointment of the rapporteur/co-rapporteur is made on the basis of objective criteria, which ensures the provision of objective scientific opinions and allows the use of the best and available expertise in the EEA in the relevant scientific area, over the lifecycle of the medicinal product. These objective criteria can be summarised in:

- **Ability of rapporteur/co- rapporteur to fulfil their role**, which refers mainly to their ability to take responsibility for the scientific assessment /evaluation undertaken by the assessment team, coordination input etc.
- **Assessment team objective criteria,** which refer to the scientific competence, regulatory experience, complementary cross-team scientific expertise and competence of the assessment team(s) as well as the availability of an adequate Quality Assurance System at the level of the EEA NCAs
- **Individual objective criteria**, which refer to the academic expertise and the practical working experience and competence of the: (1) Individual assessor(s)/expert(s); (2) Rapporteur/co-rapporteur (when acting as assessor/expert in the scientific assessment of the application).

[143] The coordination groups for human medicinal products (CMDh) and veterinary medicinal products (CMDv) were set up for the examination of any questions relating to nationally authorised medicinal products, specifically related to disagreements on the grounds of potential serious risks to public health between Member States on pending initial marketing authorisation and variation procedures. The tasks also include certain pharmacovigilance activities related to nationally authorised products.

[144] For more information on the appointment procedure: https://www.ema.europa.eu/en/documents/regulatory-procedural-guideline/procedural-advice-chmp/cat/prac-rapporteur/co-rapporteur-appointment-principles-objective-criteria-methodology-accordance-article-62-1/2004_en.pdf

On the practical level, when an application is submitted to the EMA, the secretariat of the concerned committee sends a request to all members and alternates to indicate their interest in rapporteur/co-rapporteurships. The committee Chairperson, in consultation with the Chairperson of any other involved committees, will then assess the various candidates, on the basis of the objective criteria mentioned above, and decide on the final rapporteur/co-rapporteur and their assessment team appointment as applicable.

The rapporteurs and co-rapporteurs are bound to the EMA Rules on the handling of declared interests.

– EMA budget

The budget of EMA is established and implemented in accordance with principles set out in the Financial Regulation applicable to the budget of the European Medicines Agency (EMA financial Regulation) in accordance with the financial regulation applicable to the general budget of the Union. In particular, under the principle of "equilibrium", it is intended that revenue and payment appropriations of the Agency should be in balance and that the commitment appropriations may not exceed the amount of the Union contribution plus the Agency's own revenue (fees and other sources of income).[145]

The figure below shows the relation between EU budget contribution and fee income over a 10-year period, up to 2020. It shows that whilst the EU budget contribution remained relatively constant, the Agency relied primarily on income from fees to cover incremental increases in costs associated with a steady increase in activities. Over the period 2010 and 2020 income from fees more than doubled.

[145] EMA Financial Regulation, Article 16

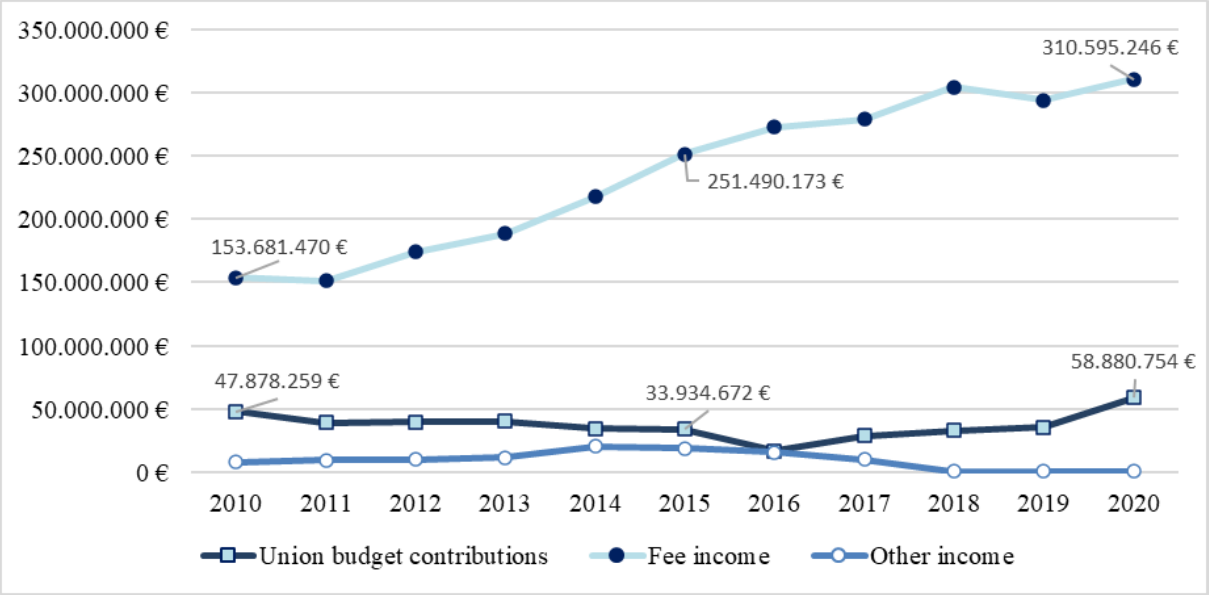


Fig 7.1: Total amount of Union budget contributions[146] vs. industry fees and other sources of income for the years 2010-2020

In 2020, the Agency's total budget was €369.7 million. Approximately 83.9% (€310.5 million) was funded by fees paid by undertakings for obtaining and maintaining marketing authorisations and for other services provided by the Agency and ca.15.9% (€58.9 million) by EU/EEA budget contributions. The remainder of the EMA revenue (0.2%) stems from other sources of income, such as administrative operations and revenue for projects and programmes.

In 2020, the EMA expenditure relates to staff costs (€115.5 million), infrastructure costs (€85 million) and operational expenditure (€169.2 million). Of the latter, 80% represents payments to experts for contribution to the centralised system, including expenditure for reimbursement of attendance to meetings (€1.3 million[147]), remuneration to NCAs for work of rapporteurs and co-rapporteurs, coordinators, inspectors and experts for their scientific assessments (€121.7 million) and remuneration to NCAs for work of rapporteurs and co-rapporteurs on pharmacovigilance procedures (€12.3 million).[148] The Regulation for a reinforced mandate of EMA adds to this expenditure € 8 million for DARWIN EU (set to become €16 million as of 2024) and ca. €15 million for the other two objectives of that regulation.

[146] 'Union budget contributions' consists of the general EU contribution, EEA contribution, specific contribution for orphan medicinal products; corrections for outturn/surplus from previous year (as provided for in Art. 17 of the EMA Financial Regulation) are taken into account.

[147] This figure dropped from €7.9 million in 2018, as an effect of the COVID-19 crisis

[148] Figures quoted are for 2020, based on EMA Budget Report for 2021, as adopted by the Management Board on 7 December 2020.

ANNEX 6: SUMMARY IMPACT TABLES FROM THE CONSULTATION

Fee revenue

Do-minimum

Total revenue	2020 €'000	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
Human medicines						
Procedural fees	194.662	202.161	207.292	213.756	219.510	226.808
Annual fees - CAP	90.342	103.685	110.556	117.809	126.214	135.199
Annual fees –PhV	9.929	10.182	10.304	10.448	10.594	10.743
Veterinary medicines						
Procedural fees	5.800	8.101	9.752	11.480	13.383	13.965
Annual fees - CAP	5.958	7.632	8.210	8.917	9.843	10.861
Annual fees –PhV	0	0	0	0	0	0
Total	306.690	331.761	346.113	362.410	379.544	397.576

Option 1

Total revenue	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
Human medicines					
Procedural fees	202.161	207.292	213.756	219.510	226.808
Annual fees - CAP	103.685	110.556	121.809	130.499	139.790
Annual fees –PhV	10.182	10.304	22.448	22.762	23.081
Veterinary medicines					
Procedural fees	13.046	14.835	16.709	18.739	19.328
Annual fees - CAP	20.752	22.321	24.246	26.809	29.594
Annual fees –PhV	3.051	3.088	3.131	3.175	3.219
Total	352.877	368.395	402.100	421.494	441.821

Option 2

Total revenue	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
Human medicines					
Procedural fees	155.478	160.379	166.804	172.972	181.624
Annual fees - CAP	125.412	133.723	146.496	156.948	168.122
Annual fees –PhV	14.991	15.171	27.383	27.766	28.155
Veterinary medicines					
Procedural fees	13.046	14.835	16.709	18.739	19.328
Annual fees - CAP	15.982	17.190	18.673	20.652	22.798
Annual fees –PhV	3.051	3.088	3.131	3.175	3.219
Total	327.960	344.385	379.196	400.251	423.247

Option 3

Total revenue	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
Human medicines					
Procedural fees	122.294	126.364	131.769	136.150	143.158
Annual fees - CAP	156.247	170.354	181.531	194.482	208.328
Annual fees –PhV	14.991	15.171	27.383	27.766	28.155
Veterinary medicines					
Procedural fees	10.203	11.675	13.207	14.779	14.986
Annual fees - CAP	18.980	20.415	22.175	24.525	27.075
Annual fees –PhV	3.051	3.088	3.131	3.175	3.219
Total	325.766	347.067	379.196	400.878	424.921

Option 3 'Light'

Total revenue	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
Human medicines					
Procedural fees	138.274	142.633	148.499	154.004	161.989
Annual fees - CAP	141.522	150.901	164.801	176.558	189.129
Annual fees –PhV	14.991	15.171	27.383	27.766	28.155
Veterinary medicines					
Procedural fees	12.104	13.786	15.538	17.433	17.872
Annual fees - CAP	16.985	18.269	19.844	21.947	24.229
Annual fees –PhV	3.051	3.088	3.131	3.175	3.219
Total	326.927	343.847	379.196	400.883	424.593

NCA remuneration

Do-minimum

	2020 €'000	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
All NCAs						
Remuneration from procedural activities	105.442	111.240	115.344	120.620	124.501	128.789
Remuneration from annual fees	29.928	34.651	36.931	39.394	42.264	45.386
NCAs conducting human medicines activities only (n=17)						
Remuneration from procedural activities	35.629	37.020	38.146	39.627	40.648	42.026
Remuneration from annual fees	10.600	12.276	13.075	13.929	14.912	15.981
NCAs conducting veterinary medicines activities only (n=12)						
Remuneration from procedural activities	959	1.144	1.462	1.791	2.130	2.159
Remuneration from annual fees	806	930	1.001	1.087	1.200	1.324
NCAs conducting both human and veterinary medicines activities (n=14)						
Remuneration from procedural activities	68.853	73.076	75.736	79.201	81.723	84.604
Remuneration from annual fees	18.522	21.445	22.855	24.378	26.152	28.081

Option 1

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
All NCAs					
Remuneration from procedural activities	113.515	117.686	123.032	126.973	131.262
Remuneration from annual fees	34.840	37.134	39.615	42.508	45.655
NCAs conducting human medicines activities only (n=17)					
Remuneration from procedural activities	36.843	37.966	39.444	40.461	41.835
Remuneration from annual fees	12.276	13.075	13.929	14.912	15.981
NCAs conducting veterinary medicines activities only (n=12)					
Remuneration from procedural activities	1.463	1.818	2.186	2.563	2.599
Remuneration from annual fees	1.004	1.080	1.173	1.294	1.428
NCAs conducting both human and veterinary medicines activities (n=14)					
Remuneration from procedural activities	75.209	77.902	81.403	83.949	86.828
Remuneration from annual fees	21.560	22.980	24.513	26.301	28.246

Option 2

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
All NCAs					
Remuneration from procedural activities	105.168	110.553	117.808	122.712	129.455
Remuneration from annual fees	15.056	16.062	17.167	18.475	19.900
NCAs conducting human medicines activities only (n=17)					
Remuneration from procedural activities	36.614	38.263	40.419	41.922	44.161
Remuneration from annual fees	4.771	5.082	5.413	5.796	6.211
NCAs conducting veterinary medicines activities only (n=12)					
Remuneration from procedural activities	1.201	1.465	1.738	2.019	2.047
Remuneration from annual fees	1.004	1.080	1.173	1.294	1.428
NCAs conducting both human and veterinary medicines activities (n=14)					
Remuneration from procedural activities	67.352	70.825	75.651	78.771	83.246
Remuneration from annual fees	9.281	9.901	10.581	11.385	12.261

Option 3

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
All NCAs					
Remuneration from procedural activities	90.945	95.909	102.657	106.683	112.565
Remuneration from annual fees	28.121	30.097	32.318	35.203	38.297
NCAs conducting human medicines activities only (n=17)					
Remuneration from procedural activities	32.067	33.604	35.620	36.832	38.774
Remuneration from annual fees	9.195	9.816	10.506	11.404	12.376
NCAs conducting veterinary medicines activities only (n=12)					
Remuneration from procedural activities	1.201	1.465	1.738	2.019	2.047
Remuneration from annual fees	1.254	1.370	1.507	1.691	1.878
NCAs conducting both human and veterinary medicines activities (n=14)					
Remuneration from procedural activities	57.678	60.840	65.299	67.833	71.744
Remuneration from annual fees	17.671	18.911	20.305	22.108	24.043

Option 3 'Light'

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
All NCAs					
Remuneration from procedural activities	101.648	106.891	114.008	118.768	125.369
Remuneration from annual fees	18.292	19.573	20.968	22.590	24.347
NCAs conducting human medicines activities only (n=17)					
Remuneration from procedural activities	35.771	37.388	39.511	40.979	43.183
Remuneration from annual fees	5.896	6.302	6.734	7.226	7.757
NCAs conducting veterinary medicines activities only (n=12)					
Remuneration from procedural activities	1.201	1.465	1.738	2.019	2.047
Remuneration from annual fees	1.004	1.080	1.173	1.294	1.428
NCAs conducting both human and veterinary medicines activities (n=14)					
Remuneration from procedural activities	64.675	68.039	72.758	75.770	80.139
Remuneration from annual fees	11.392	12.192	13.061	14.070	15.162

EMA budget

Do-minimum

	2020 €'000	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
EMA income						
Total industry fees	306.690	331.761	346.113	362.410	379.544	397.576
Total EU budget contribution	58.881	44.590	45.200	34.000	34.000	34.000
EMA expenditure						
Total expenditure on human and veterinary procedures	95.064	101.725	107.501	114.269	120.436	126.804
Total expenditure on other activities	111.590	143.693	148.895	162.141	167.818	173.264
Total payments to NCAs	135.370	145.891	152.275	160.014	166.765	174.175

Option 1

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
EMA income					
Total industry fees	352.877	368.395	402.100	421.494	441.821
Total EU budget contribution	44.590	45.200	34.000	34.000	34.000
EMA expenditure					
Total expenditure on human and veterinary procedures	101.969	107.752	114.527	120.702	127.078
Total expenditure on other activities	143.693	148.895	162.141	167.818	173.264
Total payments to NCAs	148.355	154.820	162.647	169.481	176.917

Option 2

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
EMA income					
Total industry fees	327.960	344.385	379.196	400.251	423.247
Total EU budget contribution	44.590	45.200	34.000	34.000	34.000
EMA expenditure					
Total expenditure on human and veterinary procedures	103.379	109.223	116.080	122.467	129.084
Total expenditure on other activities	143.693	148.895	162.141	167.818	173.264
Total payments to NCAs	120.224	126.616	134.975	141.188	149.355

Option 3

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
EMA income					
Total industry fees	325.766	347.067	379.196	400.878	424.921
Total EU budget contribution	44.590	45.200	34.000	34.000	34.000
EMA expenditure					
Total expenditure on human and veterinary procedures	103.379	109.223	116.080	122.467	129.084
Total expenditure on other activities	143.693	148.895	162.141	167.818	173.264
Total payments to NCAs	119.066	126.006	134.975	141.886	150.862

Option 3 'Light'

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
EMA income					
Total industry fees	326.927	343.847	379.196	400.883	424.593
Total EU budget contribution	44.590	45.200	34.000	34.000	34.000
EMA expenditure					
Total expenditure on human and veterinary procedures	103.379	109.223	116.080	122.467	129.084
Total expenditure on other activities	143.693	148.895	162.141	167.818	173.264
Total payments to NCAs	119.940	126.464	134.975	141.358	149.716

ANNEX 7: FINAL SUMMARY IMPACT TABLES AND FEE GRIDS

Fee revenue

Total revenue	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
Human medicines					
Procedural fees	143,377	148,055	154,417	159,669	168,240
Annual fees - CAP	175,454	187,081	203,355	217,863	233,374
Annual fees –PhV	11,153	11,286	23,444	23,773	24,105
Veterinary medicines					
Procedural fees	9,159	10,748	12,421	14,163	14,484
Annual fees - CAP	10,242	11,190	12,259	13,669	15,132
Annual fees –PhV	3,051	3,088	3,131	3,175	3,219
Total	352,436	371,448	409,027	432,312	458,554

NCA remuneration

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
All NCAs					
Remuneration from procedural activities	92,426	97,398	104,215	108,409	114,705
Remuneration from annual fees	55,466	59,317	63,454	68,311	73,593
NCAs conducting human medicines activities only (n=17)					
Remuneration from procedural activities	31,965	33,479	35,490	36,741	38,827
Remuneration from annual fees	17,969	19,161	20,433	21,892	23,474
NCAs conducting veterinary medicines activities only (n=12)					
Remuneration from procedural activities	1,357	1,622	1,898	2,180	2,211
Remuneration from annual fees	3,186	3,466	3,775	4,177	4,620
NCAs conducting both human and veterinary medicines activities (n=14)					
Remuneration from procedural activities	59,104	62,297	66,827	69,488	73,667
Remuneration from annual fees	34,311	36,690	39,246	42,242	45,500

EMA budget

	2022 €'000	2023 €'000	2024 €'000	2025 €'000	2026 €'000
EMA income					
Total industry fees	352,436	371,448	409,027	432,312	458,554
Total EU budget contribution	44,590	45,200	34,000	34,000	34,000
EMA expenditure					
Total expenditure on human and veterinary procedures	100,621	106,412	113,218	119,195	125,567
Total expenditure on other activities	143,693	148,895	162,141	167,818	173,264
Total payments to NCAs	147,893	156,714	167,669	176,720	188,298
Variance					
	4,820	4,626	0	2,579	5,425

Medicinal products for human use			unitary full fee	NCA REMUNERATION rapporteur	NCA REMUNERATION co-rapporteur
			€	€	€
Scientific advice	Initial request	level I	35,000	5,000	3,800
	Initial request	level II	44,700	6,700	6,100
	Initial request	level III	54,100	10,500	8,700
	Follow-up request	level I	40,600	8,700	4,500
	Follow-up request	level II	44,700	7,100	6,400
	Follow-up request	level III	60,100	14,900	12,500
Application for marketing authorisation	New active substances		684,900	217,300	189,300
	Known active substances		549,800	153,000	143,300
	Fixed combination		456,500	141,500	83,000
	'Biosimilars'		575,000	236,500	151,700
	Informed consent		26,000	4,900	1,500
	Generics		141,200	40,200	0
	Well established use		624,300	160,600	149,400
	Hybrids		339,700	89,100	89,100
	Compassionate use		541,200	160,600	149,400
	Outside EU Art. 58		541,200	160,600	149,400
	Application for MA patent (G)		22,400	2,400	800
	Application for MA patent (B)		27,600	6,800	1,000
	PIPs	New	38,400	6,700	6,700
	PIPs	Modification	23,500	6,400	5,900
	Waivers	New	13,500	1,800	1,500
	Finalised procedures for compliance check on PIPs		39,100	7,400	6,800
	Compliance checks	Interim procedure	9,000	1,000	1,000
	Compliance checks	Final compliance	9,000	1,000	1,000
'Orphan' Designation	Orphan medicinal product designation procedures		18,200	1,500	1,400

Scientific services	PMF		57,200	8,600	8,600
	PMF	Level I	57,200		
		Level II	51,800		
		Level III	17,300		
		Submitted simultaneously with a new MAA	5,800		
	PMF	Type IA (charged separately)	3,700	0	0
	PMF	Type IB (charged separately)	5,200	1,200	0
	PMF	AU re-certification (no variations) - AU (minor admin fee)	10,400	1,500	1,500
	PMF	Re-certification (AU with major T. II	10,600	1,600	1,600
	PMF	Re-certification (variations T. II)	10,400	1,500	1,500
	VAMF	lvl I, II (merged)	57,200	8,600	8,600
	VAMF	Submitted simultaneously with a new MAA	5,800		
	VAMF	Variations T. I	10,400	1,500	1,500
	Medical device	Initial consultation	198,100	23,500	23,500
	Medical devices composed of substance	Initial consultation	198,100	23,500	23,500
	Medical devices composed of substance	Follow-up	212,000	29,600	29,600
	Medical devices companion diagnostics	Initial consultation	43,800	6,600	6,600
	Medical devices companion diagnostics	Follow-up	31,400	6,300	3,500

	Follow-up	Type II / X	12,500	4,300	3,800
	Follow-up	Type IB	3,400	1,400	0
	Follow-up	Type IA	3,700	0	0
	Traditional herbal	Level I	51,600	6,200	6,200
	Traditional herbal	Level II	33,800		
	Certification for Advanced Therapies (ATMP certification)		186,800	47,400	43,600
Extension of marketing authorisation	Level I Clinical (Extension of marketing authorisation (MA))		161,000	55,300	31,200
	Level II Quality (Extension of MA - no new clinical data)		138,000	45,300	26,600
	Level III Patent Usage (Extension of marketing authorisation 1st year)		161,500	42,200	26,600
Renewals			0	0	0
Non-pharmacovigilance Referrals	Referral - Article 29(4)		83,000	2,800	2,800
	Referral -Article 30		128,200	7,300	6,200
	Referral -Article 31		180,700	13,400	11,400
	Referral -Article 13		262,400	17,600	13,000
	Referral -Article 5(3)		136,700	12,400	12,400
Variations	Type II variations	Quality	12,600	5,500	0
	Type II variations	Clinical safety & safety	13,300	7,600	0
	Type II variations	Clinical indication	99,800	29,400	29,400
	Type II variations	WS Administrative Fee	800	0	0
	Type IB variations		0	0	0
	Type IB	WS Administrative Fee	0	0	0
Pharmacovigilance referrals (Art.31, Art.20, Art.107i)	Pharmacovigilance referrals (Art.31, Art.20, Art.107i)		285,600	29,100	29,100
	1 active substance/combination of active substances and 1 MAH		172,100		

	≤ 2 active substances/combinations of active substances and ≥ 2 MAHs	≤ 2 active substances/combinations of active substances and ≥ 2 MAHs	258,200		
	> 2 active substances/combinations of active substances and ≥ 2 MAHs	3 active substance/combination of active substances and 1 MAH	314,100		
	> 2 active substances/combinations of active substances and ≥ 2 MAHs	5 active substance/combination of active substances and 1 MAH	426,100		
PASS/PSUR	Post-Authorisation Safety Studies (PASS)		43,300	17,100	0
	Number of imposed PASS result procedures started		44,900	18,500	0
	Periodic Safety Update Reports for CAPs (PSURS)		27,000	12,900	0
	Periodic Safety Update Reports for NAPs & CAP/NAP (PSUSA)		27,000	12,900	0
Other	Procedural re-examination		161,500	42,200	26,600
	Pre-submission activities		11,700	2,800	0
Inspections	GMP	In Europe	24,800	6,900	6,900
	GMP	Outside Europe	37,800	12,500	12,500
	GCP	In Europe	37,100	14,700	9,100
	GCP	Outside Europe	44,200	19,600	10,400
	PMF	Distinct inspections	36,100	10,800	10,800
	PMF	Consecutive inspections	36,100	10,800	10,800
	GLP		34,900	13,200	8,700
	Pharmacovigilance inspections		52,700	16,200	10,100
Administrative Fees	Type IA variations		0	0	0
	Transfers (of marketing authorisations between different companies)		3,700	0	0

	Worksharing ADM + other Admin fees (Type IA WS Administrative Fee)		0	0	0
	Export Certificates	Standard requests	370	0	0
	Export Certificates	Urgent requests	370	0	0
	Export Certificates	Withdrawal	370	0	0
	Parallel distribution	Initial Notifications	750	0	0
	Parallel distribution	Annual Updates	450	0	0
	Parallel distribution	Bulk change	450	0	0
	Inspections cancellations		840	0	0
Annual Fees	Centrally authorised products	Level I	185,100	20,100	17,700
		Level II	92,700		
		Level III	46,000		
	Pharmacovigilance		100	0	0

				NCA REMUNERATION	
Veterinary medicinal products			**unitary full fee**	**rapporteur**	**co-rapporteur**
			€	**€**	**€**
Scientific advice	Initial request	level I	20,700	4,300	0
	Initial request	level II	23,700	9,300	0
	Initial request	level III	23,700	6,800	0
	Follow-up request	level I	21,300	6,100	0
	Follow-up request	level II	24,300	10,100	0
	Follow-up request	level III	33,100	15,800	0
	Scientific advice CVMP classification MUMS data		16,600	6,100	0

Marketing Authorisation	New active substances		295,500	107,000	38,100
	Known active substances		267,700	82,100	35,300
	Combination VMP		295,500	107,000	38,100
	Abridged-Hybrid		136,800	30,800	17,900
	Abridged-Informed consent		136,800	30,800	17,900
	Generics (Abridged Generics)		136,800	30,800	17,900
	Reduced immunological generics		140,700	31,600	21,000
	Application under article 138 (opinion for a market outside EU)		238,600	82,100	35,300
Maximum Residue Limit	Establishment of MRL		84,700	21,400	10,300
	Modification or extension of MRL		86,100	17,300	15,800
Re-examinations	LM re-examinations		19,000	3,100	2,400
	EC re-examinations		19,000	3,100	2,400
Referrals	Referral Art 13 Reg 1234/2008 or Referral Art 33(4) Dir 2001/82/EC		152,700	21,100	9,600
	Referral Art 34 Dir 2001/82/EC		209,200	29,200	12,900
	Referral Art 35 Dir 2001/82/EC		209,300	29,200	12,900
	Procedure Art 45 Reg 726/2004 or Referral Art 78 Dir 2001/82/EC		147,200	17,500	7,700
	Procedure Art 30(3) Reg 726/2004		147,200	17,500	7,700
Variations	Variation fee level 1	(ex. Line extensions)	87,800	28,600	8,600
	Variations fee level 2	(ex. type II major)	47,500	9,800	7,600
	Variations fee level	(ex. type II quality)	23,900	3,600	3,600
	Variations fee level 4	Simple assessment	0	0	0
PASS/PSUR	Post-Authorisation Safety Studies (PASS)		37,800	15,400	0
	Periodic Safety Update Reports for CAPs (PSURS)		0	0	0
Other	Transfers of marketing authorisations		3,200	0	0
	Procedural re-examination		188,400	29,700	14,200
	Pre-submission activities		8,200	2,200	0

	Limited market classification		5,200	0	0
Annual Fees	Centrally authorised products	Level I	65,600	17,800	16,400
		Level II	0		
		Level III	16,100		
	Pharmacovigilance		100		