MTAA comment paper on

TGA's Exposure Draft Regulation Impact Statement: Changes to premarket assessment for medical devices

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1.0 Executive summary

The Medical Technology Association of Australia (MTAA) is pleased to provide comment on the Therapeutic Goods Administration's (TGA) Exposure Draft Regulation Impact Statement: Changes to premarket assessment for medical devices.

The medical device industry is committed to improving patient outcomes and welcomes any changes to regulation that better protects public health and safety. These changes should be based on identifiable and demonstrated needs, and MTAA does not believe these needs have been established. It remains of concern that the drivers for the proposed changes to the regulation of medical devices presented in the Exposure Draft Regulation Impact Statement (EDRIS) have been triggered by the perception that current arrangements do not adequately protect public health and safety.

MTAA is concerned that the three options outlined in the EDRIS are not balanced. MTAA strongly agrees that Option 3 is not viable due to the costs and workload involved. However, the packaging of Options 1 and 2 do not allow consideration of the best features of each of the original Proposals presented in the TGA's changes to premarket assessment paper, nor do these options individually address the objectives of the EDRIS.

The Senate inquiries into the PIP breast implant and ASR hip[1] have been cited throughout the EDRIS as evidence supporting the case for increased scrutiny in premarket assessment. As previously discussed in MTAA's comments on the TGA's changes to premarket assessment paper[2], the device failures of the PIP breast implant and ASR hip would not have been identified in premarket assessment, even with the additional rigour and scrutiny proposed.

MTAA is concerned that the EDRIS encourages the perception that increased premarket scrutiny guarantees that medical device failures will not occur in the future, when the proposed changes would not in fact have detected the recent high profile device failures that triggered the need for reform. Proper analysis and greater utilisation of existing postmarket systems are much stronger mechanisms to provide the regulator with all the information required to minimize the risk of identified problems reoccurring.

[1] The Senate Community Affairs Committee Inquiry into the regulatory standards for the approval of medical devices in Australia and the Senate Community Affairs Committee
Inquiry into the role of the Government and the Therapeutic Goods Administration (TGA) regarding medical devices, particularly Poly Implant Prosthese (PIP) breast implants

[2] http://mtaaweb01/docs/submissions/mtaa-response-to-tga-proposal-paper-on-changes-to-premarket-assessment-requirements-for-medical-devices-final.pdf?sfvrsn=2

MTAA continues to support the publication of decisions which promote better public confidence and consistency in the TGA's decision making. However, further stakeholder consultations are required to identify the target audience of the information and the information that would be of most value to meet their needs. The decision report should be a product of the review undertaken by the TGA as part of the application audit and therefore should not be subject to 100% cost recovery from the industry, which may inevitably be passed on to the consumer.

MTAA welcomes the change to Option 2, Proposal C to remove the requirement for TGA conformity assessment for all Australian manufacturers. However, MTAA questions why manufacturers of Class IV IVD have been excluded. MTAA also believes that Option 2 Proposal C can be implemented independently, and in advance of all other reforms.

2.0 About the Medical Technology Association of Australia

MTAA represents the manufacturers, exporters and suppliers of medical technology products in Australia. MTAA represents companies which account for the majority of products listed on the Australian Register of Therapeutic Goods (ARTG) and approximately 75% of the higher risk implantable medical devices products listed on the Prostheses List and used in the Australian marketplace. The member companies cover the spectrum of the industry in Australia, from subsidiaries of major multinational medical technology companies to independent distributors and small to medium sized Australian innovator companies.

3.0 General comments

The medical device industry is committed to improving patient outcomes and welcomes any changes to regulation that better protects public health and safety. These changes should be based on identifiable and demonstrated needs, and MTAA does not believe these needs have yet been established. It remains of concern that the drivers for the proposed changes to the regulation of medical devices presented in the EDRIS have been triggered by the perception that current arrangements do not adequately protect public health and safety.

MTAA is concerned about the way the EDRIS has been presented as the three options described are not balanced. MTAA strongly agrees that Option 3 is not viable due to the costs and workload involved. However, the packaging of Options 1 and 2 do not allow consideration of the best features of each of the original Proposals presented in the TGA's changes to premarket assessment paper, nor do these options individually address the objectives of the EDRIS which are:

"…to provide greater assurance that higher risk medical devices approved do not compromise public health and safety while at the same time:

a. *supporting the timely availability of medical devices to the Australian public;*

b. *minimising unnecessary regulatory burden and associated costs on the medical device industry (as these costs are passed on to users and funders of the health system);*
c. *improving the ability for TGA to target emerging risks in a timely manner; and*
d. *continuing Australia's commitment to promoting alignment of international medical device regulation.*[3]"

MTAA is of the opinion that Option 1, "*take no immediate action to change premarket assessment requirements for medical devices*", encourages the perception that nothing has been done to date to address the recommendations made in the TGA's Blueprint for reform. It should be noted that recent reforms, such as the reclassification of implantable orthopaedic hip, knee and shoulder joints are already increasing the premarket scrutiny of those devices.

The stated primary objective of the EDRIS *"is to provide greater assurance that medical devices approved do not compromise public health and safety*". MTAA questions how Options 2 and 3 to increase premarket scrutiny will address this objective as increased premarket scrutiny will not identify the likelihood of postmarket issues which is when a problem with a medical device will emerge. Options 2 and 3 also fail to support the following EDRIS objectives:

- Timely availability of medical devices to the Australian public as the mandatory audit requirements of Option 2 and the conformity assessment requirements of Option 3 would greatly increase assessment timeframes,
- Minimising regulatory burden and costs as the documentation requirements and costs of the Level 3 audit suggested in Option 2 and the conformity assessment requirements and cost of Option 3 would duplicate the design examination review conducted by a European Notified Body,
- Improved ability for the TGA to target emerging risks as these risks would only be identified once a product has entered the market, i.e. postmarket,
- Alignment with international medical device regulation.

As MTAA previously stated in its response paper to TGA's proposal paper[4], current postmarket systems within the Australian regulatory framework could be better utilised to meet the primary objective of the EDRIS "*to provide greater assurance that higher risk medical devices approved do not compromise public health and safety…".* The objective alludes to the fact that problems with medical devices are identified postmarket. In contrast to pharmaceuticals, the areas where medical devices cause problems are primarily in relation to sporadic manufacturing problems which are not apparent or easily detected at the market authorisation phase, and secondly, particularly in terms of implantable devices, the way they wear over time in the complex environment of the human body.

Furthermore, it remains of concern that the Senate inquiries into the PIP breast implant and ASR hip have been cited throughout the EDRIS as evidence supporting the case for

[3] EDRIS Page 13
[4] http://mtaaweb01/docs/submissions/mtaa-response-to-tga-proposal-paper-on-changes-to-premarket-assessment-requirements-for-medical-devices-final.pdf?sfvrsn=2

increased scrutiny in premarket assessment. As previously discussed in MTAA's comments on the TGA's proposal paper, the device failures of the PIP breast implant and ASR hip would not have been identified in premarket assessment, even with the additional rigour and scrutiny proposed. The incidents relating to PIP implants were identified to be attributable to deliberate fraud which increased regulation would not have prevented[5]. It is also worth noting that the ASR hip (TGA approved in 2003 as Class IIb) was CE marked through self certification and therefore did not undergo Notified Body design examination or TGA assessment. As hip, knee and shoulder replacement implants have since been reclassified to Class III, greater premarket scrutiny is already in place for these devices with these devices now requiring a full design examination in Europe to support a CE mark, followed by a TGA Level 2 audit in order for the device to be supplied in Australia.

MTAA continues to assert that increased premarket scrutiny would not address the reasons for the PIP breast implant and ASR hip high profile device failures occurred. MTAA strongly agrees with the following statement in the EDRIS:

"*No medical device is completely safe, or immune from failure, irrespective of the level of premarket scrutiny it has undergone. It is also generally recognised that medical devices are inherently different from medicines. For instance, it is not possible to accumulate a similar body of clinical trial data at the premarket stage. This makes postmarket surveillance critically important to the effective regulation of medical devices."*

However, MTAA notes the lack of consideration subsequently given to postmarket systems in meeting the objective of the EDRIS. MTAA is concerned that the EDRIS encourages the perception that increased premarket scrutiny guarantees that medical device failures will not occur in the future, when the proposed changes would not in fact have detected the recent device failures that triggered the need for reform. Proper analysis and greater utilisation of existing postmarket systems are a much stronger mechanisms to provide the regulator with all the information required to minimise the risk of recurrence of identified problems.

MTAA continues to support the publication of decisions that will promote better public confidence and consistency in TGA decision making. MTAA suggests that this document does not have to be as extensive as a medicine AusPAR for decisions based on Notified Body assessments (Level 2 audits). Further stakeholder consultations are required to identify the target audience of the information and the information that would be of most value to meet their needs. This gives assurance that the additional effort of this Proposal meets the need of stakeholders thereby providing an effective solution. The decision report should be a product of the review undertaken by the TGA as part of the application audit and therefore should not be cost recovered from industry.

MTAA welcomes the change to Option 2, Proposal C to remove the requirement for TGA conformity assessment for all Australian manufacturers. However, MTAA questions why manufacturers of Class IV IVD have been excluded. MTAA also believes that Option 2 Proposal C can be implemented independently of all other reforms as TGA conformity assessment certificates are usually valid for a five year period and would continue to cover a device if it is transitioned to an EU Notified Body prior to 2015. As it is highly probable

[5] Regulation of medical implants in the EU and UK - Science and Technology Committee

that implementation of the IMDRF[6] Medical Device Single Audit Program will commence in 2014, it is likely that the quality management systems of Australian manufacturers will continue to be audited by the TGA inspectors if Proposal C is implemented. For this reason MTAA sees no reason why the implementation of Proposal C cannot take place well in advance of July 2015.

4.0 Is there a case for increased premarket scrutiny?

MTAA has fundamental concerns that the EDRIS does not provide sufficient evidence to support the need for increased premarket scrutiny. Analysis of the information on the TGA's System for Australian Recalls Actions (SARA) database from 1 July 2012 to 20 May 2013 shows that the majority of recall actions (>60%) conducted are due to lot specific manufacturing issues and other circumstantial faults, such as software glitches, that can only be detected during normal use. These problems would not be identified by the proposed increased premarket scrutiny and can only be detected through the robust postmarket surveillance procedures which are a requirement of supply of medical devices in Australia.

The EDRIS assessment of Option 2 against the objectives states that "*It ensures that higher risk medical devices approved do not compromise public health and safety through the greater scrutiny of a greater range of medical devices"* (through Proposal A).

Analysis of TGA's SARA database found that less than 1% of recall actions on the SARA database were of AIMDs and less than 8% were of Class III medical devices; 0.3% of which were implantable Class III devices. The reasons for recall[7] of these devices were again mostly related to lot-specific manufacturing issues including labeling errors and updates to device instructions to address issues discovered during normal use.

MTAA therefore challenges the rationale for increased premarket scrutiny of AIMD and Class III implantable and long term surgically invasive devices given that, based on the analysis of recall actions, they represent the least number of issues in the market place. It is expected that we would see the least postmarket issues with these high risk devices as they undergo design examination by a conformity assessment body, such as TGA or an EU Notified Body, and are manufactured to the highest standards.

Analysis of the SARA database of recall actions undertaken for Class IIb devices showed that only 0.5% of recall actions conducted during the sampled period were for Class IIb devices identified by Regulation 5.3 or the table of devices suggested to be captured by application audit[8]. TGA has not provided objective evidence for increasing the level of scrutiny applied to the devices listed on page 17 of the EDRIS as the information from the SARA database indicates that these devices are not causing significant problems postmarket.

[6] International Medical Device Regulators Forum (IMDRF)
[7] The reasons for recall were deduced from the information provided on the SARA database.
[8] EDRIS Page 17

A clear and transparent decision making process to as how devices are selected or unselected for mandatory application audit through Regulation 5.3 (or a new legislative instrument) is required for consistency. Any regulatory framework for increased premarket scrutiny should be closely linked to the actual postmarket behavior of a kind of device. In addition, any changes to this list would need to be formally communicated to industry, including objective evidence to support the change.

5.0 Evidence that current systems are working

MTAA has previously asserted that there are existing mechanisms within the Australian regulatory framework that are not being fully utilised and could be used to more closely monitor higher risk devices in the early period in the market or made more transparent to give greater confidence in the regulatory system. These arrangements include:

- Mandatory reporting of adverse events for medical device sponsors
- Mandatory annual reporting (including Australian and worldwide complaint rates), for Class III, AIMD and Class IIb implantable devices
- TGA statutory advisory committees
- Clinical registries such as the National Joint Replacement Registry (NJRR)
- The international vigilance exchange[9]

Analysis of the TGA's SARA database from 1 July 2012 to 20 May 2013 found five recall actions triggered by a higher than expected revision rate reported by the National Joint Replacement Registry.

Postmarket data from the National Joint Replacement Registry is also being used by the TGA to determine if orthopaedic hip, knees and shoulders undergoing upclassification to Class III should be allowed to continue to be supplied in Australia if the NJRR revision rate is higher than expected. The TGA's Orthopaedic Subcommittee[10] also provides advice to the TGA in relation to orthopaedic implants that have been identified through the National Joint Replacement Registry as experiencing higher than expected revision rates.

Analysis of the TGA's SARA database also found three recall actions initiated by sponsors following the results of TGA testing and investigation of an adverse event. In two cases the sponsor initiated recalls because TGA Laboratory testing had identified that batches of an ultrasound gel may have been contaminated with bacteria which could cause patients exposed to the gel to contract an infection.

Medical device sponsors and manufacturers are required to have effective postmarket surveillance systems in place in order to supply medical devices in Australia. It is worth noting that the vast majority of recall actions on the SARA database were initiated voluntarily by sponsors/manufacturers. This demonstrates that theses postmarket feedback systems, including complaint analysis and trending, are effective.

[9] EDRIS page 14

[10] Advisory Committee on the Safety of Medical Devices (ACSMD) Orthopaedic Subcommittee (OSC)group of independent orthopaedic surgeons who provide expert advice to the ACSMD and the TGA on the safety, quality and performance of orthopaedic devices

6.0 Cost Analysis of Option 2

MTAA acknowledges the change to Proposal A in that now only certain Class IIb devices will be selected for application audit as per the table on page 17 of the EDRIS.

MTAA acknowledges the TGA's advice[11] that the amount of $22,974 stated in the EDRIS was quoted in error and the correct figure for Level 3 audit is $16,382 which is independent of the costs related to the generation of an AusPAR.

MTAA notes the estimated cost of a Level 3 audit has increased to $16,382 from the originally estimated $15,000 (a figure based on the cost of an abridged assessment) a difference of $1,382.

The costing methodology used by MTAA takes into consideration the changes to Proposal A and the additional cost of the AusPAR style document in Proposal B. The 2012-13 application and audit fees are used for Level 1 and 2 audits, and the EDRIS Level 3 fee of $16,382 have been used.

6.1 Assumptions for Proposal A

- Costing is based on 2012 ARTG entries.
- No AIMD devices approved in 2012 are combination products – i.e. require TGA Full Conformity Assessment.
- This costing does not take into consideration Australian manufactured devices that would have undergone TGA full conformity assessment.[12]
- All Class llb hip, knee and shoulder joints would undergo Level 3 audit under the reforms.
- The average cost of a notified body design examination report is $10,000.
- 100% of Level 3 audits will require a Notified Body design examination report.
- No abridgement of fees based on the grouping of applications[13].
- Costs do not include application fees.
- Systems and procedure packs have not been considered unless easily identifiable through the text filters as requiring an application audit.
- The AusPAR fee of $1,197 is applied to devices that have undergone Level 2, Level 3 audit and TGA Conformity Assessment decisions.

[11] Advice received by email.
[12] If Proposal C is implemented this costing would be accurate.
[13] EDRIS Page 19 - Grouping of applications

- The AusPAR fee of $215 has been applied to Level 1 audit decisions.

6.2 Submission costing methodology for Proposal A

- 2012 entries were extracted from the ARTG down load.

- The level of audit was assigned as per the EDRIS and the requirements of the Therapeutic Goods (Medical Device) Regulations 2002.

Device Type	Application audit	Class	Basis for selection for audit
Class III medical devices not supported by conformity assessment issued by the TGA or issued under the EU MRA - audit for targeted devices only (Implantable and long term surgically invasive),	Level 2	III	TGMDR 2002 5.3(1)(i)
Class III medical devices not supported by conformity assessment issued by the TGA or issued under the EU MRA - audit for targeted devices only (Implantable and long term surgically invasive),	Level 3	III	TGMDR 2002 5.3(1)(i)
Active implantable medical device (AIMD)	Level 3	AIMD	TGMDR 2002 5.3(1)e
Barrier contraceptives (other than condoms)	Level 1	IIb	TGMDR 2002 5.3(1)(a)
Implantable contraceptive devices	Level 2	III	TGMDR 2002 5.3(1)(b)
Medical devices that are specifically intended by the manufacturer to be used for disinfecting another medical device - audits for hardware devices i.e. autoclave	Level 1	IIb	TGMDR 2002 5.3(2)
Medical devices that are specifically intended by the manufacturer to be used for disinfecting another medical device - audits for disinfecting agents i.e. liquid disinfectants to disinfect other medical devices	Level 2	IIb	TGMDR 2002 5.3(2)
Implantable intra-ocular lenses (posterior lenses)	Level 1	IIb	TGMDR 2002 5.3(1)(g)
Implantable intra-ocular lenses (lenses other than posterior lenses)	Level 2		
Intra-ocular visco-elastic fluids	Level 2	IIb	TGMDR 2002 5.3(1)(g)
Spinal fixation devices	Level 2	IIb	List on page 17 of the RIS
Orthopaedic fixation devices	Level 1	IIb	List on page 17 of the RIS
Bone screws, plates, pins and wires	Level 1	IIb	List on page 17 of the RIS
Finger, wrist and ankle joint prostheses	Level 1	IIb	List on page 17 of the RIS
Artificial bone matrix implants	Level 1	IIb	List on page 17 of the RIS
Non-absorbable implants such as sutures, staples and anchors	Level 1	IIb	List on page 17 of the RIS
Surgical mesh	Level 2	IIb	List on page 17 of the RIS
Long-term invasive vascular access devices, such as implantable ports	Level 1	IIb	List on page 17 of the RIS
Maxillofacial implants	Level 1	IIb	List on page 17 of the RIS
Peripheral vascular stents, biliary stents etc.	Level 2	IIb	List on page 17 of the RIS
Shunts, such as portacaval shunts	Level 1	IIb	List on page 17 of the RIS
Long term implantable devices used in bariatric surgery	Level 2	IIb	List on page 17 of the RIS

a) Class III devices were identified as implantable/long-term surgically invasive using the following text filters on GMDN code description and cross checking against device intended purpose:
   - Implant

- Stent
- Port
- Mesh
- Haemostatic
- Sealant
- Prosthesis (ses)
- Shunt
- PICC + long term
- Clip
- Valve
- Fixation
- Graft
- Suture + absorbable
- Fluid
- Annuloplasty

These ARTG entries were identified as implantable/long tem surgically invasive and assigned Level 3 audit.

All other Class III entries were assigned Level 2 Audit.

b) Combination devices were separated from Class III devices using the following text filters on GMDN description and cross checking against intended purpose.

- Biological
- Animal
- Drug
- Microbial

These devices were assigned Full Conformity Assessment and their cost was not considered for the calculation of audit fees.

c) All AIMD entries were assigned Level 3 audit

d) Level of audit was assigned to Class IIb using the table provided on page 17 of the EDRIS and the following text filters:

- Implant
- Fixation +spinal/spine
- Spine
- Pins
- Ankle
- Bone + matrix
- Anchor
- Port
- Bariatric
- Fixation +orthopaedics
- Plate
- Wires
- Finger/digit
- Suture
- Maxillo…
- Shunt
- Bone +screw
- Spinal
- Prosthesis (ses)
- Wrist
- Staple
- Stent
- Portacaval

e) Class IIb devices requiring audit according to regulation 5.3 were identified using the following text filters:

- Lens
- Disinfectant
- Steril…
- Occular
- Fluid
- Barrier
- Visco
- Eye
- Autoclave
- Contraceptive
- Elasti…..

6.3 Costing result for Proposal A

a) Level of audit and cost for AIMD devices and Class III implantable/long term surgically invasive devices

Class	Number of 2012 ARTG entries	Current state level of audit	Current TGA Fees for level of Audit	Current TGA audit costs	Reformed state level of audit	Reformed state TGA Fees for level of audit	Reformed state TGA audit costs
Class III Combo	21	FCA	$ -	Not Costed	FCA	$ -	Not Costed
Class III non implantable/non long term surgically invasive	186	Level 2	$6,170	$1,147,620	Level 2	$6,170	$1,147,620
Class III implantable/long term surgically invasive	159	Level 2	$6,170	$981,030	Level 3	$16,382	$2,604,738
AIMD	60	Level 2	$6,170	$370,200	Level 3	$16,382	$982,920
Total	**426**			**$2,498,850**			**$4,735,278**

The reformed state total TGA submission costs are **$4,735,278**, which is $459,669 greater that the estimated Level 3 audit costs for AIMD and Class III implanted devices quoted in the EDRIS ($4,275,609).

The figure in the EDRIS is based on the assumption that 261 Class III and AIMD submissions would undergo a Level 3 audit. The actual figure in the EDRIS based on this assumption should be $4,275,702. This figure does not include the remaining Class III devices that would undergo Level 2 audit.

MTAA calculated costs are higher as it is assumed that all submissions for AIMD and Class III implantable and long term surgically invasive devices (LTSI) (46% of all Class III) will undergo Level 3 Audit. This figure is added to the remaining 54% of Class III devices which will continue to undergo Level 2 audit.

Working on the assumption that 100% of Level 3 audits will each require a Notified Body design examination report costing on average $10,000 per report the total cost to industry of Class III and AIMD submission in the reformed state inclusive of design examination report fees is **$6,925,278**.

219 Level 3 audits at $16, 832 each (Class III Implantable/LTSI+ AIMDs) = $3,587,658
219 Design Examination reports at $10000 each = $2,190,000
Subtotal = $5,777,658
186 Level 2 audits at $6170 each (Class III non Implantable/non LTSI = $1,147,620
Total = $6,925,278

Increase in total costs for Class III and AIMDs

Current situation	Reformed State	Difference in total cost	Percentage increase in total costs
$2,498,850	$6,925,278	$4,426,428	177%

Increase in TGA assessment cost for Class III and AIMDs

Current situation	Reformed State	Difference in TGA Fees	Percentage increase in assessment fees
$2,498,850	$4,735,278	$2,236,428	89%

b) Level of audit and costs for class IIb devices

Level of audit for Class IIb	TGA fees for level of audit	Current state number of submissions	Current TGA audit costs	Reformed states number of submissions	Reformed state TGA audit costs
Level 1	$ 3,360	12	$ 40,320	82 (49%)	$ 275,520
Level 2	$ 6,170	7	$ 43,190	84 (51%)	$ 518,280
Level 3	$ 16,382	0	$ -	28	$ 458,696
No audit	$ -	589	$ -	423	$ -
Total		**617**	**$ 83,510**	**617**	**$1,252,496**

In the reformed state 194[14] (31%) of 617 Class IIb submissions would be selected for mandatory audit. 28 of those submissions would be Level 3 audits for hip, knee and shoulder joints that would be Class III. The remaining 166 Class IIb submissions would undergo either Level 1 (49%) or Level 2 (51%) audit based on the table on page 17 of the EDRIS giving a reformed state cost of TGA audit of **$1,252,496**

This figure is significantly different from ($557,726 greater than) the figure quoted for mandatory audits for Class IIb devices in the EDRIS ($694,770). This is because the EDRIS does not consider the upclassification of Class IIb hips, knees shoulders which would be Class III. The percentage split of class IIb devices that will undergo mandatory Level 1or 2 audit is 49/51% which is different from the 70/30% split estimated in the EDRIS.

Working on the assumption that 100% of Level 3 audits will each require a Notified Body design examination report costing on average $10,000 per a report, the total cost to industry of Class IIb submissions in the reformed state inclusive of design examination report fees is **$1,532,496**.

[14] EDRIS costing for class IIb quotes 20% (139) of Class IIb applications received in 2012 which could be affected by the mandatory audit requirements.

Increase in total costs for Class IIb excluding upclassifed orthopaedic devices

Current situation	Reformed State	Difference in total cost	Percentage increase in total costs
$ 83,510	$793,800	$710,290	851%

If Class IIb upclassified devices are not considered the difference in total cost of Class IIb devices in the reformed state would be $710,290 (166 Level 1 and 2 audits).

c) Percentage increase in costs by device class

Class	Percentage increase in TGA costs current vs reformed state
Class III	76%
AIMD	166%
Class IIb*	851%

*****Based on Class IIb Level 1 and 2 audits only (n=166)

d) Percentage increase in TGA and total costs

Current situation	Reformed State	Difference in total cost	Percentage increase in total costs
$ 2,582,360	$ 8,457,774	$5,875,414	228%

Current situation	Reformed State	Difference in TGA Fees	Percentage increase in assessment fees
$ 2,582,360	$ 5,987,774	$3,405,414	132%

These costs increases may not seem significant, but they are not evenly spread across industry. The most impacted companies are those which supply AIMD and Class III implantable or long term surgically invasive devices as they will be required to undergo Level 3 audit and obtain a Notified Body design examination report.

e) Member cost analysis

MTAA members were asked to provide the numbers of submissions for the kinds of devices that currently undergo application audits in accordance with Regulation 5.3. The total cost of the submissions was calculated including the application fee and application audit fee. The calculation was repeated for the proposed application audits and costs of obtaining the technical report for the Level 3 Application Audit was added and the current situation and reformed situation compared.

Current State vs Reformed State	Minimum	Maximum	Average
Cost difference in assessment fees	$0	$313,884	$168,997
Total cost difference including the cost of obtaining a Notified Body Design Examination Report for Level 3 audit	$0	$583,884	$320,406
Total cost difference if AusPAR report costs are recovered from industry	$3,591	$620,341	$349,994

Current State vs Reformed	Minimum	Maximum	Average
Percentage increase in assessment fee	0%	316%	130%
Percentage increase in total costs	0%	489%	236%
Percentage increase in total costs if AusPAR report costs are recovered from industry.	19%	532%	257%

	Minimum	Maximum	Average
Percentage of sponsor applications affected by increase scrutiny	0%	100%	47%

	Minimum	Maximum	Average
Costs due to Design Examination reports required for Level 3 Application Audits	$0	$150,000	$46,000

Members' total submission costs were significantly affected by the proposed changes to premarket assessment with the maximum total cost difference being a 489% increase (average 236%) on the current situation and the main driver being the change of Class III and AIMD devices to Level 3 audit and the $16,382 assessment fee. These costs would be further inflated if the cost of the AusPAR report was recovered from industry making the maximum total cost difference a 532% increase (average 257%) on the current situation.

The documentation requirements for the Level 3 Application Audit also significantly affected costs with the average calculated spend on design examination reports being $46000 (maximum $150,000). As previously discussed, design examination reports are not always generated by all Notified Bodies and provided to the manufacturer. It is of note that currently it is not the TGA's practice to provide design examination reports to manufacturers on completion of a TGA conformity assessment.

f) Summary of costs by audit level current vs reformed state.

	Current State			Reformed State			
Level of Audit	**Kind of device**	**No. of submissions**	**TGA fees**	**Kind of device**	**No. of submissions**	**TGA fees**	**Total costs**
No Audit	Class IIb other than barrier contraceptive, implantable intraocular lens, intraocular visco elastic fluid	598	$ -	Class IIb other than barrier contraceptive, implantable intraocular lens, intraocular visco elastic fluid an devices on the list given on page 17 of the EDRIS.	423	$ -	$ -
Level 1	- Barrier contraceptive - Implantable intraocular lens - Intraocular visco elastic fluid	12	$ 40,320	- Barrier Contraceptives - Medical devices that are intended to disinfect other devices -hardware - Posterior lenses - orthopaedic fixation - bone screws, plates, pins and wires - finger, wrist and ankle joint prostheses - Artificial bone implant matrix - non absorbable implants such as sutures, staples and anchors - L TI vascular devices such as implantable ports - Maxilliofacial Implants - shunts and portocaval shunts	82	$ 275,520	$ 275,520
Level 2	- Class III - AIMD - Medical devices that disinfect other medical devices	412	$ 2,542,040	- implantable contraceptive - medical device intended to disinfect another medical device - liquids - implantable intra ocular lenses other than posterior - intraocular visco elastic fluids - class III non implantable or surgically invasive for long term use - spinal fixation devices - surgical mesh - peripheral vascular stents, billary stents etc - long term implantable devices for bariatric surgery	270	$ 1,665,900	$ 1,665,900
Level 3	N/A	0	$ -	- Class III implantable and LTSI - AIMD - Upclassified Class IIb hip, knee and shoulder	247	$ 4,046,354	$ 6,516,354
FCA	Class III Combo	21	Not costed	Class III Combo	21	Not costed	Not costed
	Total	**1043**	**$ 2,582,360**	**Total**	**1043**	**$ 5,987,774**	**$ 8,457,774**

6.4 Costing result for Proposal B

The EDRIS quotes an estimated AusPAR preparation cost of $1197 per complex decision and $215 for a simple decision.

This costing assumes that all TGA full conformity assessment, Level 3 and Level 2 audits will generate a complex AusPAR and Level 1 audits will generate a simple AusPAR. Device requiring no application audit will not generate an AusPAR.

The estimated cost of publishing decisions would be $661,616 based on 538 complex decisions and 82 simple decisions.

MTAA assumes that the cost quoted in the EDRIS for generating AusPARs is TGA's cost and will not be an industry paid fee.

As previously discussed, the generation of a decision report should be the product of a review conducted by the TGA and hence the cost should not be recovered from industry.

6.5 Cost Impact of Proposal C.

MTAA predicts that more that the estimated 2/3 of Australian manufacturers would opt for TGA not to undertake their conformity assessment. As Australian manufacturers only represent a small proportion of manufacturers the reduction in revenue to TGA of conducting design examinations and audits for Australian manufacturers is relatively small. TGA will easily recover the expected $1,040,936 through the increase in conformity assessment applications for combination products[15] and class IV IVDs.

7.0 Conclusions

Recognising that increased premarket scrutiny has already been implemented through the upclassification of orthopaedic joint replacements, MTAA continues to question if there is a demonstrated need for increased premarket scrutiny based on the information gained from the data mining of TGA's SARA database.

MTAA challenges if the proposed Level 3 audit for AIMDs is warranted, given that less than 1 % of recall actions on the SARA database were for these devices.

MTAA recognises that scrutiny of orthopaedic joint replacement has also been increased through the use of data from the National Joint Replacement Registry to determine if a device should be upclassified with the implementation of the TGA's ACSMD Orthopaedics subcommittee.

Should Option 2 be implemented in full, sponsors of Class III implantable/LTSI devices and AIMDs will be the most greatly impacted by the additional costs of the Level 3 audit,

[15] Drug/device or Animal origin/device

extended evaluation times[16].and the additional cost and time of obtaining a Notified Body design examination report.

MTAA continues to challenge the notion that an increase in premarket scrutiny, by means of the additional review of the Notified Body's design examination report and site audit report for AIMD and Class III implantable/LTSI devices, would improve patient outcomes with these devices.

MTAA asks that TGA provide tangible evidence from its postmarket surveillance systems (or other objective data) that supports the proposed increase in premarket scrutiny for AIMD, Class III implantable and long term surgically invasive devices, and the Class IIb devices proposed to be selected for mandatory application audit in Option 2.

MTAA also questions how the proposed increase in premarket assessment will meet the secondary objective to '*target emerging risks*'[17] ? Risks that have not already been considered by the manufacturer will only emerge when a device is in normal use – i.e. postmarket. Information from the SARA database shows that 12% of recalls were voluntarily initiated to update the device instructions for use to mitigate risks discovered during normal use in specific circumstances that could not have been predicted in the premarket phase.

MTAA also questions how the '*instrument for additional mandatory audits allows risk assessment over time*[18]'? Mandatory application audits check the work conducted by a European Notified Body and hence provides the TGA with assurance that a device meets the requirements of the Essential Principles of safety and performance at the time of the assessment. Mandatory audits cannot detect emerging risks or monitor risks over time as this can only be done using post-market mechanisms.

MTAA is encouraged that TGA has projects underway to encourage healthcare professionals and users of medical devices to report problems to the TGA. MTAA urges the TGA to concentrate efforts on strengthening the currently available postmarket surveillance systems to achieve the objectives of the EDRIS. These systems provide a true assessment of the performance of devices overtime and provide information that can be used to prevent recurrence of identified problems. This is evident from the analysis of TGA's SARA database from 1 July 2012 to 20 May 2013 which found five recall actions triggered by a higher than expected revision rate reported by the National Joint Replacement Registry.

The argument for strengthening postmarket surveillance systems is further supported by information from the SARA database showing that approximately 60% of recall actions were initiated due to manufacturing related inconsistencies and software glitches. These issues would not have been picked up through premarket assessment and are only detected through postmarket surveillance. Quality management system audits conducted by the TGA and EU Notified Bodies ensure that manufacturers of medical devices maintain

[16] 'weeks to months' EDRIS page 42
[17] EDRIS page 42
[18] EDRIS page 42

high standards and have effective postmarket surveillance and feedback systems in place. MTAA supports the work of IMDRF to achieve consistency in quality management system audits through the Medical Device Single Audit program which is developing a standard set of requirements for auditing organisations. The consistency achieved from this set of auditing requirements will build confidence between conformity assessment bodies.

The primary objective of the EDRIS "*is to provide greater assurance that medical devices do not compromise public health and safety*". MTAA urges the TGA to reconsider if the proposed options to increase premarket scrutiny truly do address this objective and will ensure that approved medical devices will not compromise public health and safety.