REVIEW OF EUROPEAN ADMINISTRATIVE LAW; VOL. 13, NR. 3, 61-87, PARIS LEGAL PUBLISHERS © 2020

Mutual Recognition and the Ever-incomplete Internal Market for Pharmaceuticals

Sabrina Röttger-Wirtz*

Assistant Professor of EU Law, Maastricht University

Abstract

This article examines the development of mutual recognition of marketing authorizations for pharmaceuticals, arguing that the sui generis approach to mutual recognition in this policy area is based, first of all, on the harmonisation of regulatory requirements. However, it additionally also required the procedural integration of mutual recognition in trans-national administrative procedures, and institutional innovation. This has created a curious mix of centralized and decentralized authorisation routes with various stages of collaboration and arbitration. In this regard, the creation of the complex, composite procedures in place to facilitate the mutual recognition of pharmaceuticals raises several questions with regard to the judicial and political accountability of the actors involved. The developments and problems described in this article with regard to pharmaceuticals are also mirrored in other risk regulation areas, where mutual recognition seems to require the integration into administrative procedures on intra-administrative and/or EU level, leading to proliferation of sui generis approaches to mutual recognition.

1. Introduction

Pharmaceuticals are extensively regulated in the European Union,[1] and may only be sold after obtaining a marketing authorisation from

* DOI 10.7590/18747982oX16007576818799 1874-7981 2020 Review of European Administrative Law

1 EU pharmaceutical law goes beyond the regulation of market access, also covering other aspects such as the research and development of medicinal products (e.g. clinical trials), as well as post-authorisation safety (pharmacovigilance), harmonised special IP rights (SPC protection), rules on labelling, packaging and advertising. Moreover, it contains rules concerning specific types of pharmaceuticals: advanced therapy medicinal products, orphan medicinal products, and paediatric medicines. Some of these regulatory frameworks also provide for mutual recognition of administrative measures; however, in this article the focus is mainly on the mutual recognition of marketing authorisations. For overviews of the pharmaceutical regulatory framework see: E Jackson, *Law and the Regulation of Medicines* (Oxford 2012); S Shorthose, *Guide to European Pharmaceutical Regulatory Law* (Alphen aan den Rijn 2013); M Manely and M Vickers (eds), *Navigating European Pharmaceutical Law* (Oxford 2015).

a competent authority.[2] Currently, a marketing authorisation can either be granted centrally by the Commission for the whole internal market or at Member State level by competent national authorities, depending on the product in question and the target market. It is within the context of national marketing authorisations that mutual recognition plays a role, in order to facilitate the free movement of goods while ensuring a high level of protection for human health.

However, due to the politically sensitive nature of pharmaceutical policy with its impact on human health, the national health care systems and also matters of industrial policy, mutual recognition did not succeed on the basis of the *Cassis de Dijon* formula alone.[3] From the very beginning of pharmaceutical regulation, automatic mutual recognition of national marketing authorisations met resistance in the Member States, leading to a *sui generis* approach to the free movement of goods.[4] In the area of pharmaceuticals, the European Union has not only adopted detailed substantive rules, but has also set up a complex implementation structure.

This article argues that the progression towards mutual recognition in the pharma area is built on three pillars: (i) harmonisation of regulatory requirements, (ii) the procedural integration of mutual recognition of marketing authorisation decisions and the corresponding administrative activities in transnational administrative procedures,[5] and (iii) institutional innovation, referring to the creation of new bodies or the fundamental re-organisation and re-orientation of existing bodies to facilitate the functioning of these procedures.

First, the historical development of pharmaceutical regulation will be examined in section 2, and subsequently the current mutual recognition procedures will be closely analysed in section 3. The role of the Court of Justice of the European Union will be referred to in section 4, explaining how the Court has taken a measured approach towards Member State discretion in deviating from mutual recognition, by respecting their autonomy to protect public health while strictly enforcing the limits of non-recognition as enshrined in the procedural framework. Based on the analysis in the previous sections, in section 5 it will be critically discussed how the complex procedural and institutional structures affect the rights of the applicant and the accountability of the authorities

---

2 Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use [2001] OJ L 311/67, art 6; Regulation (EC) No 726/2004 of of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency [2004] OJ L 136, art 3.

3 Case C-120/78, *Rewe-Zentral AG v Bundesmonopolverwaltung für Branntwein* [1979] EU:C:1979:42.

4 L Hancher, 'Creating the Internal Market for Pharmaceutical Medicines – An Echternach Jumping Procession?' (1991) 28(4) Common Market Law Review 821-853.

5 See generally on procedural integration of the EU administration: H Hofmann, G Rowe, and A Türk, *Administrative Law and Policy of the European Union* (Oxford 2011) eg 17ff. and 405ff.

involved. Finally, whether one can speak of growing trust between the Member States, and, furthermore, how this trust might impact the future of pharmaceutical marketing authorisations will be explored in section 6.

2. The History of Mutual Recognition of Pharmaceutical Marketing Authorisations in the EU

The extensive regulatory framework ensuring the quality, safety and efficacy of medicines on the internal market has developed progressively over the course of the last century. With scientific progress, the increasing industrialisation of medicine production, and internationalisation of trade, the need to regulate medicine-related risks, including production faults, but also known and unknown side effects, became more pressing.[6] Eventually, the 1961 Thalidomide tragedy, wherein a drug prescribed to pregnant women as a sedative and morning sickness remedy caused severe birth defects and malformations in their babies,[7] was a catalyst for many European countries to subject pharmaceuticals to regulatory regimes requiring marketing authorisation, which, in turn, depended on the ability to prove the quality, safety and efficacy of the medicinal product.

Although regulatory initiatives in the Member States took place around the same time, the different economic, social, administrative and political conditions in the Member States meant that legislation did not develop on the basis of a parallel approach, and diverging regulatory preferences quickly became apparent.[8] These divergences created obstacles for EU-level harmonisation when, upon proposal of the Commission, the Council started discussing the matter in 1962. The compromise agreed upon was a gradual move towards mutual recognition of national decisions, based on the harmonisation of administrative procedures, as well as an agreement on the scientific evidence that would be required from applicants.[9]

---

6 J Feick, 'Regulatory Europeanization, national autonomy and regulatory effectiveness: Marketing authorization for pharmaceuticals', MPIfG discussion paper, No 2/2002, 9.

7 For further information on the Thalidomide scandal see eg: S Krapohl, 'Thalidomide, BSE and the Single Market: An Historical-Institutionalist Approach to Regulatory Regimes in the EU' (2007) 46 European Journal of Political Research 25-46.

8 Feick (n6) 6; National Institute for Public Health and the Environment, 'Minds Open – Sustainability of the European Regulatory System for Medicinal Products', RVIM-Report 2014-0033, 15.

9 L Hancher, 'The European pharmaceutical market: problems of partial harmonisation' (1990) 15 European Law Review 9-33.

2.1. The First Steps in the Direction of EU Pharmaceutical Law

The first step towards European harmonisation of pharmaceutical regulation was taken with the adoption of Council Directive 65/65,[10] which required all Member States to introduce a mandatory marketing authorisation procedure for pharmaceuticals based on an assessment of the criteria of quality, safety and efficacy.[11] It intended to lay the foundations of future mutual recognition of marketing authorisation decisions through a harmonised list of mandatory documentation for a marketing authorisation application. However, the implementation of these general requirements left considerable discretion to the Member States.[12] For example, the Directive mentioned that clinical and pre-clinical studies needed to be submitted, but did not contain concrete requirements.[13]

It took another 10 years to take the next steps towards mutual recognition. First of all, progress was made with regard to the harmonisation of the substantive marketing authorisation requirements. Council Directive 75/318/EEC contained more detailed requirements for trials to prove the safety as well as the efficacy of a medicine,[14] and paved the way towards the approximation of the regulatory systems of the Member States.[15] In addition to this substantive harmonisation, Council Directive 75/319/EEC introduced the Community Procedure, the first collaborative, trans-national procedure to facilitate mutual recognition.[16] Under this procedure, a company that had obtained the marketing authorisation in one Member State, could subsequently apply for approval in at least five other Member States, which would decide whether or not to follow the assessment of the first state.[17]

---

10 Council Directive 65/65/EEC of 26 January 1965 on the approximation of provisions laid down by Law, Regulation or Administrative Action relating to proprietary medicinal products [1965] OJ 22, 369-373.

11 It should be noted that the marketing authorisation requirement applied to proprietary medicinal products and not to generics.

12 J Feick, 'Learning and Interest Accommodation in Policy and Institutional Change: EC Risk Regulation in the Pharmaceutical Sector', ESCR Centre for Analysis of Risk and Regulation (CARR) Discussion Paper 25 (January 2005) 7.

13 J Lisman and J Lekkerkerker, 'Four Decades of European Medicines Regulation: What Have They Brought Us?', (2005) 17(1-2) International Journal of Risk and Safety in Medicine 75.

14 Council Directive 75/318/EEC of 20 May 1975 on the approximation of the laws of Member States relating to analytical, pharmaco-toxicological and clinical standards and protocols in respect of the testing of proprietary medicinal products [1975] OJ L 147, 1-12.

15 Lisman and Lekkerkerker (n13) 75.

16 Second Council Directive 75/319/EEC of 20 May 1975 on the approximation of provisions laid down by Law, Regulation or Administrative Action relating to proprietary medicinal products [1975] OJ L 147, 13-22.

17 L Hancher, *Regulating for Competition – Government, Law and the Pharmaceutical Industry in the United Kingdom and France* (Alblasserdam 1989) 107.

Finally, to support the creation of the Community Procedure, the Directive established the Committee for Proprietary Medicinal Products (CPMP),[18] composed of national representatives and Commission representatives.[19] This committee was set up in order to advise national authorities on the authorisation of medicinal products. Where a Member State raised objections within the Community Procedure concerning the authorisation of the product, these were discussed in the CPMP. Although the CPMP could not take binding decisions, it constituted a significant step towards increasing mutual trust. As Cuvillier explains: 'The formation of this committee (...) was an important milestone. It provided the first EU-level forum for Member State representatives, from which grew networks of contacts as the committee gained more experience working together.'[20] At the same time, a separate Council Decision established the Pharmaceutical Committee,[21] composed of senior members of the Member States' administration with expertise in public health, to advise the Commission on policy issues and to foster further progress towards mutual recognition.[22]

Nonetheless, the industry hardly used the procedure and in the first four years in the 4 cases for which it was used, at least one Member State raised objections to the initial assessment and referred the discussion to the CPMP.[23] Thus, the procedure was not successful and in the eight years it operated only 41 applications were made.[24] In an attempt to reform and revive the procedure, it was renamed the 'Multi-state Procedure', and the number of required receiving Member States was decreased to two.[25] Nonetheless, Member States remained unwilling to accept each other's assessment and to mutually recognize authorisations, so, once again, every procedure contained objections from the receiving states.[26]

---

18 Second Council Directive 75/319/EEC (n16) art 8.

19 ibid (n16) art 11, 13-22.

20 A Cuvillier, 'The role of the European Medicines Evaluation Agency in the harmonisation of pharmaceutical regulation', in R Goldberg and J Lonbay (eds), *Pharmaceutical Medicines, Biotechnology and European Law* (Cambridge 2000) 139.

21 Council Decision 75/320/EEC of 20 May 1975 setting up a pharmaceutical committee [1975] OJ L 147 23.

22 Lisman and Lekkerkerker (n13) 75; Hancher (n9) 13f.

23 ibid (n9) 14.

24 Commission (EC) 'Report from the Commission to the Council on the Activities of the Committee for Proprietary Medicinal Products' COM (1991) 39, 14.

25 Council Directive 83/570/EEC of 26 October 1983 amending Directives 65/65/EEC, 75/318/EEC and 75/319/EEC on the approximation of provisions laid down by law, regulation or administrative action relating to proprietary medicinal products [1983] OJ L 332, 1-10.

26 Commission (n24) 16.; E Vos, *Institutional Frameworks of Community Health and Safety Regulation – Committees, Agencies and Private Bodies* (Oxford 1999) 209.

2.2. Mutual Recognition is Gaining Traction

New impetus to create an internal market for pharmaceuticals came with the Single European Act, aimed at establishing a single market with free movement of goods, at the end of 1992.[27] However, the lack of mutual trust amongst the Member States still formed an obstacle, causing divergent assessments in the authorisation procedures and severe delays.[28] In order to overcome these, the Concentration Procedure was introduced in 1987, which supplemented the Multi-State Procedure.[29] The procedure was compulsory for biotechnological medicines and optional for other innovative or highly technological medicines. The marketing authorisation application was made with a national authority in parallel with the CPMP. The CPMP discussed each application and forwarded its opinion – together with any objections raised by other Member States – to the Member State in which the first application had been made before that state took the final decision. However, the CPMP opinion was not binding on the Member States, and they could still take diverging authorisation decisions.[30] Overall, this procedure proved more successful than previous attempts and national authorisations followed the CPMP's positions more frequently,[31] which can be attributed to the fact that biotechnological medicines had a less extensive regulatory legacy.[32]

2.3. Synchronised Centralisation and Decentralisation

After much debate on the mutual recognition of marketing authorisation procedures, the regulatory framework was subject to a fundamental reform in 1993 that laid the foundations for the current procedural routes for marketing authorisations in the EU. Two diverging procedural routes replaced the previously existing procedures: the Mutual Recognition Procedure[33] and the Centralised Procedure[34]. The first is based on the mutual recognition of national authorisations, while the latter replaces the national authorisations

27 Single European Act [1987] OJ L 169, 1-29.
28 P Cecchini, *The European challenge 1992 – Benefits of a Single Market* (Aldershot 1988) 68.
29 Council Directive 87/22/EEC of 22 December 1986 on the approximation of national measures relating to the placing on the market of high-technology medicinal products, particularly those derived from biotechnology [1987] OJ L 15, 38-41.
30 ibid, art 4; Hancher (n4) 824.
31 ibid, 824; Feick (n12) 10.
32 Vos (n26) 209; RVIM-Report (n8) 17.
33 Council Directive 93/39/EEC of 14 June 1993 amending Directives 65/65/EEC, 75/318/EEC and 75/319/EEC in respect of medicinal products [1993] OJ L 214, 22-30.
34 Council Regulation (EEC) No 2309/93 of 22 July 1993 laying down Community procedures for the authorization and supervision of medicinal products for human and veterinary use and establishing a European Agency for the Evaluation of Medicinal Products [1993] OJ L 214, 1-21.

with an authorisation by the European Commission, valid on the whole internal market.

As argued by Feick, the fact that even the extensive harmonisation of pharmaceutical legislation, including the detailed marketing authorisation requirements, had failed to facilitate mutual recognition ultimately led to the introduction of a Centralised Procedure for at least some products.[35] The Centralised Procedure follows in the footsteps of the Concentration Procedure, and is mandatory for certain innovative medicinal products and optional for others. As it leads to a marketing authorisation for the whole internal market issued by the European Commission and binding upon the Member States, which makes mutual recognition superfluous, it is not discussed in detail here. It should, however, be noted that the CPMP was integrated into a newly created regulatory body, the European Medicines Evaluation Agency (now European Medicines Agency), as central scientific committee, tasked with issuing a scientific opinion on the marketing authorisation for the European Commission. What once was a forum for deliberation in the mutual recognition area, thus became a central organ within centralised decision-making.

However, although the authorisation procedures were partially centralised for innovative products, national procedures and, with them, the mutual recognition of authorisations, also remained in place. The newly introduced Mutual Recognition Procedure (MRP) formed the next stage in the evolution of the Multi-State Procedure. Where a product is marketed in more than one Member State, the procedure facilitates its authorisation via mutual recognition in other Member States of the applicant's choice.[36] The Mutual Recognition Procedure became compulsory for authorisations in multiple Member States on 1 January 1998. In the beginning, the binding arbitration procedure was hardly used, as companies withdrew their application from Member States that raised objections. This system was changed through legislative reform in 2004 to make withdrawal impossible.[37] Moreover, the Mutual Recognition procedure was supplemented in 2004 with the Decentralised Procedure (DCP), which applies where marketing authorisation is sought in multiple Member States, but no national authorisation has been issued yet. The MRP and DCP will be discussed in detail in the following section.

Moreover, the introduction of the Mutual Recognition Procedure has led to institutional innovations: the Member States created the Mutual Recognition Facilitation group, a forum where senior representatives from each Member State met to coordinate proceduralised mutual recognition.[38] This informal

35 Feick (n6) 8.
36 Council Directive 93/39/EEC (n33).
37 Feick (n12) 14.
38 See: Heads of Medicines Agencies (HMA) https://www.hma.eu/89.html, last accessed: 8/5/2020.

group, which was not established through any formal legal act, met from 1995 until 2005 to discuss and resolve problems in mutual recognition and to maintain an overview of the procedures and individual authorisation. The group was replaced in 2005 by the formally established Co-ordination Group for Mutual Recognition & Decentralised Procedures – Human (CMDh),[39] composed of one representative per Member State, with the Commission as observer.

To conclude, what becomes clear from this account of the history of pharmaceutical regulation in the EU is that, although the European Union attempted to interfere at an early stage with the diverging regulatory developments in the Member States and to harmonise the regulatory systems while they were developing on national level,[40] these attempts were obstructed by the Member States and, ultimately, mutual recognition had to be laboriously pursued though harmonisation, procedural integration and institutional innovation. How this complex regulatory construction works today will be closely examined in the next section.

Finally, it should be mentioned that due to the fact that the UK left the Union on 31 January 2020, the UK will be a third country also for pharmaceutical law purposes, after the transitional period until 31 December 2020 in which EU pharmaceutical law remains applicable, has passed.[41] Due to Brexit, the UK has not participated in the CMDh since the 1st of February 2020, and although it could still be a CMS in MRP/DCP procedures, it could not serve as rapporteur.[42] After the transition period, unless there is an alternative agreement, the UK will no longer be part of the mutual recognition of authorisations.[43]

3. Mutual Recognition of Marketing Authorisation Today: The Mutual Recognition and Decentralised Procedure

Today, a marketing authorisation for a medicinal product may be obtained via four procedural routes, depending on where the product is

39 The CMDh is formally established according to art 27 of Directive 2001/83/EC (n2).

40 Feick (n6) 5.

41 See further: European Commission, Notice to Stakeholders – Withdrawal of the United Kingdom and EU Rules for Medicinal Products for Human Use and Veterinary Medicinal Products, REV3, 13 March 2020.

42 The practical implications of this are elaborated on in: CMDh, Practical guidance for procedures related to Brexit for medicinal products for human use approved via MRP/DCP, CMDh/373/2018, Rev. 4, April 2020.

43 For comprehensive guidance on how Brexit affects the regulation of pharmaceuticals, see also: EMA, Practical guidance for procedures related to Brexit for medicinal products for human and veterinary use within the framework of the centralised procedure, 16 March 2020, EMA/478309/2017 Rev. 5.

meant to be marketed and on the nature of the pharmaceutical product in question. These are: purely national procedures (which can be used only if the product is exclusively marketed in this Member State), the Mutual Recognition Procedure or the Decentralised Procedure and the Centralised Procedure. A marketing authorisation is granted for an initial period of 5 years[44] and can be renewed subsequently with unlimited validity or for an additional five-year term, based on a re-evaluation of the benefit risk-balance.[45]

These procedures represent different degrees of integrated administration.[46] In this section, the Mutual Recognition Procedure (MRP) and Decentralized Procedure (DCP) will be analysed, as they constitute the procedurally integrated forms of mutual recognition. Both procedures apply whenever a medicinal product is to be marketed in more than one Member State, and where the nature of the product does not require a central authorisation.[47]

3.1. The three phases of the MRP and DCP Procedure

The MRP and DCP have as their endpoint separate national marketing authorisations in the Member State where authorisation is applied for, while the procedures aim to prevent national authorities from taking diverging decision for the same product.[48] They are hybrid procedures that sit somewhere between national and EU level, depending on the course of the procedure in question and the ability to agree between the Member States, the European level being turned to as an arbitration mechanism. In this regard, Feick has characterised three phases: (i) a national phase where Member States are involved in a process of mutual recognition, (ii) an inter-administrative phase in the coordination group, and (iii) binding supranational arbitration in the EMA and the Commission.[49]

While the procedures largely follow the same trajectory, the core difference between the MRP and the DCP is their starting point. The Mutual Recognition Procedure foresees authorisation in other Member States based on a marketing authorisation already granted in one Member State. Therefore, the procedure is compulsory if a product with an existing marketing authorisation seeks authorisation in another Member State.[50] As a marketing authorisation has

44 Directive 2001/83/EC (n2) art 24(1).
45 ibid, art 24(3).
46 S Röttger-Wirtz and M Eliantonio, 'From integration to exclusion – EU composite administration and gaps in judicial accountability in the authorisation of pharmaceuticals' [2019] 10(3) European Journal of Risk Regulation 396.
47 Directive 2001/83/EC (n2) arts 28-39. The decentralised procedure was introduced in 2004 through Directive 2004/27/EC [2004] OJ L 136, 34-57.
48 Röttger-Wirtz and Eliantonio (n46) 396.
49 Feick (n12) 15f.
50 Directive 2001/83/EC (n2) art 28(2).

already been granted, the Member State with the existing authorisation will act as the reference Member State (rMS). After the rMS has updated its assessment report and documentation where necessary,[51] it forwards the assessment to the other Member States where authorisation is sought (the concerned Member States, cMS). Contrary to this, the Decentralised Procedure is used where a product has not yet received an authorisation in any Member State. As no marketing authorisation has yet been granted, an applicant must first choose a Member State to serve as reference Member State (rMS). The rMS national competent authority will subsequently be tasked with evaluating the product and composing the draft assessment report.[52]

In both procedures, the concerned Member States subsequently recognise the assessment of the reference Member State,[53] and will grant the national marketing authorisation.[54] At this stage, the mutual recognition principle becomes important: in principle, the cMSs have to approve the report received from the rMS and grant a marketing authorisation, the only reason not to do so being potential serious risks to public health.[55] As explained by the European Commission:

'If a concerned Member State is requested to recognise a marketing authorisation granted or an application assessed by the reference Member State it can raise grounds that the medicinal product presents a potential serious risk to public health. Such grounds would have to be fully **justified** in order to ensure that they do not act as an indirect and artificial hindrance to the free movement of goods within the European Economic Area.'[56]

Learning from past experience, in order to limit the exceptional use of this ground for non-recognition, in 2006 the European Commission adopted a guideline that defines the potential serious risks to public health as 'a situation where there is a significant probability that a serious hazard resulting from a human medicinal product in the context of its proposed use will affect public health'[57], while 'serious' relates to 'a hazard that could result in death, could be life-threatening, could result in patient hospitalisation or prolongation of existing hospitalisation, could result in persistent or significant disability or incapacity, or could be a congenital anomaly/birth defect or permanent or prolonged signs

51 ibid, art 28(3).
52 Directive 2001/83/EC (n2) art 28(1) jo 28(3).
53 ibid, art 28(4).
54 ibid, art 28(5).
55 ibid, art 29(1).
56 Commission (EC) 'Notice to Applicants Volume 2A – Procedures for marketing authorisation, Chapter 2 – Mutual Recognition', February 2007, 2. Emphasis in original.
57 European Commission, Guideline on the definition of a potential serious risk to public health in the context of Article 29(1) and (2) of Directive 2001/83/ EC (n2).

in exposed human.'[58] Where a Member State invokes such a risk, detailed explanation has to be provided.[59]

In the Mutual Recognition Procedure, these concerns are discussed between the Member States in the period allotted to recognise the draft assessment report. Where different assessments concerning the potential serious risks to public health persist, this does not lead to a failed mutual recognition, but means that the next phase – the referral of the procedure to the CMDh – is triggered. In the Decentralised Procedure, the rMS will discuss its assessment with the cMSs while it prepares the draft assessment report. Thus, while the rMS will take the lead and conduct a thorough assessment, the procedure leaves more room for collaboration and 'co-decision'[60], than 'mere' recognition of an already existing authorisation,[61] as concerns can be raised by cMSs during the assessment. This will then lead either to consensus and the adoption of national authorisations, or, in case objections persist, a referral to the CMDh.[62]

In the intra-administrative phase, the Member States in the CMDh try to reach consensus and resolve differences in assessment.[63] The CMDh does not adopt a formal decision; however, if consensus on the authorisation is reached, the competent authorities in the cMSs will grant national marketing authorisations.[64] If no consensus is reached within the allocated time of 60 days, the procedure is immediately referred from the CMDh to the EMA for arbitration,[65] which marks the beginning of the supra-national arbitration phase.

The supra-national arbitration takes place at the European Medicines Agency (EMA), where the main scientific committee (the Committee for Medicinal Products for Human Use, CHMP) will provide an opinion on the matter. This scientific opinion is forwarded to the Commission, which will adopt a decision that is binding upon the Member States, after consulting the Standing Committee on Pharmaceuticals under the examination procedure.[66] The Commission Implementing Decision adopted is addressed to all Member States. Therefore, where the Commission decides positively on the application, those Member States where the applicant applied for an authorisation via the Mutual Recognition or Decentralised Procedure are required to follow the Commission and adopt a marketing authorisation.

---

58 ibid.
59 ibid.
60 Opinion of AG Bobek in Case C-557/16, *Astellas Pharma GmbH* [2017] EU:C:2017:957, para 70.
61 Röttger-Wirtz and Eliantonio (n46) 399.
62 Directive 2001/83/EC (n2) art 28(5).
63 ibid, art 29.
64 ibid, art 29(3) jo 28(5).
65 ibid, art 29(4).
66 ibid, arts 32-34.

3.2. Shared administrative supervision: mutual recognition post marketing authorisation

It is not uncommon that a pharmaceutical product also requires regulatory intervention after the marketing authorisation. Due to scientific or technical progress or also safety issues which become apparent once the product is on the market, the medicinal product or its manufacturing process might be subject to change, which consequentially requires an update of the marketing authorisation. Thus, while the authorisation of the product is a very important moment in the life-cycle of a medicinal product, it is only 'one very important "snapshot" in a medicine's life span'.[67] To account for this, the mutual recognition of the marketing authorisation also led to procedural integration in how subsequent changes or additions to the authorisation are dealt with.

A change in the marketing authorisation is called 'variation', and is regulated through a Commission Regulation.[68] Since the Variations Regulation came into force in 2010, variations to the marketing authorisation granted via the centralised and MRP/DCP procedures need to be notified to the competent authorities.[69] Depending on the level of risk these changes entail,[70] they may also require the submission and assessment of clinical and non-clinical data as well as approval, before they can be implemented.[71] In the cases where they concern a product authorised via the MRP/DCP procedures, the approval process is procedurally integrated in a format reflecting the MRP/DCPR procedures:[72] a reference Member State will take the lead in preparing a report and concerned Member States are asked to agree to the findings of the rMS. Disagreement on grounds of a potential serious risk to human health will be solved via referral to the CMDh, or through arbitration on EU level.[73] If variation concerns several marketing authorisations by the same marketing authorisation holder, they can be grouped together and assessed in a single coordinated Work-Sharing Proce-

67 Jackson (n1) 73.
68 Commission Regulation (EC) No 1234/2008 [2008] OJ L 334, 7–24. (The 'Variations Regulation')
69 ibid, arts 8-9.
70 Variations are classified as Type 1A, Type 1B or Type II according to their risk level in terms of quality, safety, or efficacy of the product.
71 Commission Regulation (EC) No 1234/2008 (n68) arts 10 & 16 jo annex IV. Where the marketing authorisation holder wants to introduce changes in the active substance, or the strength, pharmaceutical form or route of administration, it is not considered a mere variation, but an extension (see annex I Variations Regulation). These are evaluated following the same procedure as the original marketing authorisation and can lead to the granting of a new marketing authorisation or modification of the existing authorisation.
72 Commission Regulation (EC) No 1234/2008 (n68) art 10.
73 ibid, art 13.

dure, where one authority (national or EMA) will be chosen to examine the variation.[74]

Next to variations, it might also be necessary to change the marketing authorisation due to safety concerns. Pharmaceuticals are subject to strict surveillance even after the marketing authorisation has been granted: this is called 'pharmacovigilance'. In this context, the Urgent Union Procedure was introduced.[75] The aim of the procedure is to coordinate urgent responses to safety concerns and to ensure that the required level of expertise is involved in the decision-making.[76] The procedure applies to any medicinal product or group of products, regardless of whether they are authorised in the MRP/DCP and/or centralised procedure.

Where on the basis of pharmacovigilance data a Member State or the Commission is considering suspending or revoking a marketing authorisation,[77] the procedure is automatically triggered. A specialised EMA Committee – the Pharmacovigilance Risk Assessment Committee (PRAC) – will examine the safety issue. Within 60 days the PRAC will make a recommendation concerning the need for further measures.[78] If a group of pharmaceuticals subject to this referral includes at least one centrally authorised product, the PRAC recommendation is subject to a CHMP opinion and Commission Decision,[79] which will have to be implemented by the national competent authorities for MRP/DCP products. In case only MRP/DCP authorised products are concerned, the PRAC recommendation is forwarded to the CMDh, which either agrees on the necessary measures with consensus, or arbitration on EU level resulting a Commission Decision.[80]

In contrast to the extensive administrative harmonisation of the authorisation and variations process, the pricing and reimbursement decisions are entirely left to the individual Member States, as article 168(7) TFEU protects the competence of the Member States to define and organise their health policies and

74 ibid, art 20. This reference authority will either be the EMA, if at least one centrally authorized product is included, or a national competent authority, determined by the CMDh, in all other cases. (EMA, European Medicines Agency post-authorisation procedural advice for users of the centralised procedure, 18 May 2020, EMEA-H-19984/03 Rev. 85, 100).

75 Directive 2001/83/EC (n2) 67-128, arts 107i-107k. See further: M Chamon and S Wirtz, 'Complex procedures as hurdle to accountability: verticalization of pharmaceutical enforcement', in M Luchtman and M Scholten, *Law Enforcement by EU Authorities – Political and judicial accountability in a shared legal order* (2017) 141-167.

76 Regulation (EU) No 1235/2010 of the European Parliament and of the Council of 15 December 2010 amending, as regards pharmacovigilance of medicinal products for human use [2010] OJ L 348 1-16, preamble 8-10.

77 Directive 2001/83/EC (n2) art 107i(1).

78 ibid, art 107j(3).

79 ibid, art 107k(3).

80 Directive 2001/83/EC (n2) art 107k.

health care system and prevents extensive harmonisation in this regard.[81] The EU, however, has adopted the so-called Transparency Directive,[82] in order to ensure certain minimum procedural requirements for the national pricing and reimbursement decisions including time limits, the requirement to give reasons and access to judicial review, in order to safeguard the free movement of goods and prevent protectionism of the national pharmaceutical industry in the pricing and reimbursement decisions. However, there are large disparities between the pricing of pharmaceuticals in the Member States.[83] Although, admittedly, pharmaceutical prices can influence each other, as most Member States use External Reference Pricing (ERF), which takes into account the price of the product in (a basket of) other states.[84] Moreover, reimbursement decisions, which affect the pricing, rely on a Health Technology Assessment (HTA) in most Member States, which examines the added value and innovativeness in relation to treatments already on the market.[85] HTA's are not mutually recognized, but there is increasing regional cooperation between the Member States, and the EU fosters the development of common HTA methodologies in the EUnetHTA.[86] Moreover, a proposed Regulation aims for further streamlining of the Health Technology Assessment.[87]

Due to the differences in pricing, parallel trade in pharmaceuticals – where a trader buys medicinal products marketed in a Member State with low prices to sell them in a Member State with high prices – occurs. This raises administrative problems, as the product has been authorised specifically for the Member State in which it was bought. The parallel import generally concerns products where an authorisation exists for the same or for a similar product in the state

---

81 The Commission has, however, fostered dialogue between Member States, for example in the Pharmaceutical Forum (a platform for exchange on ministerial level running from 2005-2008), which had a Working Group on Pricing and Reimbursement, producing 'Guiding principles for good practices implementing a pricing and reimbursement policy'.

82 Council Directive 89/105/EEC of 21 December 1988 relating to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of national health insurance systems [1989] OJ L 40, 8-11. A proposed revision of the Directive was abandoned in 2015 due to lack of political support (Withdrawal of Commission proposals [2015] OJ C 80, 17-23).

83 A study conducted for the European Parliament shows that prices of pharmaceuticals (based on a basket of 150 medicines) vary across EU Member States with the national averages differing by up to 25%. P. Kanavos and others, *Differences in costs of and access to pharmaceutical products in the EU*, Study for the European Parliament IP/A/ENVI/ST/2010-12 (2010).

84 Manely (n1) 112; Kanavos and others (n83) 36.

85 Manely (n1) 112; Kanavos and others (n83) 41ff.

86 European Commission, Impact Assessment – Strengthening of the EU Cooperation on Health Technology Assessment (HTA), Brussels, SWD(2018) 41 final, 20ff.

87 Commission (EC) 'Proposal for a Regulation of the European Parliament and of the Council on health technology assessment and amending Directive 2011/24/EU' COM (2018) 051 final, 31 January 2018.

to which they are imported.[88] In these cases, the importer can make use of a simplified procedure in order to obtain a parallel import license.[89]

3.3. The MRP and DCP in perspective: the transnational context and their use in practice

Examining the Mutual Recognition and Decentralized Procedure through the lens of transnational administrative acts reveals the difference in approach between these two procedures. De Lucia identified four types of transnational acts within EU law: i) authorisations with automatic transnational effects; ii) joint decisions in composite procedures with all Member State administrators (and sometimes the Commission) involved; iii) authorisations subject to recognition and iv) mutual recognition in parallel.[90]

The Mutual Recognition Procedure, in this typology, falls in the third category of authorisations subject to recognition, 'made up of two or more interconnected authorisations issued in the legal systems of each Member State',[91] the transnational effect being that the second Member State relies on the examination of the first. Within this category of transnational administrative acts, pharmaceuticals represent a variation as the autonomy of the second Member State is limited through the negotiation in the CMDh and the arbitration by the Commission.[92] The Decentralised Procedure falls into category four, the mutual recognition in parallel, which unites elements of the 'authorisation subject to recognition' with elements of the 'joint decisions'.[93] According to de Lucia, this combination of consensus forming on the basis of the assessment of one Member State is conducive to 'the preventative aligning of the content of each authorisation.'[94] Indeed, although both the MRP and DCP are mutual recognition-based procedures, in the DCP the emphasis is on "mutual" whereas in the MRP it is on "recognition", without much room for collaboration. Or, as Advocate General Bobek explained: '[I]n a Decentralised Procedure, all of the Member States participate in the elaboration of their decision at the same time. To put

88 The possibility to import essentially similar products is confirmed in Case C-104/75 *De Peijer* [1976] EU:C:1976:67.

89 See further: Commission (EC) 'Communication on parallel imports of proprietary medicinal products for which marketing authorisations have already been granted' COM (2003) 839 final, 30 December 2003.

90 L De Lucia, 'From Mutual Recognition to EU Authorization: A Decline of Transnational Administrative Acts' [2016/1] Italian Journal of Public Law 90-114.

91 ibid, 97.

92 ibid, 98.

93 ibid, 99.

94 ibid, 99.

it metaphorically, cooking with friends is not the same as sharing meals that have already been prepared'.[95]

To provide some context around the past and present use of these procedures, it should be noted that the Centralized Procedure, which takes place at EU level, saw 59 applications in its year of introduction (2001), which increased over time, reaching 90 in 2007.[96] In recent years, the number was around the 100 applications mark, with an increase from 2014 (100), 2015 (111) and 2016 (114), and then a decrease to 90 in 2017 and 84 in 2018.[97] For the sake of comparison, in 2007 827 MRP/DCP procedures were finalized, and since 2008 the number has always exceeded 1000, with a peak of 1777 in 2010 and around 1300 finalized procedures since 2016 (again with a peak of 1515 in 2017).[98] Thus, the mutual recognition-based procedures by far outweigh the centrally authorized products. As explained by Hervey and Mc Hale: 'the authorisation and approval of new pharmaceuticals is still, in principle, basically a matter for national authorisation.'[99] However, the centralized marketing authorisation has also led to the adoption of a myriad of guidance documents concerning the regulatory requirements by the CHMP, leading to an indirect harmonisation of the regulatory requirements of national and MRP/DCP procedures.[100]

Within the mutual recognition-based procedures, the number of DCP procedures has significantly outweighed the number of MRP procedures since 2008. While in 2007, 441 MRP and 386 DCP procedures were finalized, in 2008 this changed to 411 MRP and 734 DCP procedures, and 332 MRP and 996 DCP procedures in 2019.[101] To assess this in the context of a Member State, the German competent authority Bfarm in 2019 received 127 purely national applications (all for already known active substances), and was involved in 943 DCP procedures (286 as rMS) and 85 MRP procedures.[102]

---

95 Opinion of AG Bobek in Case C-557/16, *Astellas Pharma GmbH* (n60), para 49.

96 See: Commission (EC) (Pharmaceutical Committee) 'Study on the experience acquired as a result of the procedures for authorisation and monitoring of medicinal products for human use' 8 March 2018 https://ec.europa.eu/health/sites/health/files/files/pharmacos/news/emea_final_report_vfrev2.pdf [accessed 17/08/2020].

97 The numbers are total applications by medical products. (as opposed to applications by active substance). See European Medicines Agency (EMA), Annual Report 2018 https://www.ema.europa.eu/en/documents/annual-report/2018-annual-report-european-medicines-agency_en.pdf [accessed 17/08/2020].

98 CMDh statistics 2019 https://www.hma.eu/fileadmin/dateien/Human_Medicines/CMD_h_/Statistics/2019_Annual_CMDh_Statistics.pdf [accessed 17/08/2020].

99 T Hervey and J McHale, *European Union Health Law: Themes and Implications* (Cambridge 2015) 289.

100 I want to thank the anonymous reviewer for rightfully pointing this out.

101 CMDh statistics 2019 (n98).

102 Bundesinstitut für Arzneimittel und Medizinprodukte (BfArM) https://www.bfarm.de/SharedDocs/Downloads/DE/Service/Statistik/AM-Statistik/stat-2019-internet.pdf?__blob=publicationFile&v=4 [accessed 17/08/2020].

With regard to how often the referral stages are triggered, a study by Ebbers et. al. provides some insight.[103] The study assessed the applications via the Mutual Recognition and Decentralised Procedures from January 2006 until December 2013 and found that within this period, 2822 MRP and 7570 DCP, thus a total of 10392 procedures, were finalized. Among these procedures, 3,6% (377 procedures) resulted in a referral, of which the majority (272 procedures) ended with a consensus in the CMDh and 105 in the supranational arbitration by the Commission via the EMA. As the referrals should only be triggered where based on a potential serious risk to human health, it is interesting to note that only 19% percent of the procedures where a referral was triggered ended with the refusal of the marketing authorisation.[104]

4. The Court of Justice's measured approach

The previous discussion made clear that Member States were and still seem to be reluctant with regard to automatic mutual recognition of pharmaceutical marketing authorisations; moreover, that the harmonisation of technical and scientific requirements, procedural integration and institutionalisation to enhance the cooperation between the competent authorities, were necessary to at least reach the *status quo*. In this section, the role of the Court of Justice of the European Union in this process towards mutual recognition will be examined.

4.1. Laying the foundations for the sui generis mutual recognition approach in the pharmaceutical area

First of all, it should be emphasised that the regulation of pharmaceuticals precedes the 1978 *Cassis de Dijon* ruling,[105] and thus was still firmly rooted in the Old Approach logic of maximum harmonisation rather than mutual recognition.[106] When the Court ruled the *Cassis de Dijon* case – which made possible the free marketing of goods lawfully marketed in one Member State, in another Member State –, one might have expected this to help alleviate the stalemate in the mutual recognition of pharmaceutical authorisations. Indeed, based on the *Cassis de Dijon* spirit, the European Commission,

---

103 H Ebbers, 'An analysis of marketing authorisation applications via the mutual recognition and decentralised procedures in Europe'(2015) 71(10) European Journal of Clinical Pharmacology 1237-44.

104 However, as also noted by Ebbers, the study did not account for cases where an MA was granted but where patient groups or indications were excluded due to concerns raised. See: Ebbers and others (n103) 1241.

105 Case C-120/78 *Rewe-Zentral AG v Bundesmonopolverwaltung für Branntwein* (n3).

106 Feick (n12) 11.

in its 1985 White Paper on Completing the Internal Market, had aimed at achieving the completion of the internal market – also for pharmaceuticals – by 1992.[107]

However, in *Cassis de Dijon,* the Court – in accordance with the Treaty – also made clear that national laws creating obstacles to the free movement of goods are acceptable where they are necessary to protect public health.[108] Indeed, the Courts' case law at the time, such as the *De Peijper* case,[109] did not force automatic mutual recognition upon the Member States, but allowed for national authorisation regimes subject to the conditions of the Treaties, including due regard to the proportionality principle.[110] As Hancher explained in 1991, where Member States invoked the public health exception or consumer protection, especially in scientifically complex questions, the Court 'preferred to err on the side of caution'.[111] She concludes that 'although the Court is prepared to narrow the scope of residual national measures (...) it is unlikely to require automatic mutual recognition'.[112]

Thus, while the Court acted as a catalyst for the free movement of goods through the mutual recognition doctrine, it did not neglect potential public health risks, which, in turn, became the roadblock to automatic mutual recognition within the pharmaceutical area. Although the Court did not actively foster automatic mutual recognition, it did not remain silent on the question in how far Member States could invoke public health reasons to deny mutual recognition within the established procedural frameworks.

4.2. Colouring within the procedural limits

With regard to the Mutual Recognition procedure, in 2008 the *Synthon* case gave the Court the opportunity to assess the limits of the public health exception to the free movement of goods, as it was asked to assess the discretion enjoyed by a Member State to refuse mutual recognition of a marketing authorisation in the Mutual Recognition Procedure.[113] The case concerned a special form of marketing authorisation via the 'abridged procedure', used for generic products.[114] This procedure relieves the applicant of the

---

107 Commission (EC) 'Completing the Internal Market. White Paper from the Commission to the European Council' COM (85) 310 final, 14 June 1985, annex, 17-18. See also: Hancher (n4) 822; Vos (n26) 210.

108 Case 120/78 *Rewe-Zentral AG v Bundesmonopolverwaltung für Branntwein* (n3), para 8. At the time, art 36 EEC Treaty.

109 Case 104/75 *De Peijer* (n88).

110 Hancher (n4); Feick (n12) 10; Vos (n26) 210.

111 Hancher (n4) 829.

112 ibid, 831.

113 Case C-452/06 *Synthon* [2008] EU:C:2008:565.

114 Directive 2001/83/EC (n2) art 10(1).

duty to submit certain studies where they can show that the product is 'essentially similar' to an already authorised product. In the case, the Danish authority had granted the company Synthon a marketing authorisation for its product, which was based on data submitted by SmithKlein for the originator product. The Danish authority found those products to be essentially similar; therefore, Synthon could rely on the data submitted for the originator product. When Synthon applied for mutual recognition of the Danish authorisation, the other Member States, and especially the UK, denied the similarity of the products and refused to recognize the Danish authorisation.

The Court confirmed, in accordance with Article 28(4) of Directive 2001/83, that only a risk to public health within the meaning of Article 29(1) entitles a concerned Member State to object to a marketing authorisation and that, if such objections are raised, the foreseen procedures must be followed.[115] Thus, the Court concluded: 'If a Member State which was asked to recognise an authorisation already granted by another Member State could make that recognition subject to a second assessment of all or part of the application for authorisation, that would deprive the mutual recognition procedure established by the Community legislature of all meaning and seriously compromise the attainment of the objectives of Directive 2001/83 such as, in particular, the free movement of medicinal products in the internal market.'[116] Moreover, the Court clarified that the failure to recognize the authorisation under these circumstances constitutes a sufficiently serious breach of EU law, which can trigger the liability of the Member State in question for damage caused.[117]

The ruling in the *Synthon* case drew from the opinion of Advocate General Bot,[118] who had examined the nature of the Mutual Recognition Procedure in detail, stating that it is based on harmonisation of the marketing authorisation conditions,[119] as well as 'mutual confidence between the Member States'.[120] AG Bot explained that, therefore, the Member State has to refrain from carrying out or repeating any examination of the substance of the application.[121] Its powers are 'reduced to the strictly legal aspect of the application'[122] and it may only refuse recognition on the basis of a potential risk to public health, which is strictly interpreted,[123] and 'which prevents it exercising any discretionary power.'[124]

---

115 Case C-452/06 *Synthon* (n113), paras. 27, 28 & 29.
116 ibid, para 32.
117 ibid, para 46.
118 Opinion of AG Bot in C-452/06 *Synthon* ECLI:EU:C:2008:565, ECLI:EU:C:2008:393.
119 ibid, para 65.
120 ibid, para 66.
121 ibid, para 70.
122 ibid, para 70.
123 ibid, para 74.
124 ibid, para 71.

The margin of discretion of Member States in the Decentralised Procedure was assessed in a similar manner in the *Astellas Pharma* case.[125] According to the Court, the DCP ends where the agreement of all concerned Member States is reached in the assessment phase, which is acknowledged by the reference Member State.[126] The Court clarified that 'once that general agreement is acknowledged, the competent authorities of those Member States may not, when making their decision on the placing on the market of that medicinal product in their territory, call into question the outcome of that procedure.'[127] According to the Court, which referenced the *Synthon* case, any other interpretation would go against the wording of the Directive and 'would deprive the decentralised procedure of all meaning.'[128] The opinion of AG Bobek in this case stresses that the obligation to mutually recognize in the Decentralised Procedure only arises once the Member States have reached an agreement, as before, there is simply no decision to recognise.[129] This is in contrast to the MRP, where an authorisation by the reference Member State exists. However, once the agreement on the authorisation has been reached, AG Bobek also concludes that Member States are bound and 'cannot unilaterally start revisiting and re-assessing those very same documents.'[130]

Thus, while historically the Court left ample room for Member States to invoke public health reasons to block mutual recognition of pharmaceutical marketing authorisations, the more recent case law that assesses national objections in the established substantive and procedural frameworks reinforces the limitations to Member State discretion. One can expect this line of reasoning, that strictly enforces mutual recognition within the limits established by the procedure, to be supported by national administrative courts as well. This is confirmed, for example, by a ruling of the German Federal Administrative Court acknowledging that the competent authority of the concerned Member State is neither obliged nor entitled to review the assessment of the reference Member State, unless in case of a serious risk to human health.[131]

---

125 Case C-557/16 *Astellas Pharma GmbH* (n 60). In the case, the concerned Member State did not refuse the assessment of the reference Member State as such, but concerned the data exclusivity period of the originator product that the generic company in question wanted to use as reference product. Thus, the argument was essentially that the generic could not be authorized because the originator was still protected.

126 ibid, para 25.

127 ibid, para 26.

128 ibid.

129 Opinion of AG Bobek (n60), para 53.

130 ibid, para 54.

131 BVerwG, Urteil vom 19.09.2013 - BVerwG 3 C 22.12, ECLI:DE:BVerwG:2013:190913U3C22.12.0. The case concerns a veterinary medicinal product, but the procedure is the same as for human medicinal products.

5. A critical look at the status quo of mutual recognition of pharmaceutical marketing authorisations

Although the marketing authorisation of pharmaceuticals has witnessed extensive substantive harmonisation as well as progressing procedural integration, which has gone hand in hand with institutional innovation, the biggest caveat is, of course, that the internal market of pharmaceuticals and true free movement of goods has still not been achieved, even 55 years after the adoption of the first piece of legislation. While Hancher in the 1990s compared the process of creation of the internal market to the 'Echternach Jumping Procession', going three steps forward and two steps back,[132] by now the complex procedural structures created and the quite unique 'institutional layering'[133] with a multitude of procedural routes for the authorisation of one type of product, seem to have become a dogma.

The procedural cooperation in the MRP and DCP has led to what Chiti describes as 'Horizontal Opening of the Member States Administrative Laws'.[134] In this regard, Chiti points out that the fact that the applicant can choose the reference Member State and also apply for mutual recognition in selected concerned Member States, will lead to competing national legal frameworks.[135] Indeed, concerns are voiced in the literature that the procedures foster competition between the national authorities not only with regard to the application fees, but also the speed and even 'strictness' of the assessment in the approval procedure.[136] Some authors have expressed concern that this will lead to a 'race to the bottom', which might negatively affect the human health protection that the regulatory framework aims to achieve.[137]

Moreover, the established framework brings challenges with regard to applicant and third party rights, as well as questions of accountability. Both the Mutual Recognition and the Decentralised Procedure have to be classified as composite administrative procedures where administrative decisions are based on the formal and informal input of administrative actors from various jurisdictions.[138] Such composite procedures can pose challenges to general principles

---

132 Hancher (n4).

133 Feick (n12) 19.

134 E Chiti, 'Is EU Administrative Law Failing in Some of Its Crucial Tasks?' (2016) 22(5) European Law Journal 579f.

135 ibid.

136 M Pilgerstorfer, 'EU law and policy on pharmaceuticals marketing and post-market control including product liability', in T Hervey, C Young, and L Bishop (eds), *Research Handbook on EU Health Law and Policy* (Cheltenham 2017) 164.

137 ibid.

138 For a more detailed discussion of the composite nature of the pharmaceutical marketing authorisation procedures, see: M Eliantonio, 'Judicial Review in an Integrated Administration: the Case of "Composite Procedures"' (2014) 7 Review of Administrative Law Journal 65-102; Röttger-Wirtz and Eliantonio (n46).

of administrative law. For example, Mendes and Eckes argued that these complex, multi-actor and multi-level procedures are prone to create gaps in procedural protection, such as the right to be heard.[139] With regard to the Mutual Recognition and Decentralised Procedure, the reference Member State will be the point of contact for the applicant, and will transmit questions or information from the concerned Member States.[140] Thus, these procedures also include an established communication channel. Moreover, the procedural framework foresees participation rights for the applicant: in the CMDh stage where Member States aim to find agreement concerning objections raised by at least cMS, the applicant has the right to an 'opportunity to make his point of view known orally or in writing.'[141] The same right is also granted where the arbitration stage at the CHMP is reached;[142] additionally, the applicant who receives a negative CHMP opinion can request re-examination.[143] Overall, the right to be heard seems to be sufficiently protected in these administrative procedures.[144]

Another potential impact of the composite nature of these procedures might be that they negatively affect the judicial accountability.[145] In this regard, the MRP and DCP procedures, with their complex and variable authorisation routes – sometimes with agreement between the Member States, sometimes with involvement of the CMDh or even arbitration by the CHMP with a Commission decision – also leads to divergence in the level of judicial protection.[146] While the marketing authorisation decisions taken by the individual Member States can be challenged in the national courts of the respective States, it is, however, highly unlikely that the national court in a concerned Member State can review the assessment of the reference Member State on which the decision is based due to the territorial nature of judicial review and the preparatory nature of the report.[147] Also, the referral of the procedure to the CMDh stage creates gaps in the judicial reviewability, arising from the intra-administrative character of the body and the fact that the CMDh does not take a formal decision.[148] Finally,

---

139 J Mendes and C Eckes, 'The right to be heard in composite administrative procedures: lost in between protection?' (2011) 36 European Law Review 651-670.

140 See eg: Commission (EC), Notice to Applicants Volume 2A – Procedures for marketing authorisation, Chapter 2 – Mutual Recognition, February 2007, 17: 'All dialogue between the parties involved should be channelled through the reference Member State.'

141 Directive 2001/83/EC (n2) art 29(3).

142 ibid, art 32(3).

143 ibid, art 32(4).

144 See also: K Rummel, 'Verfahrensrechte im europäischen Arzneimittelrecht' (2016) 52 Beiträge zum Transnationalen Wirtschaftsrecht Heft.

145 Eliantonio (n138).

146 This is argued in detail in: Röttger-Wirtz and Eliantonio (n46). See also: U Gassner, 'Europäisches Arzneimittelverwaltungsverfahrensrecht – Praxisdefizite und Reformoptionen' (2019) 5 *Pharmarecht* 209-214.

147 Röttger-Wirtz and Eliantonio (n46) 404-405.

148 ibid, 405-407.

where the procedure is referred to the CHMP, the opinion cannot be directly challenged, but only reviewed, in a challenge against the final Commission Implementing Decision.[149] However, this option exists only for the applicant and not third parties (such as a competitor or the owner of the originator product in a generic authorisation), and these parties only have the – quite fragile – option of challenging the Commission Implementing Decision through a preliminary question of validity.[150] Thus, overall the MRP and DCP procedures create a 'roulette wheel of access to judicial review'[151] that the applicant has no control over once launched.

In addition, similar problems as identified for the judicial accountability also hold true for the political accountability in composite procedures. As explained by Hofmann, '(p)arliamentary control of network administration is exercised by regional and national parliaments as well as the EP [*European Parliament*]. Each, however, only has control options over its respective administrations. Administrations linked by networks exchanging information and being integrated into composite procedures easily escape control mechanisms established through parliamentary inquiry structures and ombudsmen.'[152] Even if a national parliament might question its national competent authorities involvement in and the outcome of a specific in the MRP/DCP procedure, it is questionable what meaningful remedies would exist, given that the national authorities' discretion is severely limited, as was explained in the previous section.

6. Growing mutual trust: where are the limits?

After having examined the past and present of the mutual recognition of pharmaceutical marketing authorisations, one is of course bound to question how the mutual trust that forms the basis of the procedures has developed over time and where this might lead in the future. The procedural integration and institutional innovation described in this article aspires to 'transform conflict into cooperation'.[153] At the same time, the preceding harmonisation of substantive requirements is meant to provide a foundation for mutual trust. Thus, although historically the pharmaceutical market integration met several hurdles and failures, these steps, and the procedural and institutional innovations they entailed, provided an instructional framework surrounding

149 ibid, 407-409.
150 ibid, 409.
151 ibid, 410.
152 H Hofmann, 'Decision-making in EU Administrative Law – The Problem of Composite Procedures' (2009) 61 Administrative Law Review 218.
153 De Lucia (n90) 102.

the administrative and regulatory actors involved.[154] Alongside increased understanding of the different national practices and the common development of best-practices, an element of affective learning and trust building also took place.[155]

To a certain degree, the mutual recognition-based procedures, as well as the Centralised Procedure, are founded in a cost optimization rationale that prevents the duplication of risk assessment.[156] However, the procedural integration and centralisation of the marketing authorisations also requires commitment and capacity from the national authorities. Writing about the Croatian experience of joining the EU and therefore the regulatory framework for pharmaceuticals, Škrnjug et. al. discuss several costs and benefits: while joining the EU led to a 45% increase of granted marketing authorisations in Croatia, and thus positively affected the accessibility of medicines, the participation in the MRP/DCP requires the 'establishment of internal mechanisms and structures as well as strengthening of specific expert teams for administration and assessment'.[157]

Of course, from an external perspective it is difficult to establish in how far the mutual trust between the Member States has increased. A good indicator might be the number of referral procedures triggered and how this has evolved over time. Notably, the number of referrals declined from 14,5% in the year 2006 to only 1,6% in 2013.[158] Looking at recent numbers, the referral rate has decreased even more to below 1% from 2016 (0,9%) until 2019 (0,8%).[159] Overall, it thus seems reasonable to conclude that the trust and the sincere cooperation between the Member States has significantly improved. Ebbers et. al. attribute the decreasing referral number to 'regulatory learning' not only to the adoption of the Commission guideline on serious risks to public health,[160] but also to companies improving their applications and being more strategic about withdrawing applications that raise concerns or only applying in selected Member States.[161] Interestingly, in the period between 2006 and 2013 8,6% of the MRP and 1,8% of DCP procedures led to a referral, which means that it was five times more likely that a referral was triggered in the MRP than in the DCP.[162] The fact that MRPs are far more likely to lead to a referral, according to Ebbers et. al., may be explained by the reference Member State being more

154 Feick (n12) 23.
155 ibid.
156 Cuvillier (n20) 147.
157 I Škrnjug et. al., 'Mutual recognition in the European system: A blueprint for increasing access to medicines?' (2019) 106 Regulatory Toxicology and Pharmacology 270-277.
158 Ebbers and others (n103) 1239.
159 CMDh Statistics, 2019 https://www.hma.eu/fileadmin/dateien/Human_Medicines/CMD_h_/Statistics/2019_Annual_CMDh_Statistics.pdf [accessed 17/08/2020].
160 Ebbers and others (n103) 1241.
161 ibid, 1241.
162 ibid, 1239.

willing to change its assessment in response to concerns raised by other Member States when no marketing authorisation is in place yet, but may also be partially attributed to companies having more leeway to withdraw applications in the first assessment phase of the DCP.[163]

One might wonder whether automatic mutual recognition might ever become feasible in this area. As argued by Feick, 'the MRP/DP protects the interest of national authorities in regulatory autonomy and organisation continuity'[164] and, looking back at the historical development of these procedures, automatic mutual recognition seems unlikely (though not impossible). To put this into context, other risk regulation measures, comparable to the regulation of pharmaceuticals where they are subject to European harmonisation and mutual recognition, such as the authorisation of GMOs or plant protection products, also use complex administrative procedures on intra-administrative and/or EU level to facilitate mutual recognition.[165] Next to facilitating the forming of consensus, these procedures also aim to share and pool expertise, as well as fostering rational decisions.[166] Regarding the question whether the Centralised Procedure could be extended to cover all products currently subject to the MRP/DCP, Hervey and McHale argued that national interests seem to prevent full centralisation.[167]

This seems to be a very reasonable prediction, based not only on the past debates discussed in this article, but also given that very recently a legislative initiative, aimed at fostering the cooperation of Member States in the health technology assessment (HTA) of new medicines, came to a grinding halt in the Council.[168] Thus, it seems that in these rather sensitive areas there is general resistance against both automatic mutual recognition as well as centralized decision-making on EU level. However, the COVID-19 crisis has brought new impetus to the debate concerning further harmonisation in the context of public health.[169] With regard to pharmaceuticals, it led to a certain degree of

163 ibid, 1243.
164 Feick (n12) 34.
165 De Lucia (n90) 110.
166 ibid.
167 Hervery and Mc Hale (n7) 298.
168 European Parliament, Legislative Train Schedule, Health Technology Assessment (HTA) https://www.europarl.europa.eu/legislative-train/theme-deeper-and-fairer-internal-market-with-a-strengthened-industrial-base-products/file-health-technology-assessment [accessed 17/08/2020].
169 See eg: A Alemanno, 'The European Response to COVID-19: From Regulatory Emulation to Regulatory Coordination?' (2020) 11(2) European Journal of Risk Regulation 307-316; A Pacces and M Weimer, 'From Diversity to Coordination: A European Approach to COVID-19' (2020) 11(2) European Journal of Risk Regulation 283-296; K Purnhagen and others, 'More Competences than You Knew? The Web of Health Competence for European Union Action in Response to the COVID-19 Outbreak' (2020) 11(2) European Journal of Risk Regulation 297-306.

centralisation for the procurement of a COVID-19 vaccine,[170] which might set an example for more future collaboration in this regard. Nonetheless, further harmonisation might be threatened rather than invigorated by the burden placed by COVID-19 on the healthcare systems and the economy in general. Still, the Pharmaceutical Strategy currently under preparation by the European Commission appears to aim for further coordination, especially with regard to pharmaceutical pricing.[171]

7. Conclusion

This article has depicted how, over time, the mutual recognition of pharmaceutical marketing authorisations has led to a complex regulatory construct of centralised and decentralised procedures, leading to institutional innovation in terms of the creation of the CPMP, CMDh, the Pharmaceutical Committee and, later, the European Medicines Agency which integrated the CPMP. It became clear that the harmonisation of the marketing authorisation requirements was not sufficient to overcome mutual mistrust, but that institutionalisation as well as procedural coordination and centralisation of mutual recognition was necessary to advance the internal market for pharmaceuticals.

While one can observe that the trust-building between the Member States through coordinated, composite procedures seems to have been – at least to some extent – successful, neither automatic mutual recognition nor full centralisation of the procedures appears attainable at the moment. This leaves marketing authorisation applicants with the ever-incomplete internal market for pharmaceuticals. Moreover, it shows that the mutual recognition principle as understood in the sense of a *Dassonville*-like automatic mutual recognition has been denied and only introduced in a weakened form within the safety-net of a composite procedure.

This *sui generis* approach is endorsed by the Court, which, once the procedural integration has taken place, does not shy away from enforcing the procedural limitations to Member State discretion. However, the creation of these complex, composite procedures, the course of which depends on the level of agreement between the Member States, raises several questions with regard to the judicial and political accountability of the actors involved. These flaws, however, are not pharma-law specific, as has been shown in the growing literature on composite procedures.

---

170 European Commission, Communication – EU Strategy for COVID-19 vaccines, Brussels, 17 of June 2020 COM (2020) 245 final.

171 European Commission, Roadmap: Pharmaceutical Strategy – Timely patient access to affordable medicines, 03.06.2020, Ref. Ares (2020) 2858413.

It appears that sectors where products are subject to risk regulation and require some form of administrative approval challenge the scope of automatic mutual recognition and tend to resort to procedurally integrated forms of mutual recognition. What requires further reflection and continuing research by administrative lawyers in the field is why procedural integration and institutional innovation has taken diverging forms in these sectors, and the ensuing proliferation of diverging *sui generis* procedures.[172] The historical account and explanation of the current procedures laid down for pharmaceuticals in this article, for example, does not necessarily provide an insight into mutual recognition with regard to pesticides, which resorts to a complex system of mutual recognition of product approvals where the Member States are divided into separate zones for recognising each other's assessment.[173] One might question whether the proliferation of widely divergent approaches to achieve the same aim – mutual recognition of a regulated product – might in itself create accountability problems, as it requires political accountability fora to understand this plethora of complex procedures, and poses challenges to judicial review, as they rely on varying forms of informal measures.

[172] See for example the procedures described by Eliantonio (n138).

[173] For a detailed account see: E Bozzini, *Pesticide Policy and Politics in the European Union: Regulatory Assessment, Implementation and Enforcement* (Palgrave Macmillan, 2017).