

Statement By

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Coalition for a Stronger FDA

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Committee on Energy and Commerce

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INTRODUCTION

Mr. Chairman and members of the Committee, I am William K. Hubbard. Before my retirement after 33 years of Federal service, I served for many years with the U.S. Food and Drug Administration, and for my last 14 years was an FDA Associate Commissioner responsible for, among other things, FDA's regulations and policy development. Although I have remained retired since my departure from FDA in 2005, I have agreed to provide advice to a remarkable group of patient, public interest, and industry groups that have recently formed themselves into a Coalition for a Stronger FDA (whose mission is to urge that FDA's appropriations be increased). Throughout my career at FDA, I was deeply involved in improving one of FDA's most important functions—the review and marketing approval of new pharmaceuticals. Accordingly, I wish to thank the Committee for inviting me to testify on the Prescription Drug User Fee Act that the Committee is considering for reauthorization.

BACKGROUND

As you know, the process for assessing new drugs for approval is a complex and challenging undertaking. In any one year, FDA must oversee thousands of drugs undergoing testing, and review hundreds of applications to market the drugs that emerge successfully from the testing process. FDA's scientists have very little margin for error,

as the approval of a new drug makes it available to millions of Americans, and often also triggers approval in many other countries, thus exposing any given drug to a potential patient population in the billions around the globe.

When I began my career at the FDA, the review of new drugs was the most troubled program in the agency, and remained so for many years. The signs of distress were rampant:

- Applications to market new drugs often lingered three or more years in the FDA review process;
- Patients pleaded with FDA for more rapid access to new therapies, particularly for serious and life-threatening illnesses, and sometimes felt compelled to travel overseas for therapy they could not get in the United States;
- Drug sponsors were increasingly frustrated that years of effort to develop new products were put on hold while FDA reviewers labored to process a flow of drug applications that greatly outpaced their capacity to manage a growing workload;
- Investments in pharmaceuticals and medical product research and development were moving to Europe and industry leaders decried the lost jobs and other economic detriments caused by the “drug lag” with Europe,
- And FDA officials proposed and developed a series of initiatives to speed the review of new drugs, none of which managed to significantly reduce drug review times.

Then, in 1992, this Committee took the lead in drafting legislation to create a new program for addressing the “drug lag,” and it has been, in my opinion, one of the most successful statutes ever enacted for improving public health.

THE PRESCRIPTION DRUG USER FEE ACT

The drug user fee act, known by its acronym, PDUFA, has been a remarkable success story. In rapid succession after PDUFA’s creation, FDA’s time to review new drugs dropped steadily; new, life-saving drugs flowed to patients more rapidly than ever before; investment in medical R& D climbed steadily, resulting in yet more new drug discoveries; and the United States seized and maintained its lead in global pharmaceutical development. Today, thanks to PDUFA, drugs are reviewed in the United States as fast as or faster than anywhere else in the world, with no diminution in FDA’s historically high standards for drug safety.

In essence, Congress instructed FDA that review speed mattered, but not at the expense of safety; and mandated that FDA be given new resources to apply to drug reviews, but would be expected to manage those resources in a documented, business-like method--with program activities closely tracked and progress carefully assessed. Drug sponsors, in turn, were given more access to FDA scientists, so that they could better understand FDA’s requirements and design better clinical trials, resulting in better applications that could be reviewed more easily by FDA scientists. Thanks to this remarkable program,

well over a thousand new treatments have flowed expeditiously to patients since its enactment, saving countless lives and reducing untold suffering. For this reason, I join the many others who have urged you to act quickly to reauthorize the PDUFA program as negotiated between FDA and the pharmaceutical industry.

THE DOWNSIDE TO PDUFA

Despite its overwhelming success in improving the process for reviewing new drugs, I must take note of some effects flowing from the PDUFA program that are problematic. First and foremost, budget managers have allowed the infusion of new user fee funds to offset appropriations, despite efforts by Congressional drafters to utilize “triggers” to prevent that outcome. As a result, while total FDA resources and staffing have increased since PDUFA’s inception, the agency’s non-user fee resources have actually declined. This is best illustrated by the attached graph, which shows total FDA staffing growing, while staff paid by appropriated dollars have declined by a thousand over the past decade—an enormous decline for an agency as small as the FDA. The practical effect of this has been the loss of staff for such critical FDA programs as drug safety and protection of the food supply.

A second concern raised by PDUFA is the extent to which user fees are paying for drug review expenses. When the program was first developed fifteen years ago, it was conceived as a relatively limited supplement to the existing drug review staff, to enable FDA to deal with a large and growing drug application workload. By the end of PDUFA

II, in the early years of this decade, fears arose that the percentage of the drug review program that would be paid by user fees was approaching 50%. FDA leaders, joined by industry, consumer, and patient groups, expressed concern that the program not pass the 50% point, out of fear that over-reliance on industry fees could slowly but inexorably lead to greater industry influence in FDA's decisions whether to approve or disapprove a given drug. Unfortunately, that 50% level was passed in PDUFA III. This has been caused by decisions to hold down or reduce FDA's annual appropriations. So, for example, in a given year the PDUFA fees are adjusted to stay even with FDA's increased costs—usually about 6% per year. But FDA's appropriations in recent years have been well below its inflationary costs, meaning that the portion of the drug review program funded by fees has risen steadily. If this continues unabated, it is quite possible that the percentage of the program paid by user fees could exceed 70%, a level that raises both fairness questions for drug sponsors and concerns about industry influence in FDA decision-making. Therefore, I urge the Committee to consider ways of “rebalancing the ledger” so that the original intent of PDUFA is restored.

THE NEXT CHALLENGE IN DRUG DEVELOPMENT

I will close with a final observation about FDA's drug program. PDUFA has been momentous for its success in improving the speed to market of new drugs. But there are two other critical legs to what one might call the drug development “tripod.” The first is one the Committee will likely be wrestling with this year as well—the safety of drugs once they are on the market. As new funds have flowed to FDA for the drug review

program, the drug safety staff that monitors drugs on the market has not been increased, despite an ever-increasing workload. I have attached a graph that demonstrates the enormous increase in adverse event reports being submitted to FDA—reports that are intended to give FDA early clues as to whether a marketed drug should be relabeled, restricted, or even withdrawn. This increase in workload has overwhelmed FDA’s drug safety function, and as a result, problems with drugs such as Vioxx are likely to continue. FDA officials have ideas for substantially improving the drug safety system—focused on using new technologies to capture drug safety “signals” sooner and more thoroughly. I urge you to hear their views and to assist them in gaining the appropriations to fund their solution to this vexing problem.

My last point relates to drug development time—the years, often a decade or more, from the time a new drug is synthesized in a laboratory to the time it actually starts treating patients as an approved drug. While drug review times within the FDA dropped rapidly and substantially thanks to the PDUFA program, drug development times have remained too high. Further, drug manufacturer continue to pursue “dry holes” that are expensive and shift focus away from successful therapies (the vast majority of drugs making it to the human testing phase ultimately fail). Also, the number of submissions of new drugs for approval by the FDA has flattened out, suggesting that the next wave of new drug discoveries will be harder to find and develop. Indeed, there is substantial evidence that the current “path” to new drug development is increasingly challenging, inefficient, and costly. FDA has made a proposal to decision makers that it calls “The Critical Path.” It is offering to bring to bear its considerable experience in drug assessment to the

development of powerful new scientific and technical methods (such as computer-based predictive models, biomarkers for safety and effectiveness, and new clinical evaluation techniques), to help drug manufacturers become more efficient and more successful in their decisions about which therapies to pursue and bring to market -- with the expectation, of course, that the public will ultimately benefit by having more and better drugs made available for their treatment as rapidly as possible. But FDA has been unable to secure funding for this initiative, despite widespread expressions of support for the concept. I urge you to consider the Critical Path program an important part of your mission to improve the FDA's drug program and to impress upon your Appropriations colleagues the importance of funding that initiative.

Indeed, Mr. Chairman, an increase of just \$40 million a year for five years, for a total increase in appropriations of \$200 million annually by the fifth year, would, in my opinion, both "fix" drug safety and provide the necessary funding for the Critical Path initiative. I believe that such relatively modest sums would be repaid many, many times over in the development of new therapies and the successful treatment of our citizens and, as such, would be an investment of tremendous value to our society.

I again applaud the Committee for its groundbreaking work in enacting PDFUA and thereby successfully addressing a major national problem. And I thank you for letting me express my views today on its reauthorization.