Comments about ” Rare diseases: Europe’s challenge”

Question 1: Is the current EU definition of a rare disease satisfactory?

There has to be a definition, and for many purposes the current definition is adequate.
From an epidemiological point of view, there is a problem with the definition. Prevalence may be interpreted as *birth prevalence* or *population prevalence*. That explains why different figures are sometimes found. If 1 in 1000 live born infants has a disorder, and life expectancy on average is only a quarter of the average life expectancy of European citizens, the population prevalence is 1 in 4000. Is this a rare condition?
A disease that is rare at one point in time might not stay rare if treatment improves. If life expectancy increases, the population prevalence will increase. Thus an effective rare diseases program might lead to the consequence that a disease will not be rare any more after a while, and thus will not receive adequate attention due to the success of the program.
I suggest that the definition of rare disease relates to birth prevalence OR population prevalence below 5 per 10 000.

A different problem is that the very rare diseases still receive least attention.

Question2: Do you agree that there is a pressing need to improve coding and classification in this area?

Yes, I agree. Currently public health priorities in the Netherlands are selected on the basis of organ system (cardiovascular disorders), pathogenesis (cancer) or exposure (smoking). Etiological pathways are often not taken into account, because the coding system often used (ICD) is based on organ system or pathogenesis. Many health care costs relate to “mental disorders”, but prevention of mental handicap for instance can not be studied because we have no idea which cases are related to maternal use of alcohol, inborn errors of metabolism, traffic accidents or infectious diseases.
Both the coding and classification systems on the one hand and the use of existing classification schemes on the other hand need improvement.

Question 3: Can a European inventory of rare diseases help your national/regional system to better deal with RD?

The availability of Orphanet already helps to inform Dutch health care workers on rare diseases. Data on the prevalence of many rare diseases is however lacking for the Netherlands (Hegger I, De Vries C. Databank voor zeldzame aandoeningen. Is een “weesbase” haalbaar? Bilthoven, RIVM, 2007. Email: Rogier.Bos@rivm.nl).
Funding for this type of activity should be continuous. Funding from research grants does not guarantee sustainability.

Question 4: Should the European Reference Networks privilege the transfer of knowledge? The mobility of patients? Both? How?

University Medical Centres (UMC) in the Netherlands have to fund several of their activities as a center of reference from fixed budgets. Increasing the number of rare diseases for which a UMC is expert-centre does not always lead to an increase in the budget. Thus expertise depends on physicians who wrote a PhD thesis on a rare disease or professionals that happen to have some patients with a specific rare disease, but not on a pro-active policy to divide (for instance) all rare diseases between the UMCs and thus guarantee access to adequate medical care.
European support could be helpful indeed.

Mobility of patients should be limited to activities that are needed only once (or a few times) in a lifetime (surgery, diagnosis). Since health care for rare diseases is often life-long care, this should be guaranteed by transfer of knowledge.

Question 5: Should on-line and electronic tools be implemented in this area?

Yes.

Question 6: What can be done to further improve access to quality testing for RD?

Guarantee access (funding; also for countries with a limited health care budget or patient without adequate insurance), quality (continue work of EUROGENTEST), exchange of information (Orphanet).

Question 7: Do you see a major need in having an EU level assessment of potential population screening for RD?

The WHO criteria (Wilson and Jungner 1968) form the basis of many schemes for the assessment of new possibilities for screening and testing in populations at low risk. These scemes include analytic validity, clinical validity and utility of test, but also ethical, legal, cultural and societal aspects. Some of the information needed to weigh pros and cons can be generated at an EU level, but some other aspects will differ between countries (availability of resources, cost-effectiveness in countries with higher or lower prevalences of disorders, political choices).
The parameters needed for evaluation in each member state (such as test sensitivity, specificity, effectiveness of the intervention, effects at long term follow up of patients) can certainly be better assessed at EU level, but there has to be room for national decision making.

Question 8: Do you envisage the solution to the orphan drugs accessibility problem on a national scale or on an EU scale?

Developing best practices for primary prevention (folic acid to prevent neural tube defects) can certainly help other EU countries that want to implement prevention strategies.
Developing new orphan drugs and evaluating them may be more feasible at an EU level.
Funding treatment with orphan drugs can be governed by (rich) member states, but might be problematic in Eastern European countries, and certainly in developing countries. Accessibility could be improved with EU support.

Question 9: Should the EU have an orphan regulation on medical devices and diagnostics?

Yes. The problem of diagnosis is similar to the problem of treatment. Commercial parties will not invest in medical devices and diagnostics for rare diseases unless there is some incentive.

Question 10: What kind of specialised social and educational services for RD patients and their families should be recommended at EU level and at national level?

At EU level services through the internet could be made available. Information (in own language) as well as recreational computer applications can help people in all member states. Best practices can help patient organisations in other EU member states to organize local and national patient and parents organisations.

Question 11: What model of governance and of funding scheme would be appropriate for

registries, databases and biobanks?

Apart from the questions that hold for all biobanks and registries, the role for patient organizations could be different in governance. Patients and their families have clear interests in products that might become available, the use of patents and licensing.

Question 12: How do you see the role of partners (industry and charities) in an EU action on rare diseases? What model would be the most appropriate?

Since there are many rare diseases and there is limited public funding, public-private partnerships should be welcomed. Industry and charities should obviously not interfere with the freedom of researchers to publish their results. Potential “conflicts of interest” should be mentioned for transparency, but often interests of patients and industry and charities will be similar.

Question 13: Do you agree with the idea of having action plans? If yes should it be at national or regional level in your country?

Yes, national in the Netherlands.

Question 14: Do you consider it necessary to establish a new European Agency on RD and to launch a feasibility study in 2009?

I am not sure whether an Agency is needed. Sustainable networks might be adequate. The disadvantage of current activities is that they lack sustainability.

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