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It is clear that greater use of generics and biosimilars could greatly decrease healthcare costs and thereby increase availability of important medicines. It is equally clear that these potential savings are seldom achieved. The disconnect between what is possible and what is being achieved is related to a lack of trust on behalf of patients, healthcare providers, legislators and even some payers. The depth of this distrust is well illustrated by the title of the Abstracted Scientific Content, 'To prescribe generics is to play with the life of the patient': misconceptions of generics in Guatemala'.

There are a number of causes of this distrust; only some of which are legitimate, especially in resource rich countries. At least some of this distrust comes from the fact that many stakeholders have only a very limited understanding of processes controlling the development, marketing, regulation and post-marketing monitoring of generic and biosimilar medicines. This issue of the *GaBI Journal* contains manuscripts dealing with both expressions of this distrust and attempts to overcome it.

The Commentary by Godman B et al. is on a manuscript that appeared in the prior issue of the *GaBI Journal* by Venkatesan S et al. on the tyrosine kinase inhibitors (TKIs). The TKIs have revolutionized the treatment of a growing number of cancers; especially their remarkable success in treating chronic myeloid leukaemia (CML). The authors discuss why TKI patents are so long and why their costs remain so high. The problems discussed suggest (to me at least) that it is time for payers and society to consider, likely to be resisted, drastic corrective actions such as no longer allowing cancer treatments to enjoy 'special attention' and/or for governments and non-profit organizations to consider manufacturing and distributing generic TKIs themselves.

The Original Research is by Mr Stephen P Murby and Mr Michael S Reilly from the Alliance for Safe Biologic Medicines, which receives funding from a number of sources. The authors used a survey to obtain the opinions of selected Australian physicians about the major biosimilar issues: their approval, labelling (including name), extrapolation of indications, and substitution. A limitation of all such survey data is that they provide information on what the respondents report doing rather than what they actually do. The lack of trust evident in their responses is important to understand. However, what is not reported is also important. For example, were these practitioners aware of the fact that, 'Clinical trials in only one condition' are done on the condition most likely to demonstrate differences? Or that there are changes in how brand-name biologicals are made over time?

A Review Article by Trifirò G et al. presents some 'real-world' data on 'patterns of use and the comparative effectiveness of biosimilars and originator biological drugs in Italy'; what physicians (in Italy) actually do. The authors review the results of a number of observational studies done by the Italian Ministry of Health. Other studies used 'Italian administrative databases to explore the switching patterns between biosimilars and originators and the clinical consequences of switching'. There was marked heterogeneity in biosimilar uptake, but overall increasing use of biosimilars. Data on the results of switching between originator and biosimilar erythropoiesis-stimulating agents suggested they had comparable effectiveness; a study that is an example of how well-designed electronic databases can be used to conduct post-marketing monitoring as well as to gather data that can be used to overcome mistrust. I strongly endorse the authors' call for countries to combine multiple healthcare databases in order to perform more effective post-marketing monitoring of biological (and generic) drugs.

The Special Report 'Physician associations comment on FDA's interchangeability guidance' presents a summary of comments received by the US Food and Drug Adminstration (FDA) in response to its draft guidance on extrapolation of indications, switching, labelling and naming, post-marketing studies, and other issues concerning biosimilars. The comments offer insights into concerns and mistrust of biosimilars, but potential conflicts of interest were not easily identified. Many comments were from physician associations and expressed concerns about biosimilars and called for expanded use of external disease experts for the evaluation of biosimilars.

The first Meeting Report by Bloom et al. is from a Roundtable hosted by GaBI with the Association of the British Pharmaceutical Industry (ABPI) and funded by Amgen on patient and disease registries. This meeting focused on the potential of biological drug registries to provide useful, 'real-world' data such as those presented in the Italian paper discussed above. It was noted that for registries to be successful 'will require an aligned vision amongst stakeholders, appropriate resourcing and a sustainability model, extensive collaboration and linking across registries, and the universal implementation of standards for record headings and clinical terms'. Establishment of effective registries is not trivial. Funding is only one important issue. Of the issues not discussed at this Roundtable is the fact that such registries can be used to inhibit switching of patients from brand-name biological to biosimilar products. This can happen if physicians are paid only when the data they provide is for patients receiving the product made by the sponsor of the 'registry.' Also, while changing rapidly, familiarity with electronic data entry and requirements can differ between older and 'new generation' healthcare workers and patients. Unfortunately, as noted by

one discussion group, 'It was agreed that pharmacovigilance was poorly understood, not just by patients, but also clinicians and nurses'.

Pharmacovigilance was in fact the topic of the satellite symposium described in this issue's second Meeting Report by van Gelder T et al. This satellite symposium entitled 'Biosimilar medicines in clinical practice – important role for hospital pharmacists!' was organized by the Biosimilar Medicines Group. Speakers discussed data on pharmacovigilance, traceability, building trust in biosimilar medicines, and the role of hospital pharmacists. Denmark has one of the highest rates of biosimilar uptake. At least in part this is the result of actions described which have been taken by the Danish Medicines Agency to 'address patients' concerns and inform physicians about biosimilar medicines'. A second presentation highlighted methods, including incentives that can help build trust in biosimilar medicines. The third presentation highlighted what hospital pharmacists need to do when biosimilar medicines enter the hospital.

The third Meeting Report by Stoller C et al. describes a second satellite symposium sponsored by Medicines for Europe entitled 'Value added medicines: what value repurposed medicines might bring to hospital pharmacists'. The main message of this meeting was that, 'established medicines that can be used for totally new therapeutic uses, through drug repositioning, drug reformulation, or complex combinations', but that, 'further steps need to be taken to increase collaboration and innovation and remove barriers to the market'. This is an important aspect of generics and biosimilars that deserves more attention from clinicians, regulators, patients as well as drug developers. I want to encourage authors to submit manuscripts dealing with such 'super generics' as well as so called, 'bio-betters'.

Such meetings identify causes of mistrust in biosimilars/generics. Healthcare workers who attend or read about such meetings need to be aware that such information can be used to reinforce unjustified concerns rather than to overcome unjustified mistrust through education.

The Abstracted Scientific Content entitled 'To prescribe generics is to play with the life of the patient': misconceptions of generics summarizes the lack of trust in generics in Guatemala and the causes of this mistrust. Unfortunately, wherever there is a lack of reliable, informed, non-corrupt regulatory processes such mistrust will be justified. For countries without the resources to provide such regulatory infrastructure it may even be necessary for non-profit groups such as the World Health Organization (WHO) to consider providing external review and quality control programmes. It is not clear, however, whether there is the political will to use such programmes even if offered. What is also needed is a way to police the companies and people who profit from selling inferior, counterfeit drug products. Clearly much needs to be done to ensure that all people have access to effective, reasonably priced, needed medications.

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