COMMENT

Treatment and time zones: A transatlantic perspective on cancer drugs sustainability

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In May 2015 I had the privilege of participating in the Applied Research in Cancer Control (ARCC) and the Canadian Health Services and Policy Research (CAHSPR) conferences in Montreal. As a United Kingdom (UK) National Health Service (NHS)-trained physician and public health doctor studying fair access to cancer drugs in the UK, what was there for me to learn in Canada?

Despite the countless references at these conferences to the recommendations of the UK’s National Institute for Health and Care Excellence (NICE), Canada’s assessment agencies actually predate those in Britain. The Canadian Agency for Drugs and Technologies in Health (CADTH) predated NICE (1999) by a decade. And Ontario’s New Drug Funding Programme (NDFP) was launched in 1995, 15 years before the English Cancer Drugs Fund in 2010. Therefore, the open-mindedness of the Canadian health research community to continually learn from international perspectives is clearly not a sign that their own system has been slow to adopt health service policy solutions, but rather testament to an ongoing commitment to evolve.

Participation at the conferences provided me an opportunity to compare and contrast Canadian and UK approaches to cancer drugs and consider some shared challenges.

HEALTH VALUES

The NHS constitution includes a commitment to “provide a comprehensive service available to all…promot[ing] equality…,” while also “providing best value for taxpayers’ money with…fair and sustainable use of finite resources.”

The Canada Health Act describes the aim of Canadian health care to provide “reasonable access to health services without financial or other barriers.” Enshrined aims also include universality, comprehensiveness, accessibility and portability.

In other words, the aspiration for a fair health system, available to all, is clearly expressed in both systems. Canada’s travails to achieve this are all the more remarkable for sharing a border with the United States, whose healthcare spending is double that of the UK’s and substantially higher than Canada’s, with lower average life expectancy and far greater health inequality.

However, the rising costs of cancer drugs, with decreasing marginal health gains, are challenging decision makers in the UK and Canada to balance equity and efficiency in publicly-funded health systems. The ARCC and CAHSPR conferences highlighted concerns that are mirrored in the UK: issues of equity of access to cancer drugs; concern for the sustainability of cancer drug spending; and evidence that cancer is given preeminence in decision making despite limited empirical evidence that the public support its supremacy. It has been suggested that cancer’s prominence in society and policymaking is a sign of a revealed societal preference. Whatever the underlying reason, the challenge of fairly evaluating, valuing and funding cancer drugs is pertinent, pressing and finds expression in policy decisions in each country.

CANCER DECISION MAKING

England established a Cancer Drugs Fund (CDF) in 2010 that gives access to cancer drugs either not appraised or not recommended by NICE due to poor cost effectiveness. Circumventing NICE decisions solely for cancer drugs has been controversial. The CDF is available in England, however due to political devolution, not for Scottish, Northern Irish or Welsh NHS users. Cries of geographically unfair postcode lottery of access to these high-cost end-of-life anticancer therapies have been widely publicized.

England’s decision to treat cancer drugs “differently” is evident in that the CDF was estimated to yield 4,000 quality-adjusted life years (QALYs) per annum, but displace 8,000 QALYs, meaning the CDF valued end-of-life care in cancer twice as much as other NHS treatments. Paucity of real-world evidence of the impact of CDF high-cost cancer drugs on cancer survival also undermines evidence-based decision making, and the opportunity cost of treatments may be even higher.

The Scottish New Medicines Fund, introduced in 2014 as a means to fund “orphan, ultra-orphan and end-of-life drugs,” funds a significant number of high-cost cancer drugs. The Fund’s budget, much like the CDF in England, has escalated considerably since its inception (£20 million [Can$39 million] per annum 2013/14 quadrupled to £80 million [Can$157 million] per annum 2015/16). In Northern Ireland, a Specialist Medicines Fund is currently being proposed, which will mirror the Scottish fund. In other words, despite the significantly smaller geographical size of the UK, and a commitment to promote equity of access, the devolved policy environment has led to variability in access to cancer drugs, and raised concerns similar to those expressed in Canada around inter-provincial variations in coverage and reimbursement.

To an outsider, some aspects of Canadian cancer decision making seem mysterious. For instance, why does the NDFP cover high-cost intravenous (IV) pharmaceuticals, but not high-cost oral medications? Also, the denial by pCODR that it has an explicit willingness-to-pay threshold
is strangely familiar to any UK physician who heard NICE deny such a threshold for many years before finally publicly admitting its existence. In Canada, there is no doubt that pCODR has some kind of cost threshold, or will before long, based on the accumulation of case studies. Another interesting dichotomy between the two countries is that NICE recommendations for health technologies are mandatory, and local commissioners must fund recommended pharmaceuticals within three months of the recommendation. In Canada, pCODR recommendations are not mandatory. However, despite NICE technology appraisal being mandatory, there is still variation in practice. Therefore, whether recommendations should be made mandatory to reduce variation in practice requires further study.

The Canadian healthcare system and the NHS in England face the same challenges: evaluating equity of access to cancer care, considering the causes and impact of overutilization of anticancer therapies toward the end of life, and working toward a sustainable health system when faced with growing expectation and rising costs. While political and decision-making structures differ between the two countries, we continue to have much to learn from each other’s successes and failures. Canada may wish to take a close look at England’s experience with the CDF in particular. The absence of real-world evidence of benefit from CDF and unsustainable increases in drug fund budgets for England and Scotland are forcing a redesign of the program, and the CDF has recently introduced a prioritization process that considers cost effectiveness in order to rein in spending. Perhaps the CDF has been an expensive educational tool to remind us of the importance of cost effectiveness — something NICE has known all along.

References:
8. Sanders A. New process to stop NHS Medicine postcode lottery. Wales Online 2013 [updated 10/06/2013/29/06/2015]. Available at walesonline.co.uk.