

Escalating drug prices: the curious case of cancer

An English perspective

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Director, NICE International

National Cancer Policy Forum Workshop,
Institute of Medicine, June 2014

Why are drug prices going up?

- The supply side: because it costs a lot to develop
 - Clinical research costs
 - Regulation costs
 - Marketing costs...
- The demand side: because there is money
 - Investors are (still) betting big on potential winners
 - Big Pharma most profitable (after tobacco industry)
 - The market can bear it – (US) payers will pay – access not a concern
 - Disconnect between ROI and Value for Money

But is it sustainable?

“One point your numbers tell you is how horrendous the failure rate is and how that causes the cost of success to be so much higher” Francis Collins, NIH, [Forbes 2013]

Is a cost-plus model which pays for failures, combined with the mono(oligo)poly of very few big players, encouraging inefficiency instead of innovation?

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used in transplants. Through chemotherapy, anticonvulsants,

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U.S. Meds Drop Part D drug

BY DAVID MORGAN

WASHINGTON Tue Feb 25, 2014

CMS Drops Proposal To Change Part D Protected Drug Classes

By Scott Steinke / [Email the Author](#) / [View Full Issue](#)

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remove a requirement

UK payers pushing back

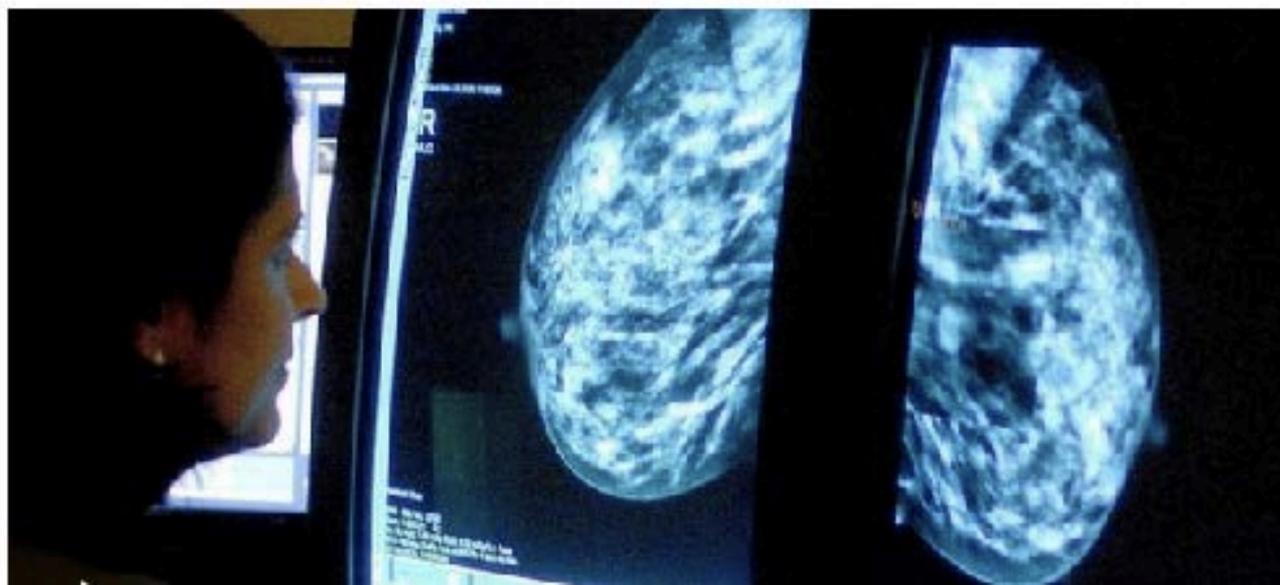
Ne 22 April 2014 Last updated at 23:02 GMT



Breast cancer drug price reduction urged

By Michelle Roberts

Health editor, BBC News website



Comment is free

Breast cancer drug Kadcylla is too expensive for the NHS – not to pay for it is the correct decision

The NHS watchdog, Nice, is being portrayed as penny-pinching over its refusal to fund a hugely expensive new cancer drug. But shouldn't we be asking why its manufacturers want to charge so much?



Deborah Orr

The Guardian, Friday 25 April 2014 17.30 BST

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“I couldn't help thinking back to the awful day I learned that my breast cancer had spread to my lymph nodes, and the even more awful day when I was tested to see if it had spread to my chest wall and lungs. The relief that it hadn't was indescribable. However, eternally grateful as I am for my NHS treatment, I know that, had money been no object, less invasive treatments with fewer side-effects would have done the trick, possibly rather better...”

But, ghastly as the treatment I had was, I'd rather have been in a large room with other people also getting that treatment than in a small room, otherwise empty, because all the money was being spent on me. That's what Nice has to think about – the number of people that can be helped, not the absolutely best way of helping one individual.”

The view of the UK's major cancer charity



Let's beat cancer sooner

- “Any healthcare system has to make difficult decisions about how to allocate its finite resources. Cancer Research UK believes that, in general, NICE performs this difficult job well, and should be properly resourced to continue to do so, and to improve into the future. This is especially important in the context of the current financial pressures on the NHS, the move to value-based pricing and the expansion of NICE’s remit to include social care.”
 - Health Select Committee, written evidence from Cancer Research UK (Oct 2012)



www.parliament.uk

Washington Post Interview with Bill Gates, May 17 2013



- **Ezra Klein:** We're very uncomfortable putting a value on human life. The way I see our [US] health system is we've chosen to pay a huge premium in order to avoid these questions.
- **Bill Gates:** Yes, someone in the society has to deal with the reality that there are finite resources and we're making trade-offs, and be explicit about that.

In the US



- You need political, professional and general public backing openly to manage access and prices...
- Does this exist in the US and how can one help build such support amongst key stakeholders? What institution can drive the movement of priority setting?
- Is Obamacare the “access hook” which will drive some form of open priority setting?

NICE – a (tax)payer's perspective

The NHS definition of patient centeredness

- You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.
- You have the right to expect local decisions on funding of other drugs and treatments to be made **rationally** following a **proper consideration of the evidence**. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

All diseases are equal but cancer is more equal than others...



Donkey and pigs from the 1954 film Animal Farm. Photograph: Halas & Batchelor

It is about politics (2010/11)

“We will create a Cancer Drugs Fund to enable patients to access the cancer drugs their doctors think will help them...”

- £200m pa
- evidence of variation by geography and medication

Freedom

Fairness

Responsibility

The Coalition:
our programme
for government

Why cancer?

“Coronary heart disease (CHD) is the UK's biggest killer, causing around 82,000 deaths each year. About one in five men and one in eight women die from the disease.”

www.NHS.uk May 2014

...but there is no heart disease fund...



**'Cancer is our number-one killer' -
Jeremy Hunt defends drugs fund**

And what about the evidence that people care...?

Title: Impact Assessment of Proposal for a Cancer Drug Fund Lead department or agency: DH Other departments or agencies:	Impact Assessment (IA)
	IA No: 5012
	Date: 26/10/2010
	Stage: Consultation
	Source of intervention: Domestic
	Type of measure: Other

- “While there may be support in principle for greater weighting of QALYs provided to patients with severe conditions, there is currently no robust evidence in the literature to support a particular magnitude of weighting. It should also be noted that no evidence has been found for prioritising cancer above other severe conditions, or for prioritising drug treatments above any other interventions for cancer.”

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30 September 2012 Last updated at 08:24



- His team surveyed more than 4,000 people across Wales, England and Scotland to find out whether they valued delivering health benefits to cancer patients more highly than to patients with other conditions.
- "The result that we found were that the majority - about 64% - were not in favour of prioritising one or the other. They wanted fair allocation, regardless of the disease, all else being equal. There was a consistent message that there wasn't general support for cancer [being a special case] versus other conditions." [Linley and Hughes, 2013, Health Econ, 22(8), 948]

N evidence that it will improve quality of life or survival rates.

In the US



- Are most Americans worried about Death Panels (more so than they are they fed up with dealing with insurance claims)?
- Is overt priority setting including costs really a non-starter in the US?
- Is there a platform for eliciting and applying the general public's views on priorities for spending?

Value Based Assessment

NICE seeks views on how it assesses drugs and other technologies for the NHS

[Read the news](#)

[Read the consultation](#)



Attribute	Measurement
Burden of Illness	Proportional QALY shortfall (to encompass EOL/severity)
Wider Societal Benefits	Absolute QALY shortfall (a proxy for productivity)

An example*

Disease	Average age	QALYs without new treatment	QALYs without the disease	Proportional QALY loss	Absolute QALY loss
Metastatic prostate cancer	69	0.89	14	94%	13
Osteosarcoma	14	33.11	64	48%	31
Asthma	43	25.31	35	27%	10

*http://www.nice.org.uk/media/FE3/97/Illustrative_TA_list_and_QALY_shortfall.pdf



The Telegraph

Monday 26 May 2014

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Fears for the elderly under new NHS drugs policy

Charities urge rethink on plan which would only see new drugs licensed for NHS if judged to be a benefit to wider society amid fear elderly could lose out

- **Guidelines on how funding for new drugs is allocated may be changed**
- **'Wider societal benefits' must be considered before medicine is prescribed**
- **Fear drugs aimed at older people might not be approved by watchdog**

By [EMILY DAVIES](#)

PUBLISHED: 04:31 GMT, 10 January 2014 | **UPDATED:** 08:58 GMT, 10 January 2014

In the US



- Is there a way to link reimbursement to value?
- Are the Wellpoint (\$350 per patient following the protocol) and UnitedHealth (bundled payments linked to pathways) approaches the way forward?
- Can CMS ever follow the example of private payers? Can insurers achieve much without CMS?

Are formulas the solution?

**“God forbid that Truth should
be confined to Mathematical
Demonstration!”**

William Blake

Thank you!

Thanks to Dr Amanda Adler, Chair of
NICE’s Appraisal Committee

