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EDITORIAL

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Throughout my career as a health economist, one issue has always been a mystery to me—why does cancer enjoy such a dominant position within healthcare systems throughout the world?

The debate concerning the reconfiguration of the Cancer Drugs Fund (CDF), which is addressed in this journal [1], represents a microcosm of a much wider debate reflecting the complex and ever-changing interface between political expediency and clinical rationality within health services internationally. Within the UK National Health Service (NHS), the CDF has been the subject of controversy since its inception because it creates a 'backdoor' to healthcare funding that circumvents health technology assessment (HTA) programmes in the UK and is only available for cancer drugs. The existence of a more favourable funding mechanism solely dedicated to extending the use of cancer drugs (irrespective of their clinical and cost effectiveness) represents a major health policy issue as it introduces significant inequalities into a UK system that was founded on the premise of providing equal access to patients in equal need. The very existence of the CDF is contrary to this founding principle as it creates a two-tier definition of 'need'—one for cancer and one for patients from every other therapeutic area. Such a fundamental realignment of health service principles in favour of cancer patients inevitably imposes significant ethical, economic and health implications as a direct consequence of this inequity, which is now built into the funding basis of the NHS.

It is important to acknowledge that the funding of any individual drug may be justified by a range of factors beyond its cost effectiveness, such as considerations of unmet clinical need, innovation or equity. Such factors are already considered on an individual basis as an integral part of the UK National Institute for Health and Care Excellence (NICE) appraisal process, and it is difficult to comprehend why such factors should be of particular relevance in the case of cancer drugs. However, surely society should be able to prioritise its structure of healthcare provision in whatever manner it wishes, and if 'society' makes an informed judgement that it wishes to 'overfund' treatments for cancer, then so be it!

Although this may be a realistic representation of the political reality, I remain unconvinced that 'society' is truly aware of the opportunity cost imposed on non-oncology patients as a direct consequence of the CDF and similar 'onco-favouring' policies. It is important to continuously remind ourselves and others of one key fact: the very existence of a more generous funding stream for cancer drugs inherently takes us into a 'second best' world, which is an affront to our commitment as health economists to the concepts of both efficiency and equity.

To return to our Panglossian vision of the 'best of all possible worlds' would simply require the additional NHS funding allocated to the CDF to be made accessible to all therapeutic areas. This would ensure that such resources would be allocated purely on the basis of incremental patient benefit rather than therapeutic favouritism.

In this regard, I must admit that one further fact mystifies me. I fail to understand the apparent unwillingness of clinicians from other therapeutic areas to effectively

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challenge the unduly privileged funding position enjoyed by oncology. This would help to overcome the inherent disadvantage their patients inevitably suffer as a consequence of the failure to achieve a level playing field in terms of healthcare funding. Such disadvantage is epitomised by the very existence of the CDF, the sole objective of which is to fund cancer drugs that are either unevaluated or that (perhaps even worse) have been evaluated and found to not meet thresholds expected of non-cancer drugs in terms of their clinical and cost effectiveness. It appears that we afford cancer funding a special status that is not shared by heart, liver, lung or kidney patients (to name but a few). If this is the case, then optimising healthcare decision making subject to this constraint requires us to identify the health 'exchange rate' between cancer and other therapeutic areas. As a society, are we willing to let one, five or ten patients suffer death and disability to prevent (or more likely slightly delay) a death from cancer?

One of the guiding principles underlying the formation of the NHS was that of 'equal access for equal need'. Therefore, as a former member of a NICE appraisal committee, I was aware that our decision making was guided by two principles: standardisation and comparability. We perceived our role as ensuring that, wherever possible, resources were allocated in a manner that optimised the health of the UK population. In attempting to achieve this, the committee was acutely aware that in choosing to allocate resources to any new intervention there was a risk that funding may consequently have to be withdrawn from an existing service that may have been of perhaps greater value. The controversies surrounding the nature and level at which quality-adjusted life-year (QALY) thresholds should be set [2–5] speak eloquently to the difficulties involved in making such decisions. However, I found two principles invaluable. First, continuous reference to the founding principle of the NHS (equal access for patients in equal need) enabled decisions to be made on the basis of science and evidence rather than political expediency and populism. Second, the concept of opportunity cost emphasised the need to 'make visible' patients from the services that would have to forego funding if we chose to support this treatment. Having been inculcated in evaluating drugs from such a perspective, the concept of funding drugs that have failed to prove their value on a level playing field compared with drugs from other therapeutic areas seems to be an anathema. In cases where non-oncological drugs exceed the NICE threshold, their only option if they are to gain access to the NHS is to offer a 'risk-sharing scheme' (i.e. a price discount) until their cost becomes more commensurate with their clinical benefits. In the case of the CDF, the NHS bears all the risk while the sponsor accepts all the benefits. If the sponsor truly believed in the 'value' provided by their drug (and that the evidence was not yet sufficiently available), surely they could simply offer a discount that would achieve market access (at the normal threshold value) during this interim period while this enhanced evidence set was being generated.

The starting point for resource-allocation decisions should be that drugs that generate equal population health (in terms of their capacity to enhance the quantity or quality of a patient's life) should be valued equally. Any move away from this principle inevitably reduces the capacity of the health system to maximise population health and should only be contemplated if there is unambiguous evidence of a clear value judgement on behalf of society that health benefits generated in one particular therapeutic area are 'worth' far more than health benefits delivered to patients with 'less worthy' conditions. Where is this clear and unambiguous evidence that cancer patients are perceived as being more deserving of funds than those from other therapeutic areas? This is the obvious implication of a 'two-speed' system of funding that diverts funds away from conditions where they could generate greater health gain to cancer treatments, where they knowingly generate less. The greater this disparity, the greater the health losses suffered by patients in other therapeutic areas as a direct consequence of such a two-tier system.

Finally, please do not misinterpret this editorial as being in any way 'anti-cancer'. Rather, it is a respectful acknowledgement of the effectiveness with which every element within the cancer health system advocates on behalf of their patients. That is their role, and they perform it with a rigour that perhaps holds lessons for health professionals from other therapeutic areas. Therefore, this editorial represents a plaintive plea for an answer to a simple question—why do we as a society appear to perceive the suffering and death experienced by patients from every other therapeutic as being of so little value?

Compliance with Ethical Standards

Conflict of interest The author has no conflicts of interest that are directly relevant to the content of this editorial.

References

1. McCabe C, Paul A, Fell G, Paulden M. Cancer drugs fund 2.0: a missed opportunity? Pharmacoeconomics. Epub 22 March 2016.
2. Haycox A. How much should the NHS pay for a QALY? Pharmacoeconomics. 2013;31:357–9.

3. Claxton K, Martin S, Soares M, et al. Methods for the estimation of the NICE cost effectiveness threshold. CHE Research Paper 81. York: University of York, Centre for Health Economics; 2013.
4. Towse A. Should NICE's threshold range for cost per QALY be raised? Yes. BMJ. 2009;338:b181.
5. Rafferty J. Should NICE's threshold range for cost per QALY be raised? No. BMJ. 2009;338:b185.