If we don’t talk about value, cancer drugs will become terminal for health systems

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Narcyz Ghinea, Postdoctoral Research Associate at the Centre for Values, Ethics and the Law in Medicine (VELiM) at University of Sydney

Ian Kerridge, Associate Professor in Bioethics, Centre for Values and Ethics and the Law in Medicine at University of Sydney

Wendy Lipworth, Senior Research Fellow, Bioethics at the Centre for Values, Ethics and the Law in Medicine (VELiM) University of Sydney

More than 100 prominent oncologists from across the United States have called on cancer patients to challenge the high prices charged by pharmaceutical companies for new cancer drugs. They claim drug companies, insurance companies, some patient advocacy groups and many hospitals and physicians are too financially conflicted to be driving the debate.

Their call is motivated by the astronomical prices charged for some new cancer drugs. And Australia is in the same boat. Earlier this year, for instance, the Therapeutic Goods Administration started subsidising pembrolizumab (Keytruda) for the treatment of patients with advanced melanoma. The drug is expected to cost A$150,000 per patient for each year of treatment, which is almost twice the national average annual income.

Unlike in the United States, where patients’ insurance covers the costs, the Australian taxpayer subsidises drugs listed on the Pharmaceutical Benefits Scheme (PBS). In cases where new drugs are not subsidised, they’re paid for directly by patients, or by state-funded hospitals (often after approval by drug committees). They can also be provided free or subsidised by pharmaceutical companies for “compassionate use”.

Blurred by emotion

Decisions to subsidise drugs and improve their accessibility should be based on an assessment of their value. In Australia, for instance, the Pharmaceutical Benefits Advisory Committee examines new drugs for effectiveness, safety and value for money compared to other treatments before recommending PBS listing – or not.
But the imperative to “save lives” or “beat cancer” — particularly where there’s vigorous public, professional and industry advocacy — can be so profound that it overwhems the requirement that medicines should be efficacious and cost-effective. This tension between emotional and economic considerations frequently challenges and compromises public decision-making about the value of drugs.

Consider the case of eribulin (Halaven), a drug for treating advanced breast cancer. The UK National Institute for Health and Clinical Excellence (NICE is the rough equivalent of PBAC although it has a broader role) considered the drug but rejected it as too expensive.

Eribulin was subsequently covered by the UK Cancer Drugs Fund, a pool of public money allocated to pay for drugs not approved via the usual route. The price accepted by the fund was among the highest in Europe for the drug; the price rejected by NICE had been the lowest.

Clearly, when standards of cost-effectiveness are reduced in the name of “improved access”, prices can rise arbitrarily. In most markets, supply and demand, competition and consumer choice curtail such arbitrary fluctuations in price.

But the market for innovative cancer drugs doesn’t follow this pattern because prices can increase dramatically even in “growing” markets, without clear reasons. In 2013, for example, a group of experts in chronic myeloid leukemia described how the price of imatinib (Gleevec) increased three-fold over a decade. This happened even though all research and development costs were accounted for in the original price, and the number of people using the drug was dramatically increasing. Heightened demand alone cannot explain such an increase.

What makes cancer drugs different

Cancer drug markets clearly behave quite differently to what we might expect. There are three key reasons for this.

First, governments are creating a “price deregulation eco-system” for cancer drugs by establishing special funds that challenge accepted standards of value, and by curtailing the ability of payers to negotiate prices. The UK government has the Cancer Drugs Fund discussed above, while US legislation limits the ability of Medicare – the US government’s health insurance program for people who are 65 and older and certain others – to negotiate drug prices. Laws in the latter country effectively force the health insurer to pay for cancer drugs used for a “medically accepted indication”, and prevent it from considering related cancer drugs as interchangeable.

In other words, US Medicare cannot make the call about whether the drug is worth its asking price, or negotiate prices based on cheaper available alternatives. The fact that the US pays the most for many drugs — including many cancer drugs — should therefore be no surprise. And if other countries are paying high prices for drugs, it makes it easier to justify these high prices elsewhere.

Second, there’s a lack of significant competition for many new cancer drugs. In an attempt to understand why South Korea paid so much less for drugs used to treat chronic myeloid leukemia — in some instances less than 20% of the US price — the same group of experts
mentioned previously noted the country had its own locally discovered drug for treating this disease. The price of competing products appeared to be based on this local drug’s price.

The lack of competition in the cancer drugs market is exacerbated by the rise of new “biological agents”, which are more difficult to replicate than small-molecule drugs, and by industry practices aimed at extending the patent lives of existing products, thwarting generic competition.

Finally, markets in health care, including for high-cost cancer drugs, are powerfully influenced by existential and moral considerations — specifically fear of death and disability, and desire for greater quantity and quality of life. Cancer patients, their families and the oncologists who care for them are often willing to try drugs in the hope they will work, regardless of the price or prospect of benefit, which is frequently quite limited in the case of new, expensive cancer therapies. And as long as there are people willing to pay high prices or, as is usually the case, to demand subsidised access to cancer drugs, there’s no reason for the industry to reduce its prices.

Hope, fear and desperation, along with the unique characteristics of the cancer drug market, create a “perfect storm” that continues to drive up prices for cancer drugs. Unless we regain sight of the need to use regulatory incentives to reward only genuine innovation, and ensure that we receive sufficient value for the money we spend on new medicines, this upward trend for cancer drug prices is set to continue.

The call by the US oncologists for patients to demand reductions in the price of the new drugs may be too much of an ask as these people have more to lose in this debate. It may also be too narrowly focused as it’s not just cancer patients but all of us who should demand the drugs we need at a price that our publicly funded health systems can afford.