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Submission to the High Cost Highly Specialised Medicines Review Panel

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Key Messages

The Cancer Control Strategy states that to reduce morbidity and mortality from cancer, effective diagnosis and optimal treatment must be provided for all those with cancer (Goal 3). Areas identified for action include: ensuring timely access to treatment currently recognised as providing optimal outcomes, and systematically assessing new treatment approaches (MOH 2003). A significant part of many cancer patients' treatment includes chemotherapy agents, some of which are new drugs often with a high cost. This submission covers the key areas of concern in the area of high cost highly specialised medicines, for the Cancer Society of New Zealand on behalf of all those with cancer. These areas are:

1. The application for funding process
2. The separation of prioritisation from purchasing functions
3. The management of the overall budget
4. Support for the presence of Pharmaceutical companies in New Zealand
5. The establishment of a high cost, highly specialised medicines and treatment panel

Introduction

Over the last one or two decades there have been rapid developments in cancer research, with increased understanding of what and how cellular changes cause cancer, which have increased the opportunities for more targeted therapies. The pharmaceutical industry has increased their investment in cancer research and oncology drug development in a way

never seen before (Jonsson & Wilking 2007a). The results have been an increasing number of new drugs, often for defined population groups and frequently at high cost.

In New Zealand during 2007/2008, over 90,000 prescriptions for chemotherapeutic agents were written at a cost of over $30million dollars. A further 40,000 prescriptions were written for endocrine (hormone) therapies adding another $10+million dollars to the drug bill for oncology (PHARMAC 2008). As a percentage of the overall pharmaceutical expenditure of $635.35million, oncology is a small (approximately 8%) but well defined portion of the budget, (PHARMAC 2007). It should also be noted that expenditure on chemotherapy agents has increased fourfold in the last 5 years from $5.1 million in 2003 to $21.1 in 2008 (PHAMAC 2008). Cancer is increasingly being seen as a chronic condition, treatable and sometimes curable. So where once short term treatment courses were the norm increasingly therapies are being seen as multiple interventions with lifelong implications.

Current issues

It is important to note that the Cancer Society does acknowledge the difficulties in managing the often conflicting demands from the number of long term, chronic conditions In the New Zealand population. In a country the size of New Zealand with a relatively low population number, providing the income streams for pharmaceutical funding is not easy. That been said, the Cancer Society of New Zealand has a number of concerns about how the “oncology basket” component of the high cost, highly specialised medicines is managed. There are four main areas of pressure with regard to oncology treatment and therefore funding. First the number of oncology drugs being developed and licensed- especially targeted therapies- is on the rise. Secondly, treatment might be lifelong rather than a few cycles with a well defined cost. Thirdly, with the increase in combination therapies, chemotherapy and radiation treatment at the same time, the costs are additive from a budgetary perspective, which increases budgetary uncertainty. Lastly there is a need to consider service delivery environment, for example intravenous vs. oral therapy, the increasing trend to deliver chemotherapy in outpatient rather than inpatient settings. All these factors have budgetary impact and need to be considered to ensure that equity of care is achieved for all patients (McCabe, Bergmann, Bosanquet et al 2008).

Recommendations

1. Application for funding process

There is concern that small, single interest lobby groups can have undue influence on the funding process. The process needs to be open, transparent, and fully evidenced based. Some formal review process should also be included. Indication of timelines would be helpful for applicants (Simpson 2005). Better representation of preferred value

judgements could be made, by clearly articulating valid criteria and their relative importance for deciding which pharmaceuticals receive funding (Hansen 2006).

2. Separation of prioritisation from purchasing

With both the prioritisation and purchasing being done by the one organisation, there will be conflicts around the negotiating table. Separating these two functions would ensure that the process of prioritisation is not influenced by the negotiations with pharmaceutical companies for more advantageous purchasing agreements. As noted by PHARMAC "what is and is not considered "cost-effective" will vary with the amount of funding available (not just in terms of the total budget each year, but the available budget at any point it time). An application to fund a pharmaceutical can, therefore, be considered "cost-effective" in comparison with other applications under consideration at any one particular time" (PHARMAC 2009).

3. Management of overall budget

District Health Boards ability to plan for future events is limited. It is necessary to plan several years in advance in order to make budgetary allowance for future new treatment alternatives. The ability of patients to access cancer drugs is highly dependent on the allocation of appropriate and adequate funding or financial resources within the health system (Jonsson & Wilking 2007b). Having all budget setting managed from a central point, would make forward planning a national priority rather than a regional decision. This would also reduce some of the geographical variation that occurs, with some DHB's not funding all treatment options.

4. Support of presence of Pharma in New Zealand

A report commissioned by Pfizer entitled 'Pharmaceutical Research and Development in New Zealand- on the Brink of the Abyss' (Watson 2006) indicated that unless there was a change in the way PHARMAC managed its relationships with pharmaceutical companies they would continue to withdraw from this country. Working out the relationships with pharmaceutical companies, would help retain their top researchers and develop the health research landscape that could not only evolve into an embedded local biotechnology sector but is also important to the future success and health of New Zealanders (Watson 2006). Access to level one trials can give some patients the possibility of treatment if all other options have been exhausted. These trials will only involve New Zealanders if the drug companies have a presence in this country.

5. The establishment of High Cost, Highly Specialised Medicines and Treatment Panel

The Cancer Society of New Zealand suggests that a high cost, highly specialised medicines and treatment panel be set up discreet from PHARMAC. This panel would prioritise new therapies based on evidence and quality of life indicators. The panel would include representation from Non-government organisations, clinicians, scientists, ethicists, health economists and particularly consumers. This model separates policy from purchasing process and has been explored by a number of countries eg. Finland (Mossialos and Srivastava 2008), and the UK (NICE 2008). PHARMAC has been successful in the purchasing process with decreased drug costs but has slowed the assimilation of new treatments into New Zealand when compared with OECD countries.

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