Quality, quantity and affordability of life

Helen Johnson, Managing Director of public affairs consultancy, HJCL, discusses the costs of treatements for long-term conditions, and cancer in particular

I do not claim to be an expert on cause and effect, but it is surely a great testament to the NHS and its staff that I have the opportunity to discuss cancer at all in a supplement devoted to chronic, long-term conditions.

After decades of high mortality and some of the lowest survival rates in Europe, cancer mortality in people under 75 years fell by over 17% between 1996 and 2005, survival rates for some cancers (such as colorectal and breast cancer) are improving year on year, and the 2007 Cancer Reform Strategy (CRS) even included policy recommendations for people who were living 'beyond cancer' (Department of Health (DH), 2007).

Unlike many of the other long-term conditions considered, however, cancer has also had more than its fair share of policy interventions and government interference over the last 15 years.

Starting with the Calman-Hine report (DH, 1995), successive administrations have introduced the 2000 NHS Cancer Plan, the 2007 CRS and, in between, a plethora of policy documents and initiatives covering cancer workforce issues, end-of-life care, palliative care, waiting times, research, data collection, screening, and every conceivable aspect of cancer prevention, diagnosis and management. The optimist in me hopes that government policy has had at least some part to play in delivering these achievements and improvements in cancer outcomes .

There are plenty of commentators who are much better qualified than me to opine on whether these policies have been successful. I am more interested in a different issue. Recent government cancer policy has exposed a much wider debate—and one that is relevant to many other long-term conditions: should the NHS prioritise quantity of life over quality of life, and are other long-term conditions losing out to cancer?

Let's take prescription charges as one example. In an important and welcome move announced in September 2008, people with cancer in England have been eligible for free prescriptions since 1 April 2009. Gordon Brown vowed that free prescriptions for people with other long-term conditions would soon follow (http://news.bbc.co.uk/1/hi/health/7631775.stm). Sadly, those people are still waiting and have had to settle for a review of policy led by Professor Ian Gilmore instead, which is due to report in autumn.

Policy on access to new drugs provides a second example. In its 2007 CRS, the DH stated that the default position for all new cancer drugs and significant new licensed indications would be to referral to NICE for rapid appraisal. The aim was to ensure that cancer patients had access to clinically- and cost-effective new treatments as soon as possible after licensing. National Cancer Director, Mike Richards, reaffirmed his view that all patients across the country should continue to have access to cancer drugs with a positive recommendation by NICE.

There is no doubt that the issue of ensuring access to cancer treatments has been a controversial and highly charged political hot potato for several years. Who can forget Patricia Hewitt, the then Secretary of State for Health, taking the decision away from NICE when she said: 'Herceptin has the potential to save many women's lives and I want to see it in widespread use on the NHS' (http://news.bbc.co.uk/1/hi/health/4311140.stm).

No other long-term condition has benefited from similar government intervention.

Take rheumatoid arthritis, a chronic, progressive and disabling auto-immune condition which affects over 500 000 people in the UK and is estimated to cost between £3.8 and £4.75 billion pounds a year. Rheumatoid arthritis does not kill you but, among other things, it is extremely painful and debilitating. It can cause cardiovascular and other comorbidities, and reduce life expectancy. In contrast to the CRS commitments, rheumatoid arthritis patients have been waiting for NICE to issue guidance on the sequential use of adalimumab, etanercept and infliximab since late 2004, and guidance is not expected until 2010.

The CRS plans were somewhat thrown off course when it became clear that pharmaceutical manufacturers had declined to make submissions, either to NICE or to the equivalent body in Scotland, the Scottish Medicines Consortium, presumably on the basis that their medicines had no prospect of receiving a positive recommendation under the oft-applied maximum cost-effectiveness threshold of £30 000 per Quality-Adjusted Life Year (QALY).

The solution was the Richards' Review on top-up payments and the simultaneous instruction to NICE to consider where or not there were circumstances for particular 'life-saving' medicines, where it might be appropriate to disapply the usual cost-effectiveness threshold.

The political intent behind these dual initiatives was clear: address public and media concerns about restricted access by permitting cancer patients to top-up their NHS care with private funds, while at the same time changing the rules at NICE, to allow more cancer medicines to be approved for NHS use, and so limiting the numbers of people who would need to pay for treatments privately.

A politically-expedient solution, yes. But what have the consequences of these recent policies been for those with cancer and other long-term conditions?

First, they have skewed NICE's work programme in favour of cancer, arguably at the expense of other long-term conditions. In NICE's current work programme, 56 of the 105 technology appraisals currently in development relate to cancer medicines, compared with just 50 out of 172 completed technology appraisals.

Secondly, the flexible application of the cost-effectiveness threshold to so-called life-saving medicines has not necessarily resulted in more treatments being recommended by NICE.

Of the 16 technology appraisals (reviewing 22 technologies) carried out by NICE between January and April 2009, only six qualified to be considered under the supplementary end-of-life guidance and only three of these medicines was recommended for NHS use (sutinib (firstline) for renal cell carcinoma and gastrointestinal stromal tumours; lenalidomide for multiple myeloma.

These policies have reopened the debate about affordability and healthcare priorities, with certain life-extending medicines apparently now subject to a higher cost-effectiveness threshold than those which merely maintain or improve quality (but not quantity) of life.

The three cancer medicines previously referred to were all approved as a cost-effective use of NHS funds at figures of up to £50 000 per QALY. The QALY is widely regarded as an imperfect, blunt instrument, but it does at least allow for comparisons across therapeutic areas—a level playing field for all technologies going through a NICE appraisal.

If the new willingness-to-pay threshold for end-of-life medicines is now in the region of £50 000, there must be less money left in the NHS pot to spend on treatments for other long-term conditions, which are cost-effective at £30 000 per QALY, but which are not national clinical priorities. At the end of the day, the NHS is a zero-sum game.

Many would argue that long-term conditions and quality of life have the same right to access medicines and NHS funds as 'end-of-life' conditions, such as cancer and quantity of life.

Recent government policies, however, have demonstrated a clear preference for the latter. As a society, we are ageing and an expectation of a longer life brings with it an increase in the length of time an individual can expect to live with a chronic, often disabling, condition.

The NHS, the DH, and NICE need to do more to convince us of their commitment not only to preserve life, but also to ensure that quality of life and wellbeing are not overlooked. BJHCM

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