The Circle of Strife

How building in a postcode lottery will not assist patients, pharma or the NHS

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The Circle of Strife:

In the first of a series of thought-pieces, John Spoors looks at current issues around the "postcode lottery" in healthcare

A circle is a simple geometric shape, consisting of a plane curve where every point is equidistant from a fixed point called the centre. If one imagines a postcode lottery at the centre, it is not difficult to see that the current direction of healthcare and Health Technology Appraisal (HTA) policy seems to tie the NHS, and the patients that use it into an ongoing, cyclical pattern – a never-ending circle of strife.

Sides to the story

Recently, the *Daily Mail* claimed victory for patients that the fourth hurdle to drug access had finally been smashed, allowing patients to revel in the glory of an NHS which provides medicines to all. Conversely, Polly Toynbee of *The Guardian* attacked the notion that NICE will have its power to select cost-effective treatments for the NHS taken away. Toynbee hit the nail on the head when she said "every health system is rationed, always was, always will be". Whether it is NICE, GP consortia, or the Government, someone has to make the decision on what to buy and at what price.

Why NICE in the first place?

It is fundamental that we remember why NICE was set up in the first place. In 1999, GPs were coming under pressure due to inequity of care amid claims of a "postcode lottery" and feared being the scapegoats for rationing treatments. As BMA GP negotiator Dr Hamish Meldrum said at the time "We have to make choices, set priorities, but that is increasingly having to be done in an uncoordinated way. People have been mucking about trying to avoid the word "rationing" – what we would like is a whole public debate". NICE was set up to provide national guidance that would tackle the postcode lottery of prescribing and to quote Sir Michael Rawlins in 1999, provide "a much more even treatment pattern across the country". A lot of the focus in recent years has been on the drugs that NICE turns down, due in part to the influx of oncology drugs being appraised by NICE as a result of the previous Labour Government's Cancer Reform Strategy. Oncology drugs, due to their price and limited data availability, are difficult to review under traditional cost-effectiveness thresholds. NICE then introduced additional measures to try and give extra weighting to drugs given at the end of a patient's life. Was this enough? The Rarer Cancers Foundation and others would argue not, but let us examine some of the "injustices" and inequities that already exist in the context of a publicly funded health system and, arguably, will always do so.

Quantity versus quality

Firstly, there is the issue of prioritising oncology treatments and quantity of life, over quality of life. There is no question that cancer is a tragic condition that is estimated to directly affect 1 in 3 of us, according to Government figures. In 2007, 127,800 people died from cancer in England. From an ethical viewpoint though, should the NHS fund drugs and treatments that can offer people a few months of life? Or should it fund drugs that can make a dramatic and often long-term difference to people's quality of life - such as those who suffer from rheumatoid arthritis, multiple sclerosis or Alzheimer's disease. Tough decision? Yes. That is the job NICE has to face on a daily basis. No one is claiming that NICE is perfect. The QALY is certainly not a perfect instrument, but as Professor Sir Ian Kennedy claimed during his review into the value of innovation in 2009, "it is the best tool for the job". But the Government's policy seems to be that by prioritising cancer and taking away the power from NICE to select cost-effective treatments, this issue will seemingly evaporate. It is naïve at best; and does not tackle the fundamental issue of finite resources.

Decision-making

Secondly, who will make these funding decisions going forward? As outlined in the Government's White Paper, GP consortia will make local decisions on which treatments to fund. The current Cancer Drugs Fund (CDF) consultation highlights that the Government, after weighing up the risks and benefits, prefers a regional approach. This is endorsement of a postcode lottery; as local providers will inevitably choose different treatments according to local needs. Let us bring this issue back to cancer and the *Daily Mail* "victory". The Government has announced that there is to be a £600 million cancer drugs fund over the next three years; ignoring the inequality arguments comparing cancer to other long-term conditions as discussed earlier, will £200 million per year fund every treatment for every deserving patient? If this amount of money does not cover the cost of all the treatments, then GP consortia or local providers have to make decisions on which drugs to fund. This will inevitably lead to variation in access to treatments and further outcry from patients and the public. The parallels to pre-NICE in 1999 are clear to see.

So which treatments will be funded? Toynbee points to the pharmaceutical industry being able to lobby effectively and the "survival of the fittest". The reality is probably much different. A shift to value based pricing is certainly being met with a lukewarm response from industry, which has staunchly defended its ability to price freely under the PPRS. Arguably with HTA, and developments such as Patient Access Schemes (PAS), "free pricing" for oncology drugs is not quite what it seems. By offering PAS as the concession to achieve cost-effectiveness, the ability to maintain freedom of pricing may be more myth than reality.

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Those of us who have worked in oncology Technology Appraisals appreciate the considerable challenges posed by the limited data available for these drugs, particularly at market launch. Would shifting the pricing system to one which is based upon clinical effectiveness and the value of medicines really improve access? The Government line is that if these drugs cannot prove their effectiveness, then pharmaceutical companies will have to reduce their price until clinical effectiveness or "value" is proven. This is again somewhat simplistic; and does not offer pharmaceutical companies an incentive to launch the drug early in the UK. Pharmaceutical companies are likely to turn the UK into a "late launch" market if they are forced to pay a lower price than the innovation premium that they attach to the drug – which includes the risk and R&D costs in investing in these molecules. This would inevitably lead to a delay in patients in the UK getting the most up-to-date medicines.

So, to complete the circle of strife; when local commissioning consortia have exacerbated the postcode lottery, patients are being denied the medicines they require, and the pharmaceutical industry is alienated from the UK, a call will be made for a body to reduce the variation in drug access. This body will also have to be open about the need to ration medicines spend without completely alienating the pharmaceutical industry. The body will take the pressure off the Government, by making difficult decisions from an independent viewpoint using robust internationally recognised methodology. This body already exists. It is called NICE.

John Spoors, November 2010

HJCL is an independent healthcare policy and public affairs consultancy which specialises in market access and HTA issues. If you have any comments or questions about this article, please contact us by email: john.spoors@helenjohnsonconsulting.com.