Top-up insurance for cancer drugs

NHS patients lag behind those in Europe with regard to access to new cancer drugs. In a comparison of 19 countries, a study from the Karolinska Institute (Wilking and Johnson, 2006) showed that for several drugs licensed for use in cancer in the early part of this decade, the UK falls far behind our immediate neighbours and is on the level of Poland and Hungary. The combination of National Institute for Health and Clinical Excellence (NICE) delays and financial pressure on overstretched and poorly managed primary care trusts (PCTs) have created a powerful barrier to the ability of British oncologists to use novel agents.

With forty new sophisticated molecularly targeted compounds scheduled for registration over the next 4 years the situation ahead looks gloomy (Sikora, 2007). An update of the same comparative study is scheduled for release in 3 months' time and is bound to show a dramatic worsening of the situation for British patients. At least six cancer drugs are now given regularly to patients in Calais but not Canterbury.

Inequity

The availability of many of these compounds is riddled with inequity. Obviously if you are rich you can pay for them privately but some cost £5000 a month (Bosanquet and Sikora, 2006). Those with health insurance can usually get them under their policy – indeed the insurers are vying with each other to show how liberal they are with cancer care. But for the patient who relies on the NHS the situation is very confused.

In Scotland lung cancer patients can obtain the tyrosine kinase inhibitor, erlotinib. This is not so in England where decisions are made on a case by case basis at a relatively junior level by the local PCT. Indeed I recently got involved in a negotiation for one of my patients – a retired colleague. After some discussion the PCT agreed to fund the drug but I was not to tell anybody – hardly transparent decision making. The use of expensive drugs is clearly influenced by geography and timing – PCTs near to bankruptcy are naturally not at all keen. And what happens if a patient goes to stay with a Scottish relative – does that change their entitlement?

Top-up payments

There is now evidence of a growing use of top-up payments to break access barriers in the NHS (Charlson et al, 2007). This applies to areas as diverse as implanted hearing aid devices, access to diagnostics such as scans and even home nursing care services. Politicians of all persuasions are in denial about their existence and reluctant to get involved in debate. But cancer patients are beginning to become very sophisticated consumers of extra clinical services, either from the NHS or through the selective purchase of upgrades privately.

Last month a private insurer came up with the first top-up plan for cancer. Now a new dynamic has emerged. For a relatively small premium – the same in pounds per year as a person's age – the Western Provident Association (WPA) will fund any appropriate drug licensed by the European regulator (www.mycancerdrugs.org.uk). Interestingly, WPA is a Taunton-based not-for-profit social enterprise over 100 years old and a forerunner of the NHS. As always there are important bits of small print. The policy is not available to those who have cancer and does not start for 3 months after its purchase. It stops at the age of 65 years and is limited to a ceiling of £50 000 in drugs and the cost of their administration. Financially this is a huge gamble as nobody knows how rapid the rollout of new agents will really be or what impact they will have on survival. But we do know they will be consistently expensive.

Legal and ethical issues

Policyholders are expected to use the NHS for their basic care, including any standard chemotherapy available. A senior legal opinion obtained by WPA concluded that such a mix and match type of care was perfectly legal under the NHS Act and the NHS Code of Conduct on Private Practice. Furthermore the advice on the duties of a doctor given by the General Medical Council is clear (2007). Patients must be able to trust doctors with their lives and health. To justify that trust, doctors must show respect for human life and must make the care of their patients their first concern. Patients must be given the information they want or need in a way they can understand and their rights to reach decisions about their treatment and care respected. Does the withholding of information about treatments that might be in a patient's best interest but are available only either in the private sector or abroad constitute a contravention of General Medical Council guidance? This is a very difficult issue with far-reaching consequences for the NHS. No doubt some colleagues will find this all very disturbing.

Solutions

Cancer care costs are spiralling out of control in every health-care environment. Aging populations with a wide range of medical problems are consuming vastly increasing amounts of care. New technology – drugs, devices and procedures – are powerful inflationary drivers in an information rich, consumer-oriented world. Different health-care systems are using a variety of approaches to dampen demand. The NHS seems to be just dithering.

There are two clear policy decisions now needed. The first is how much the NHS is willing to pay for an extra year of good quality life with cancer. NICE needs to provide far more timely assessments of cost effectiveness and clarity on how it reaches its conclusions. The core package available to those that use the NHS as their insurer has to be the same throughout the UK with no postcode lottery.

The second decision is how we will allow individuals to contribute to their care in an equitable way, whether by direct payment or insurance. What mechanisms do we need to put in place to ensure safe, streamlined care with good information flow? Consumerism and social solidarity simply do not sit comfortably together. A survey by the charity Cancerbackup (2006) showed that 67% will vote in the next election on the basis of health policy and for 76% of us cancer is the most important health issue. No politician can afford to ignore these results. Yet we are impinging on the very core of NHS doctrine – care given freely on the basis of medical need and not ability to pay. For the sake of our patients we need to discuss these issues openly. The Mycancerdrugs policy is welcome because it forces us all to consider these challenges. BJHM

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KEY POINTS

- At least forty new expensive cancer drugs will be licensed by the European regulator over the next 4 years.
- The tax-based NHS insurance system will not be able to finance all of these.
- Inequity based on geography, timing in the financial year and type of cancer is currently widespread in the NHS.
- The availability of a relatively cheap top-up insurance policy forces us to look at our policy for co-payment for drugs, devices and services in the NHS far more closely.