Access to cancer drugs: local autonomy or local tyranny?

In cancer we have seen an incredible change in the way malignancy is treated, from a time where the only prospect for patients was chemotherapy, and the only diseases that were considered responsive were leukaemias, testicular cancer and lymphoma. We are now in a situation where there have been major improvements in survival for many solid cancers. These improvements have been multifactorial in origin, with benefits from screening and reduced cigarette smoking, as well as from chemotherapy and hormonal therapy, given as adjuvant treatments for the major groups of solid tumours.

Currently, in the first decade of the 21st century, pharmaceutical company research and development investment has led to the availability of targeted therapies for solid tumours. These include antibodies and small molecule inhibitors of cancer cell surface growth factor receptors. These amazing developments have led to the possibility of improved prospects for patients with what were previously thought to be comparatively unresponsive tumours.

We are now potentially able to nearly treble the duration of survival of patients with metastatic colorectal cancer, double the survival of women with metastatic breast cancer, produce durable responses in significant number of patients with kidney cancer, and improve the survival of men and women with lung cancer.

The problem

While these new treatments for cancer have been tried and tested, and are available in civilized countries, the bureaucratic process of prescription regulation in the UK means that these 'life-saving drugs' are not available for men and women with malignant disease. But why is this?

The regulatory route for drug approval comes through the European Medicines Agency (EMEA) which reviews product safety and efficacy for the European Union market. New agents are then considered by the National Institute for Health and Clinical Excellence (NICE) and thereafter by the primary care trusts (PCTs). While the Department of Health has made it clear that funding for newly licensed treatments should not be withheld because guidance from NICE is unavailable, in practice this means that the drug is unavailable.

NICE was set up in 1999 with a brief to provide clinical guidelines and technology assessments for England. There are different advisory panels for Scotland; Wales and Northern Ireland are meant to follow the English decision. In the period 2001–2008 there have been 407 NICE guidances on cancer. Input into NICE is through the Department of Health, health professionals and patients, the National Horizon Scanning Centre, and pharmaceutical companies. The agenda for the consideration of each new drug is set by the Department of Health, and the Department of Health tells NICE when to start the review process. It may be of interest to the reader to consider the specifics of the progress through NICE of one group of new drugs for cancer.

The results of treatment of kidney cancer by a new group of drugs that are targeted to vascular endothelial growth factor receptor and epidermal growth factor receptor, and their tyrosine kinases, have been appearing over the last 5 years, and major articles confirming their activity appeared in *The New England Journal of Medicine* 18 months ago (Motzer et al, 2007). The Department of Health asked NICE to start considering this group of agents in the late spring of 2008, and a decision from NICE will emerge in mid-2009. It is a puzzle why the potential use of these agents should be delayed so many years, but many of us feel that the puzzle has an obvious answer.

Another example that may be of interest to the reader is that of a new chemotherapy treatment for prostate cancer. The headline trials were published in October 2004 (Tannock et al, 2004), and approval was given by the Food and Drug Administration (FDA) for the use of this treatment in the United States at the end of that month. The approval process through NICE, with which I was involved, when it got going, took 2 years. Two doctors gave evidence to the NICE Committee on the second docetaxel appraisal which consisted of, at my counting, some 43 men and women of whom only the chair was a clinician. NICE, in making a decision on the cost effectiveness of treatment, use a financial hurdle. This hurdle is represented by something that is called a QALY, which is the cost of a year of quality-adjusted life. The cost target is £30 000.

So there is a considerable delay between observations of drug effect and their availability to patients for treatment as a result of NICE approval.

However, this is not the only barrier to treatment for our patients. The NICE output, or decision, comes with a framework guidance, which is that:

'local health organisations should review their management of clinical conditions against NICE guidelines.'

So, the production of a guideline does not automatically lead to availability.

Availability: the postcode lottery haunts us

The availability of a drug to a patient is dependent upon a decision made by a PCT. When the PCTs were set up there were approximately 250, each with their own decision-making process. The decision-making process focuses on a public health doctor, a GP and a pharmacist. All of course will have some degree of general medical knowledge, but how do they achieve specialist views on an enormous diversity of subjects?

When the PCTs were established I would find myself approached to ask my views as to the management of malignant disease. I would give my opinion, only to have the request repeated by other PCTs, and this seemed to me a multiplication of a process that should be centralized. As

a result of some degree of rationalization, there are now 149 PCTs. Information concerning the PCTs is widely available on the web (www.nhs.uk/servicedirectories/pages/primarycaretrustlisting.aspx).

Let us look at one example of PCT structure.

Our local PCT, the Hammersmith and Fulham PCT, has a structure which includes a board of directors, audit committee, professional executive committee, clinical governance and risk management committee, executive director team and a performance monitoring committee.

It has a regulatory pathway which involves a local delivery plan, operating plan, Healthcare Commission core and developmental standards, fitness for purpose program, annual health check, auditors' local evaluation and the NHS Litigation Authority risk management standard assurance framework.

The PCT staffing is as follows:

Medical and dental staff	36
Administration	259
Health-care assistants	32
Nurses	191
Scientific and technical	145
Other	6
Total	669

So, for each patient in each GP's practice, local PCTs will make a decision upon whether or not a particular cancer drug, or indeed any other drug, can be provided for that patient.

Within my own experience, there is a certain whimsy attached to the decision-making process so, for example, for one of our patients who needed treatment with sunitinib, approval was denied by Brent PCT. The patient was advised by a colleague to move to another GP's practice, and this move led to the decision-making process concerning approvals being delivered by Hammersmith and Fulham PCT, who kindly agreed to the prescription of this drug.

Decisions, decisions, further decisions

Regardless of the decision of the PCT with respect to drug availability, decisions are neither final nor finite. Decisions may change when special cases appear. Publicity in local newspapers often leads to reversals of decision-making processes. Decisions from NICE may be subject to judicial review and finally, when an issue received national headlines, and particularly if it involves a breast cancer patient, Secretaries of State for Health do intervene to make sure that treatments are made available before NICE decision-making processes.

The solutions

So what's needed? Well, instead of local autonomy, asserted through the ignorance and arrogance of PCTs, which is tantamount to local tyranny, we need centralization of process which, and perhaps I am being dreadfully naïve, might lead to cutting in costs, particularly in the area of administration.

What is puzzling is that the current regulatory process occurs on a background of an extraordinary investment by the government into health care. Before 1997, just 4.5% of gross national product was spent on the NHS. The current percentage has risen to 9.5%, with estimates of total spend for the current financial year of between £90 billion and £100 billion.

What else do we need? Well, it's quite clear that the NICE process needs to be fast tracked, and we do have hopes that this will happen as a result of the Darzi review. BJHM

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KEY POINTS

- Primary care trusts should be rationalized.
- The decision-making process from the National Institute for Health and Clinical Excellence needs to be fast-tracked.
- Minimizing bureaucracy would save time and money.
- Clinicians should be empowered and specialists engaged.