

Access to cancer drugs: local autonomy or local tyranny?

Sir,

Jonathan Waxman (vol 69(8), 2008, p. 436) is absolutely right. We have the most expensive and emotionally fraught system in the world for making decisions on high cost cancer drugs. A total of 149 primary care trusts (PCTs) are responsible for commissioning health care for their populations. Although most will provide drugs and treatments approved by the National Institute for Health and Clinical Excellence (NICE), those without guidance are considered in different ways. Some PCTs determine a general policy in consultation with relevant specialists and the cancer network. Others convene a sub-committee to consider each patient on their own merit. Social, domestic and other factors may be taken into account with such individual funding requests.

The names and composition of these groups differ enormously around the country and none apparently have any oncology specialist knowledge. One PCT has junior administrators with no clinical background working as clinical prioritisation officers – pure Soviet stuff. This diverse approach to rationing is the underlying cause of post-code prescribing. It causes untold stress to patients, their families and PCT staff who are forced to be serial purveyors of bad news. This is an expensive and inherently unfair way to make decisions. And the judicial review process is even more costly and cumbersome.

I'm afraid Professor Waxman's solution to get Darzi to speed up NICE won't work. NICE will ask for yet more money to do this – its budget is already vast – and will inevitably then reject most of the molecules coming through. Never before have we had so many new cancer treatments in the pipeline. Never before have we had such a big difference between the treatments available in the UK compared to the rest of the EU. There are now ten cancer drugs given regularly in Brussels, Paris and Rome but not in London except to private patients and the list is set to grow dramatically.

A far more pragmatic approach to increasing the funding of cancer care is

needed. If it can't be done by getting efficiency savings out of the NHS or by increasing taxation then top-up payments, however unpalatable to champagne socialists, are the only way forward.

Karol Sikora

*Medical Director
CancerPartnersUK
London W1U 1BD*

Sir,

Professor Waxman is understandably concerned that people with cancer are not getting the treatments they need, however, he undermines his arguments with an inaccurate assessment of the contribution NICE has made to promoting effective treatments for cancer.

Since 1999, we have assessed 59 treatments (not the 407 he states) for cancer and found value in virtually all of them. In only five cases has either the clinical or cost effectiveness of the treatments caused us to recommend against general use in the NHS. We know that our guidance on cancer is implemented, because our own published surveys show it to be so and because two reports from the National Cancer Director confirm it. It is because of NICE guidance, not despite it, that thousands more patients with cancer have been treated and are benefiting as a consequence. Our guidance also directly applies to England, Wales and Northern Ireland and since January 2002, the NHS has been legally obliged to provide funding in England and Wales for medicines and treatments recommended by NICE's technology appraisal guidance within 3 months.

Professor Waxman suggests that many of our recommendations have been overruled by judicial review or by ministers. Our guidance has, so far, only been judicially reviewed once and it has never been overruled by a minister. And rather mystifyingly, he misunderstands the regulatory role of the medicines licensing agencies. They do not assess the 'value' of new drugs. The agencies' role is to assess their safety and efficacy. What they do not do, but precisely what NICE does do, is to assess their real added value compared to current standard care.

Our advisory bodies are not lacking in clinical input. In fact the committee Professor Waxman refers to consisted of 16 clinicians, testimonials were also heard from patients and clinicians and a number of

clinicians responded to our consultations. His criticisms also contradict his opinion at that time, when he wrote to the committee chair that he was 'impressed with the thoroughness and quality of the review' – this is published on the NICE website.

We accept that we have not always been able to start evaluating new treatments sufficiently far in advance. However, following the introduction of the single technology appraisal process at the end of 2006, and with more timely referral, we will increasingly be able to issue recommendations on new technologies close to launch (within 3 months). But we can still do better.

Let's not forget that cancer, although devastating for those who live with it and those who care for them, is not the only demand on NHS resources, there are other distressing disorders that need our attention.

Andrew Dillon

*Chief Executive
National Institute for Health and Clinical
Excellence
London WC1V 6NA*

Sir,

The information on the number of NICE appraisals comes from the NICE website. Perhaps Mr Dillon would like to amend the site before he corrects my text.

He also comments on my own appearance at NICE. I have appeared on two occasions, not one, and it is the first that I reference with regards to the lack of medical representation. On the second occasion I wrote to the committee commenting on basic errors in their assessment of risk factors for prostate cancer. For some reason this letter does not appear on the NICE website.

On 27 August Mr Dillon publicly apologized for the delays that resulted from the NICE appraisal process. Perhaps he would like also to apologize for the blindness, dementia and deaths that have resulted from this committee's inappropriate presence. Maybe the blind, the dead and the demented will accept his apology ... I think not.

Jonathan Waxman

*Professor of Oncology
Department of Oncology
Division of Surgery, Oncology, Reproductive
Medicine and Anaesthetics
Imperial College London
Hammersmith Hospital
London W12 0NN*