

Who gets expensive cancer drugs? A tale of 2 nations

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The well-worn notion that patients in the United States have unfettered access to the most expensive cancer drugs while the United Kingdom's nationalized health care system regularly denies access to some high-cost treatments needs rethinking, a team of bioethicists and health policy experts says in a report out today.

Delving into the question of expensive cancer drugs and who gets them, the team, led by Ruth R. Faden, Ph.D., director of the Johns Hopkins Berman Institute for [Bioethics](#), found both systems are far from perfect and both drew them into a hot-button issue of the current U.S. [health care reform](#) debate: rationing.

Critics of the U.K. system say care there is rationed — that patients are denied some expensive therapies so that better health care can be provided to the nation as a whole. Critics of the U.S. system say care is rationed here, too — that only those with the very best insurance and those who can afford sky-high out-of-pocket expenses have meaningful access to any and all high-priced therapies, especially at the end of life.

The authors found that with regard to very expensive cancer drugs, both characterizations are largely correct. "The issue is not whether rationing is a good thing or a bad thing," Faden says. "The issue is what we should do about extraordinarily expensive treatments, some of which do very little to improve how well or how long people live." At the same time, she adds, "there is no ethically defensible reason why some Americans have access to expensive cancer drugs and some do not."

"Policy makers and our society now need to do the hard work of developing a reasoned, evidence-based system of using health care resources wisely, and the first step is to engage in an honest and transparent conversation about the values that should guide these decisions, a conversation that is informed by facts, not politics," she says.

Faden and her colleagues, writing in the December issue of *Milbank Quarterly*, compared the costs of 11 high-priced cancer drugs. Seven of the medications are free to all British patients, who pay no out-of-pocket costs. The other four are not covered in the National Health Service because policy-makers have determined the costs are not worth the limited benefits they provide. Patients in the U.K. who still want these drugs have to pay all the costs on their own.

By comparison, most patients in the United States who have health insurance have some coverage for all 11 drugs, the question is how much they must pay out of pocket even with insurance. For example, the out-of-pocket costs for people on Medicare range from \$1,200 to \$24,000, and because many cancer patients on Medicare are on more than one drug, their out of pocket costs are often much higher. Access to expensive cancer drugs for patients with no insurance or very limited insurance may be completely out of reach, with costs exceeding \$100,000 annually in some cases.

Even more telling, an American cancer patient faces the same financial obstacles regardless of how much benefit the cancer drug provides. For example, drugs like Herceptin, that can mean the difference between life and death for some breast cancer patients, can be no easier for American cancer patients to access than drugs like Avastin, which studies suggest has little or no impact on patient survival.

In comparing the two health care systems, though they wish they had

more data to work with, the researchers find that the British system is in many ways fairer than the American system and that it is better structured to deal with difficult decisions about expensive end-of-life [cancer drugs](#).

Faden says the notion that every patient should have unrestrained access to every drug available, no matter how unlikely the drug is to help and no matter how modest the benefit, is just not feasible. The problem is figuring out access strategies that work best for most people and that respect the range of values that patients facing serious illness and death hold. "Neither system is well equipped to think through the kind of challenges that all systems confront," she says.

For many people, certain drugs will only extend life for a few weeks or months, and that time can be marked by severe side effects from the drugs themselves, Faden notes. Still, choosing which path to pursue at the end of life is an agonizing decision.

"We're managing [health care](#) costs by not allowing some people to be treated at all or forcing them to face financial ruin by getting treatment," she says. "Who has an extra \$100,000? That's why people sell their homes. That's why people's kids don't go to college. There's probably no more anguishing kind of decision than what a patient and her family face at the end of life."

Source: Johns Hopkins Medical Institutions

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