



Access to cancer care is a key factor to progress in cancer treatment outcome



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We are very pleased and honoured by the interest from *EJHP Practice* in our reports on access to cancer drugs. The description and the interpretation of our results, give additional insight and we are grateful for that. We would like to add only a few comments on the two articles published.

Our reports do not focus on differences in cancer survival rates between countries but on differences in the use of cancer medicines.

The discussion about a relation between use and outcome (survival) is prompted by observations that there is a correlation between variations in uptake and survival. We have tried to perform studies to investigate if there is a causal link or not, i.e. to estimate how much of the differences can be attributed to the use of medicines, acknowledging that there are many other factors which may also influence outcome. The data we use are available for similar analysis by other groups. As far as we know, no other conclusions have been drawn from these sets of data. In addition, we have performed similar analysis within other scientific constellations, without any 'commercial involvement', and have come to very similar conclusions.

There is a link between access to therapy and outcome for certain tumour types, a fact that has been reported by others. The most recent examples in this area are imatinib for patients with chronic myeloid leukemia where we have seen a dramatic improvement in outcome [1] and trastuzumab for patients with HER2 over expressing breast cancer tumours [2]. We now know that the outcome for patients with HER2 positive breast cancer has changed significantly both in the early stage of the disease (with adjuvant trastuzumab) and in the metastatic stage. In tumours previously thought to be less sensitive to medical treatment, substantial

improvements have been seen even on a population level, as reported by von Plessen et al. [3]. This population-based study on the outcome of advanced non-small cell lung cancer in Norway shows a significant improvement in survival linked to the introduction of palliative chemotherapy in Norway in the late 1990s.

We acknowledge that much effort and money has been invested in British cancer care during the last decade, but access to cancer drugs, new and old, is still lower in UK than in the rest of Western Europe. If this gap is to be ignored as non-significant with respect to outcome, or taken as a signal that there is room for improvement in cancer care in UK, then it should perhaps be discussed both in UK and elsewhere from a more scientific viewpoint than has been the case so far. The criticism of this work came from Professor Michel Coleman in UK and we believe we have addressed this in previous communications [4]. We note that new guidelines have been issued to improve the access to new cancer drugs in UK.

We are concerned that the available data on cancer incidence, mortality and survival are suboptimal, and that this may explain variations. Thus, we strongly advocate the need for an improvement in the availability of cancer statistics in Europe to make it possible to undertake studies of the potential link between treatment and other healthcare interventions and outcome for the population. Such statistical studies are an important comple-

ment to clinical trials, not an alternative or replacement. Regulatory decisions about the introduction of new drugs must be based on information from clinical trials and other medical research on targets, mechanisms, etc. But the design of policies to promote efficiency and equity in the access to effective cancer drugs, also needs data on how these medicines are used and how they perform in clinical practice in large populations.

The lack of data also pertains to data on spending on cancer. While we have rather detailed data on spending on cancer drugs, we have very limited data on how much different healthcare systems spend on cancer. We also have little information on how this spending is allocated between prevention, early detection (screening programmes), different treatment modalities, and supportive care within and outside the healthcare system. Since half of life years lost are in the economically active populations, indirect costs due to loss of production are also important to estimate and take into account when making resource allocation decisions to and within cancer treatment.

It is correct that the recent sliding value of the pound in relation to the Euro have made drug prices relatively lower in UK, but this is not a major part of the explanation of differences in use. Lower prices do not explain the lower use in UK. You may expect that lower use should increase the uptake, but counting in milligram instead of value (Euro) gives the same relative

low uptake in UK. It is said that UK is a leader in health technology assessment and economic evaluation, and that this could explain the low uptake. But nearly all NICE evaluations of cancer drugs in different indications conclude that they are effective and cost-effective. As Professor Jönsson has shown in an editorial in the *European Journal of Cancer* [5], the UK lag is not primarily due to NICE, but to other factors; organisation and financing of health care, including mechanisms for making resource allocation decisions, and attitudes among the medical opinion leaders about the value of new drugs (which is sometimes labelled as therapeutic conservatism but is not just restricted to the cancer field). One example of this is the NICE appraisals of trastuzumab, see Figure 3, *Eur J Hosp Pharm Prac.* 2009;15(4):25. The first appraisal in advanced breast cancer, which was positive, did not impact its use in UK. The second appraisal in early breast cancer, also positive, came well after a dramatic increase in the use of the drug in UK. This increase was most probably driven by media attention.

It is also important to point out that the low level of use of cancer drugs in UK not only relates to new drugs. UK also uses 'mature' drugs approved 5–15 years ago to a lesser extent than the rest of Western Europe [6] and see Figure 5, *Eur J Hosp Pharm Prac.* 2009;15(4):26.

We welcome the discussions that have been raised by our reports and we have them available on the website [7]. Our results have also been brought into a broader discussion addressing disparities in cancer care in Europe as reported by Kathryn Senior [8]. In her excellent review she has interviewed several key persons in this field in Europe. She points out the disparities that exist in Europe, not only between 'old' Western European members and 'new' Central and Eastern European members, but also disparities between Western European members with better outcome like France and Sweden; and countries with poor outcome such as Denmark, as well as UK. All seem to

acknowledge that these differences exist, but point to different explanations for these disparities. We do believe that there are key roles for prevention, early detection and a multidisciplinary approach in cancer care, but we also believe that drugs are a fundamental part of the progress we have seen in outcome for cancer patients, as well as the progress we can expect in the future.

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