UK government to cut number of cancer drugs available on the NHS

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17 August 2015

UK government officials are planning cuts to the Cancer Drugs Fund (CDF). The fund allocates money to purchase drugs for National Health Service (NHS) patients that have not been approved by the National Institute for Health and Care Excellence (NICE) and are not normally obtainable on the NHS in England.

The CDF was set up in 2011 by the Conservative/Liberal Democrat coalition government, to meet a Conservative 2010 election manifesto pledge to end the rationing of cancer drugs that had taken place under the previous Labour government. Under Labour, stories frequently filled the pages of the press of patients being refused life-saving drugs by NICE because they were too expensive.

Prime Minister David Cameron declared, "Other European countries are doing better than us at giving people longer, happier lives with cancer.

"We want to get more drugs to people more quickly and in the UK today there are some people—thousands of people—who want a certain cancer drug, whose doctors tell them they should have a certain cancer drug, who don't get it."

Cameron promised to bring in a new system of "value-based pricing," rather than one based purely on cost. It was supposed to increase the availability of new drugs, lower their cost and encourage the pharmaceutical industry to carry out research it would otherwise not have done.

Over 50,000 patients have benefited from the fund since 2011, half of them in 2014. It has become a vital lifeline for patients allowing them to obtain the latest drugs, particularly in cases of terminal cancer.

However, due to entirely predictable rising demand, the CDF's original annual budget of £200 million has risen to £340 million. The government now wants to reduce the list of 65 cancer drugs by 37 items, severely depleting the capacity of oncologists in the fight against cancer and affecting the survival rates of an estimated 10,500 cancer patients next year.

Last month, the independent cancer taskforce established by NHS England called for restructuring of the CDF, declaring it "no longer sustainable or desirable … in its current form."

Last week, Rarer Cancers Foundation chief executive Andrew Wilson said, "This process is a shambles and it is harming patients."

He added, "Thousands of desperately ill cancer patients could lose out. The NHS should be focusing on improving the system not introducing knee-jerk cuts."

Beating Bowel Cancer chief executive Mark Flannagan said, "We are extremely concerned further cutbacks to the Cancer Drugs Fund will compromise the NHS's ability to provide the best treatment choices for advanced bowel cancer patients and ultimately cut lives short."

A new more effective treatment for bowel cancer has quadrupled the life expectancy of cancer patients from eight months to three years. It is now facing the axe if the cuts go ahead.

However, the CDF has been criticised by some in or associated with the medical profession because it has opened the way for manufacturers to sell cancer drugs to the NHS at prices far higher than world prices, creating a form of Private-Public Partnership (PPP) of cancer funding.

In the UK, public-private partnerships have been used widely as a means to privatise the public sector.

In the opinion of Karl Claxton, professor of economics at the University of York and a leading authority on public health care funding, "There is no doubt that the CDF has done more harm than good for the NHS patients overall. The real beneficiaries of the

CDF are manufacturers who have been able to sell their drugs to the NHS at prices that are unaffordable."

Claxton has previously explained, "The key issue remains that of finding a mechanism allowing manufacturers to agree potentially lower prices in the UK that reflect their value to the NHS (whichever attributes of benefit are included).

"Unfortunately for the NHS, this critical issue appears to have been entirely neglected, despite a number of suggestions about how UK transaction prices for drugs could be insulated from parallel trade and international reference pricing."

Claxton concludes, "NICE cannot be held responsible for this policy failure. The only price negotiation mechanism in place is that which has always been available: discounts offered product by product (e.g., Patient Access Schemes). Consequently, the best that can be expected is the rejection of effective drugs when manufacturers are unwilling to offer sufficient discounts to global prices. The worst that can be expected is that NICE will find reasons to approve them nonetheless and inflict considerable damage on the NHS and the patients it serves."

The chaotic, piecemeal approach involved in the CDF saga is symptomatic of a long-standing crisis of publicly funded health services around the world, under conditions in which the means of production of drugs and health equipment are in private hands, owned by transnational pharmaceutical giants.

In the case of cancer treatment, they provide lasers, magnetic resonance machinery and other equipment for treatment and prevention and drugs for the world health market. At the same time the delivery of health care is generally socialised fully, as in the UK, or partly as in Asia.

The market, we are constantly told, is supposed to be the mechanism to encourage competition and drive down prices. However, an investigation by Bloomberg News published earlier this year found that in recent years the increases in the prices of competing prescription drugs rose in lockstep by about the same amount at the same time. "Contrary to the consumer's ideal in which bare-knuckled rivals cut prices to grab market share," the report notes, "competitors in branded pharmaceuticals often drive each other's prices higher."

Drug companies evade anti-monopoly laws by closely following each other's drug price increases in a practice known as "shadow pricing."

Only 37 percent of world drugs, including those treating cancer, are of generic origin, which means they are free from patent royalties to drugs manufacturers. Generic drugs are far cheaper than proprietary drugs. In cancer treatments, however, generic drugs are not the most effective as they are not the product of the latest research and development. The most effective and newest drugs are non-generic.

Consequently, the best cancer treatments are now only available to the few richest patients on the planet.

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