Counting the cost of cancer care

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UK patients often miss out on the benefits of drugs developed through UK research as availability is delayed after licensing

The UK is one of the leading centres for cancer research and clinical trials. Many of the most significant drug developments of the last decade have come through UK research.

Yet UK patients are increasingly missing out on the benefits of these discoveries as the UK's cancer budget fails to keep pace with European countries. The UK spends around 40% less per patient on cancer drugs than countries such as France or Germany.

Newly licenced drugs in the UK, unlike in say France, are not immediately available to NHS patients but have to pass through a second post-licence hurdle – the National Institute for Health and Clinical Excellence (NICE). This results in delays, often of several years between licence and widespread availability. In the interim between licence and NICE decision, availability is determined by local Primary Care Trusts (PCTs). This costly process results in differing decisions by place of residence. Where drugs are denied funding this sets doctors and patients in often lengthy and sometimes very public conflict with the PCTs.

Frequently, the final result of the NICE appraisal will be to deny NHS funding for drugs freely available (on the basis of proven efficacy) elsewhere in Europe. Hence for cancer patients, access to new drugs is patchy, late and capricious compared to their counterparts in Europe.

The problem facing clinicians is exemplified by the drug sorafenib (Nexavar), a drug that was first licensed for use in renal cancer in 2006. Despite this we estimate that only a third of UK patients had access to the drug between licence in 2006 and 2009 when NICE recommended against NHS funding for the drug. In 2007 the drug was licensed in Europe and the US for the treatment of liver cancer (after studies showed a survival benefit) but was again refused NHS funding approval by NICE in 2009.

Our own audit of survival in renal cancer patients attending clinic between 2006–2008 showed that patients given access to sunitinib and sorafenib had substantially better survival than those denied treatment (average survival 22 versus 7 months).

This exemplifies both problems – the delay in decision and the ultimate refusal of a life-extending, safe drug to desperate patients.

The inequalities are not limited just to access to cancer drugs but to the whole treatment process. Whilst cancer mortality in the UK is decreasing it still lags behind countries like France and Sweden. 60.3% of men and 61.7% of women in Sweden survive a cancer diagnosis; in the UK survival stands at 40.2 to 48.1% for men and 48 to 54.1% for women. England spends 5.6% of its public healthcare budget on cancer, which is far less than France 7.7%, the United States 9.2% or Germany 9.6%.

Nonetheless, the last 10 years have seen considerable improvement in cancer outcomes in the UK. The NHS Cancer Plan in 2001 and Cancer Reform Strategy in 2008 tightened systems considerably, with consequent reductions in delays to diagnosis and treatment and reduced death rates. Despite these improvements, there is still considerable scope for progress when measured against Europe.

As the pace of drug discovery increases this problem of drug access will become more acute. Politicians of all parties need to address whether they support continuation of the NICE process, with its inherent delayed access and rationing. If the answer is yes then people need to be explicitly told that NHS cancer care is only provided up to certain limits, which will become increasingly stretched by advancing technology.

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