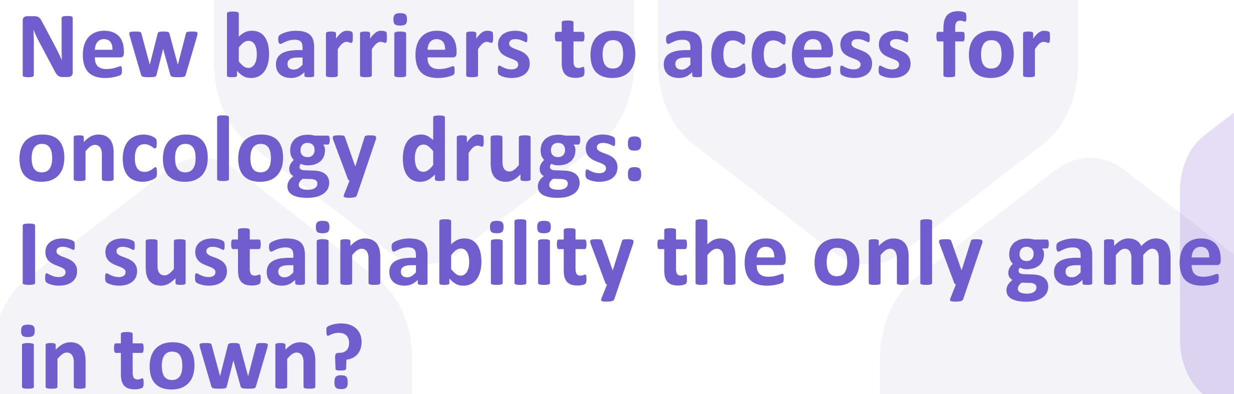

New barriers to access for oncology drugs: Is sustainability the only game in town?

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THE STRAITS TIMES SINGAPORE LOG IN SUBSCRIBE

'I thought I couldn't go through any more of it': Cancer patient gets help after insurer says 'no' to $33k bill

Ms Koh Ee Miang (left) and her oncologist, Dr Choo Su Pin, were in a quandary over the high cost of the treatment. ST PHOTO: ALPHONSUS CHERN

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SINGAPORE - Good Samaritans have stepped forward to help a cancer patient, who hopes to spend more quality time with her 15-year-old daughter while keeping the disease at bay.

The drug that Ms Koh Ee Miang, 45, needs to control the spread of her cancer is expensive, and her insurance company has refused to pay for it - leaving her with an outstanding bill of more than $33,000 for treatment carried out between November and January.

The Straits Times, 25 May 2022

The context

Allowing subsidies, IP coverage for off-label cancer drugs will drive up costs: MOH

Changes to cancer treatment financing are slated to kick in from September. PHOTO: ST FILE

- MediShield Life (MSHL) introduced on 1 Nov 2015
  - Universal health insurance coverage for life
    - Mandatory enrolment; no lifetime caps
    - PEI coverage at a premium (transitional); means tested government subsides
    - Selected specialist outpatient cover (incl. oncology)
- The establishment of Agency for Care Effectiveness (ACE) in 2015
  - Health Technology Assessments, utilization reviews and pricing negotiations
- The issuance of the Cancer Drug List wef 1 Sep 2022 (MSHL and MediSave) and 1 Apr 23 (Private plans)
  - For MSHL and MSV, no coverage for non-CDL drugs

The situation of rare cancer patients

- … [R]arity tends to bring with it a collection of characteristics that are ethically significant;
  - we tend to know less about rare conditions and their treatment; they are often harder to diagnose;
  - we tend to conduct less research on these conditions than those that are more common;
  - the costs of treatment tend to be higher; and there is less market interest.
- When groups of patients with rare conditions compete directly with other healthcare interventions*, they are systematically at a disadvantage and importantly, equality of opportunity is lost*.
  - E Jessop and M Sheehan (2015)

- Increasing cost burdens of new health technologies – especially drugs and medical devices
  - ACE – "the general picture is one of rapidly escalating drug costs with marginal improvement in clinical outcomes…"
- The 'right to try' movement/Accelerated access programmes/Off-label treatments
  - Increased efficiency in evaluation
  - Registration bypass or modification
  - Relaxation of financial reimbursement requirements
- Fundamental tension between the two

I think such judgements (on the value of health improvements) are inescapable in a system which is expected to behave in a non-capricious manner in discriminating between the well and the ill, between the severely ill and the slightly ill, and between those likely to benefit from a particular treatment and those unlikely to do so, in order that some systematic priority-setting can take place in the face of inescapable resource constraints."

Alan Williams, "Cost-effectiveness analysis – is it ethical?" (1992)

- Health economics
  - Maximise population health given limited resources – equal concern for all health interests
  - Embedded in cost-effectiveness methodology
- Other objectives
  - Egalitarian/Equity concerns – reducing social inequality in health
  - Meeting needs - Non-abandonment
    - Rule of rescue - Prioritise identifiable over statistical lives (?)
  - Avoid unfairness to disadvantaged groups for morally irrelevant reasons

Principles of justice in Singapore healthcare

- Individual and community responsibility; mitigating moral hazard
  - MediSave, co-payments, targeted subsidies that are means tested
  - Age-rated national health insurance (in the past)
- “Ultimately, as it is society who bears the cost, the government’s role is to design a system that maximises value and health outcomes from the available resources.”
  - Deputy Secretary Lai Wei Lin, MOH

Principles of justice in Singapore healthcare

- Major shift to more inclusive, socialised medicine after 2011
  - MediShield Life introduced in 2015 -
    - Mandatory, universal coverage, including PEIs
    - Subsidised premiums to ensure affordability
    - Socially rated premiums to reduce burdens on the elderly
  - "Equal Opportunity for Welfare" principle (Arneson; Menzel) (EOW)
    - Form of luck or responsibility-sensitive egalitarianism
    - Just sharing of the costs of illness - "Financial burdens ought to be shared equally… unless individuals can be reasonably expected to control those misfortunes by their own choices."

Principles of justice in Singapore healthcare

- Beyond cost-effectiveness:
  - Medication Assistance Fund (Aug 2010)
    - Extends to non-standard drugs that doctors have assessed to be *clinically necessary and appropriate* for the treatment of the patient's condition
  - The establishment of the Rare Disease Fund (July 2019)
    - Further subsidies for expensive rare disease treatments (<5 in 10k; <2 in 50k)
    - Charitable fund with matching government co-funding (3:1)
- EOW principle or Rule of rescue/Non-abandonment?

- Special funding measures:
  - Cancer Drug Fund (UK), Life-Saving Drug Fund (Aust)
  - Separate budget and process
  - Transparent criteria
  - Duty or charity?
- Managed Entry Agreements (Europe), Coverage with Evidence Development (US)
  - Negotiated compromises on evidential standards (e.g. Observational studies instead of RCTs)
  - Complexities in design, management and enforcement
- Risk-sharing Agreements/Outcomes-based contracting
  - Between payers and pharmaceutical companies
  - Different prices for same drug depending on how it actually performs