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ETHICAL ASPECTS ON PRIORITISATION OF NEW CANCER DRUGS

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My background

- Researcher in bio-, medical, health care, public health and health policy ethics
- National council of medical ethics (2000-2006)
- Ethics delegation of the Swedish Society of Medicine
- Member of the pharmacological regional ”NICE” of Västra Götaland County Government

Priority-setting and rationing of resources is a core ingredient of medical practice, policy ethics

- **A special case of distributive justice**: the desirable allocation of available resources in some area. Base question is: according to what principles?

- **Different levels**: society as a whole (between sectors), between areas within a sector, between type-cases within an area, between cases within a type, …

- **Always constrained** by (a) higher levels determining the amount of resources, (b) dynamic effects: how a distribution will affect the future demand and amount of resources.

- Basic rule: what you give the one, you deprive another

Basic considerations

- **Benefit to individual patient** (depending on seriousness of disease, effect on disease, side-effects, and evidence-base). Benefits may include QUALY aspects, but also e.g. intergrity and autonomy aspects**. Internal tensions/conflicts may occur**.

- **Benefit to society** (depending on prevalence of disease, level of impairment, likelihood of patients recovering functionality and returning to work, etc).

- **Opportunity costs**: look at all options and patient groups at once and compare effects, not only one option/group at the time – this implies a **requirement of cost-efficency**.

- **Normative constraints**, e.g., that patients should never be treated by the harming of other patients or people, that a treatments must respect autonomous decisions of patients, etc.

- **Justice constraints**: that only some of the aspects above should be considered and that they must be considered equally for all (the principle of human worth).

- Swedish law excludes benefits to society from playing any role in priority setting *within* the health care sector, but not *between* health care and other sectors (as in public health management)

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New Cancer Drugs: General Considerations

- **Very serious diseases**, but cancer is as such no more important than other conditions with similar effects (although there is a public culture to that effect: ”the Big C”).
- **Increasingly expensive**, either per patient or due to rising number of patients
- Tendency towards more specific strategies (”personalization”) ➔ consumer group/ product shrinking ➔ higher prices per unit (pure arithmetic of business)
- **Highly variable and often limited effects**, albeit symptoms may be reduced for a limited time, but usually with quite pronounced side-effects (may still be better than the standard today!)
- **High opportunity cost** as resources might be better used for other serious conditions
- **Cost-efficiency goes down** ➔ if benefits to society are allowed, this upshot is stronger

New Cancer Drugs: Radical Effect Variation

- In some cases: effect may be relatively good (actaul survival), but also quite bad, this varies in a way impossible to foresee.

- **Using such a drug means introducing a lottery through which some patients are probably killed (unintentionally by side-effects), and through this other patients can survive some time more.**

- **The principle that patients should never be harmed for the sake of someone else seems to apply.**

- At the same time, patients may accept these odds, just as they may ask for therapies not considered responsible to use by the profession

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The Ethics of Pharmaceutical Pricing

- **States/societies must resist the business strategy of steady increased prices of drugs**, and this can only happen if they say ”no” to some offers, in order to incetivise producer to offer lower prices.

- **Otherwise, publicly funded health systems will be systematically milked of resources** by commercial companies, and this will hit many more patients much more seriously.

- **The price of a drug** set by a company is ultimately determined by the financial return expectations of the owners of that company: these are **chosen freely**.

- At the end of the line, these **owners are people who have a moral responsibility** for contributing to a situation where seriously ill patients are denied treatment.

Conclusion

- Given the new strategies of commercial producers of pharmacological products, there are strong arguments for states to resist the offers.

- Also: strong ethical reasons for health systems and health professionals to ration and set limits based on ethically well-founded priority-setting ➔ what this means depends on how much public health perspectives are allowed to play a role.

- Now: nationally centralized price negotiations are coming rapidly, next step is multnational alliances to press prices further, e.g. Nordic Countries, NC + Holland + UK, entire EU (?)

- This is a time of flux, hopefully a new equilibrium will settle itself in the future, where the issue of what drugs are to be publicly funded can be better foreseen.