Reducing the Costs of Cancer Treatment

By Dr Jeremy Lim, Editorial Board Member

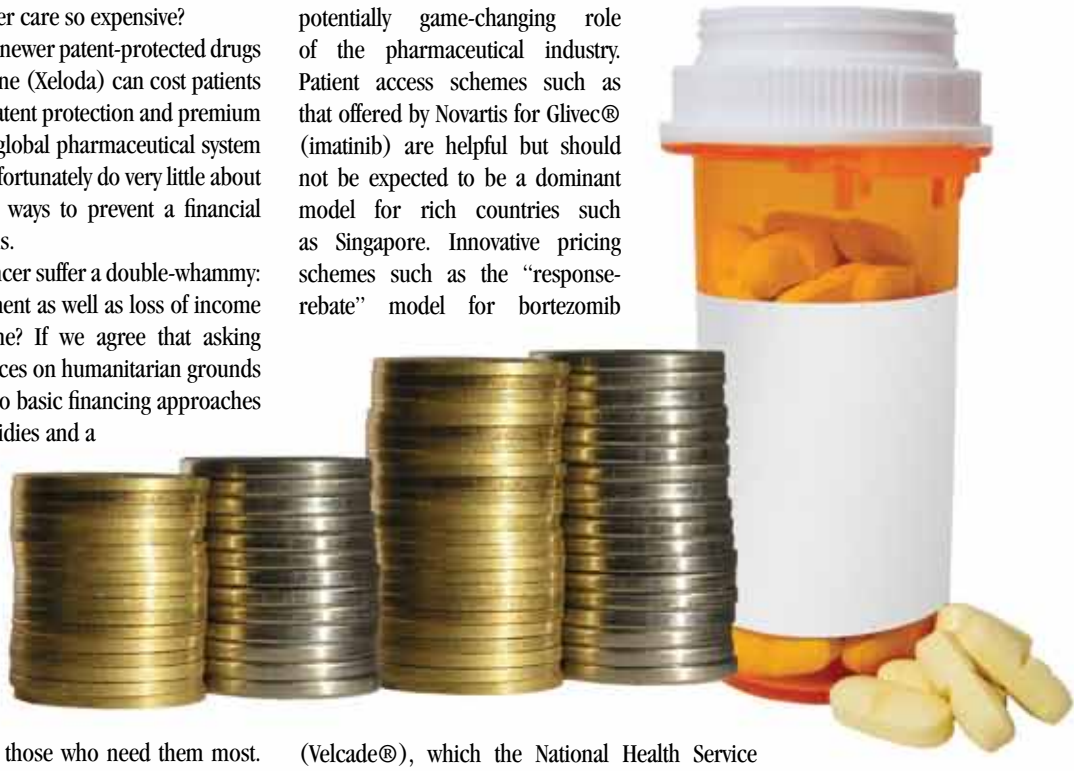
World Cancer Day falls on 4 February. As we celebrate the impressive advances in medical science, let us reflect also on the cost of cancer care and what can be done.

"Cancer treatment can be very, very expensive. This is something our health system will have to deal with. It is not surprising if some patients have to sell their house."

The ranting of an opposition politician? No, these words were spoken by Senior Minister of State, Dr Balaji Sadasivan before his untimely demise late last year from colon cancer. Why is cancer care so expensive?

Oncology is a rapidly advancing field and newer patent-protected drugs like trastuzumab (Herceptin) and capecitabine (Xeloda) can cost patients hundreds to thousands of dollars a month. Patent protection and premium prices for new therapies are a reality of the global pharmaceutical system which Singapore, as a "little red dot", can unfortunately do very little about directly. Instead, we should be striving for ways to prevent a financial catastrophe on top of a catastrophic diagnosis.

Remember that patients afflicted with cancer suffer a double-whammy: managing the disease and the costs of treatment as well as loss of income through stopping work. What can be done? If we agree that asking pharmaceutical companies to lower their prices on humanitarian grounds is naive and not likely to be effective, then two basic financing approaches could be adopted in parallel – targeted subsidies and a wider risk pooling.



Targeted Subsidies

Last year, the Ministry of Health announced a Medication Assistance Fund (MAF), which would offer subsidies for drugs such as paclitaxel (for breast/ovarian cancer) and oxaliplatin (for colon cancer) on a means-tested basis. The approach is correct as it conserves scarce subsidies for those who need them most. After all, the point of government intervention is not to reduce out-of-pocket or cash payments per se but to minimise financial catastrophe and prevent medical bankruptcy; those who can pay more should so that those who cannot do not have to. That said, I do hope the pace of introduction of more drugs into the MAF can be quickened, and timely reviews conducted to keep pace with advances in medical science.

Wider Risk Pooling

The government has resisted calls to include more conditions for coverage under MediShield, citing the need to then raise premiums, which may compromise enrolment of the healthy "average Singaporean". Need this be the case? Will Singaporeans balk at higher premiums and drop out of MediShield? Perhaps the question should be framed as "What are Singaporeans' willingness to pay higher premiums for a more equitable society, at least when it comes to health?" One academic analysis has proposed that raising premiums by $167 annually will enable diagnosed patients to have $50,000 worth of additional ammunition in the war against cancer. Is this politically tenable? I personally do not think so, but a combination of measures may be.

A possible recipe of interventions could be a mix of: more generous coverage under MediShield through a more modest premium increase of tens of dollars, expansion of the MAF and direct premium payments for the financially vulnerable (the government already provides for Medisave top-ups) to keep them enrolled within MediShield.

Let us not forget also the potentially game-changing role of the pharmaceutical industry. Patient access schemes such as that offered by Novartis for Glivec® (imatinib) are helpful but should not be expected to be a dominant model for rich countries such as Singapore. Innovative pricing schemes such as the "response-rebate" model for bortezomib (Velcade®), which the National Health Service in England and Wales adopted are worth exploring. In this scheme, multiple myeloma patients at first relapse who show a full or partial response to bortezomib can carry on with the treatment, fully funded by the government. Patients who show no or minimal response are taken off the drug and the drug costs refunded. Perhaps "nuancing" this with some measure of government subsidies and patient co-payments can increase access and affordability.

There are no silver bullets that will, in one fell swoop, overcome the financial challenges of oncology care access. However, more aggressive combinations of policy interventions, treating the perspective of the individual patient with as much importance as the larger societal need for an affordable health system collectively, can achieve the end objective of not requiring patients to "sell their house" as Dr Balaji cautioned. No Singaporean should have to lose his home to win his life. SMA

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