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Shifting cancer care back to public hospitals is no cure

Expensive or unapproved drugs are a headache in the new cancer drugs policy. Here's how to let the private sector have a viable supporting role.

The National Cancer Centre Singapore in Hospital Crescent. The writer notes that at least two issues have emerged in the heated discussion about the Cancer Drug List. The first relates to off-label drug use, while the second has to do with the large discrepancy between public and private drug prices. ST FILE PHOTO

Wee Hwee Lin
For The Straits Times

There has recently been a flurry of articles and forum letters in The Straits Times discussing the impact of a new Cancer Drug List policy on patients with cancer.

It comes into effect in September for people with MediShield Life and for MediSave withdrawals, and in April next year for those with Integrated Shield Plans (IPs).

At least two issues have emerged in the heated discussion about the list, which comprises clinically proven cancer drugs that are also cost effective. The use of MediShield Life and IP insurance to reimburse outpatient cancer treatment will not be allowed if other drugs are used, or if the drugs are used for other indications – for example, one listed only for breast cancer cannot be used for other cancers.

The first issue that reared its head relates to off-label drug use – using a drug in ways that have not been approved by the Health Sciences Authority.

The second has to do with the large discrepancy between public and private drug prices.

The Ministry of Health (MOH) has suggested that patients with cancer seek care at public cancer centres. But shifting cancer care back to public cancer centres most likely does not truly address the crux of the problem. Here's why.

NOT SUSTAINABLE FOR PUBLIC HOSPITALS

Existing national cancer centres are already experiencing high caseloads. In response to the rising number of patients with cancer, we built the second national speciality centre for cancer in 2008, and expanded the first speciality centre for cancer in 2018. But how sustainable is this option of continuing to build national cancer centres in land-scarce Singapore?

Along with cancer, the incidence of other chronic medical conditions – including diabetes, chronic kidney disease and heart failure – continues to rise. In due course, other speciality centres, too, inevitably require expansion in capacity.

How do we manage the needs of patients with cancer and those with other chronic medical conditions? More importantly, how are we to equip these new speciality centres with skilled nursing manpower given the ongoing labour crunch?

The private sector plays a critical role in Singapore's healthcare ecosystem.

The Covid-19 pandemic allowed us to witness first-hand the swift response of the country's private healthcare sector players in supporting the overwhelmed public healthcare sector.

As laid out in the Healthier SG initiative, general practitioners will continue to play a critical role in ensuring its success.

Yet, to assume that the primarily profit-driven private sector will naturally support this initiative might be erroneous.

The robust public-private partnership we now see in the healthcare sector has taken years to cultivate. As with any public-private partnership, such relationships are works in progress requiring constant recalibration.

So it is important to recognise that in order for the private healthcare sector to play the much-needed supporting role in cancer care, we need to co-create win-win solutions for all stakeholders, with the health and well-being of our citizens as the top priority.

ADDRESSING DRUG PRICE DISCREPANCIES

Health technology assessment (HTA) is a tool used around the world to determine whether new treatments provide value for money. In Singapore, the Agency for Care Effectiveness, too, uses HTA as a vital assessment tool.

While HTA is not primarily intended to be used as a cost-containment measure, it does drive down drug prices as it holds drug companies accountable in ensuring that the hefty price tags are commensurate with evidence ("Cancer patients can access more affordable care and financial support at public healthcare institutions", The Straits Times, June 27).

Still, HTA does not directly address the issue of the large discrepancy between public and private drug prices, which arises due to the public sector's ability to command much lower drug-acquisition costs.

HTA requires evidence of clinical effectiveness, usually based on the average treatment effect observed among a large number of patients in trials.

In the case of rare cancer and rare diseases, it is particularly difficult to generate robust evidence of clinical effectiveness because there are very few patients. Plus, patients with the same cancer diagnosis may present clinical symptoms and complications differently.

The term off-label does not mean that the drug does not work. Some patients do respond well to drugs used off-label ("Cancer patient ends up with $33,000 bill after insurer refuses to pay for drug", ST, April 21).

ALTERNATIVE APPROACHES TO COST CONTROL

First, we should enable central purchasing for high-cost cancer drugs and set a mark-up limit to control the prices of these cancer drugs in the private sector.

Setting a mark-up limit will ensure that the private sector does not profiteer from the lower purchasing cost achieved via central purchasing, and that the savings would be passed on directly to patients.

Differential pricing between public and private drugs would inevitably persist, but that would be due to differences in operating costs, and we expect that price gap to narrow. We can allow the mark-up limits to differ between citizens and non-citizens so that the private sector has room to improve its margins while performing its national duties to provide care for citizens.

Second, we should allow portable subsidies from the public to private sector.

MOH already employs means testing to ensure that subsidies are targeted at those most in need.

Permitting portable subsidies will allow MOH to fulfil its obligations to take care of citizens without overwhelming the public sector. Setting a mark-up limit, as previously suggested, would mitigate any potential abuse of portable subsidies.

Finally, we should expand current risk-sharing agreements (RSAs) to include off-label drugs.

HTA agencies globally and locally have used RSAs, also known as managed entry agreements, to address the issue that the benefits of some new treatments are unclear.

For example, Pembrolizumab was approved in Australia for Stage 3/4 skin cancer, which cannot be surgically removed.

When the company subsequently applied to have the drug used in a different group of patients, the committee was less clear about the potential benefits to patients. It required that an RSA and a special pricing arrangement be put in place to limit the cost that the public sector has to bear, should the drug not work in this other group of patients.

We may expand the RSA to include off-label cancer drugs on the condition that they have been recommended by professional organisations such as the National Comprehensive Cancer Network in the United States.

Drug companies are often reluctant to invest the time and money to register a new indication for a small number of patients. Hence, an RSA provides a calibrated approach to gathering evidence of clinical effectiveness, while meeting needs of patients.

Lowering private drug-acquisition costs and setting a mark-up limit, allowing portable cancer drug subsidies, and managing unclear benefits with RSAs may be more viable alternatives for the long term.

stopinion@sph.com.sg

• Dr Wee Hwee Lin is an associate professor and director of the Centre for Health Intervention and Policy Evaluation Research at the Saw Swee Hock School of Public Health, National University of Singapore. She is also a member (selected) of the Health Sciences Policy Council, International Society for Pharmacoeconomics and Outcomes Research.