Cancer52 Viewpoints on VBP and CDF:

60 second interviews with
Eric Low, Dave Ryner and Leela Barham

Cancer52 has been closely monitoring policies that affect access to medicines for our members. With the deadline for Value Based Pricing (VBP) fast approaching and a decision needing to be taken on the Cancer Drugs Fund (CDF) imminently, Cancer52 spoke to Eric Low, Chief Executive of Myeloma UK, Dave Ryner, Head of Policy at Cancer 52, and Leela Barham, an independent health economist, to get their views on these controversial policies.

So what's new with VBP?

Eric: "Well, the truth is that VBP as it was originally set out by former Secretary of State for Health, Andrew Lansley in 2010, just doesn't exist anymore. It's really boiled down to Ministers requiring the National Institute for Health and Care Excellence (NICE) in England to include Burden of Illness and Wider Societal Benefits in their assessment of new medicines."

Dave agrees. He said "NICE is now working on implementing the Terms of Reference for VBP that they received from the Department of Health. Many decisions on how it will be done have been taken given the very tight timelines."

Leela said that: "The opportunities to change VBP now are probably limited, but there is a real opportunity to push for proper evaluation of VBP. The goals of VBP are good; who doesn't want patients to have access to innovative new medicines that offer good value to the NHS and society? But I doubt that this is what will actually happen. We have to remain focused on the benefits for patients, so patients need to be part of evaluating whether VBP is a success or not."

What don't we know about VBP?

"We know more from the Department of Health about how NICE will be changing their approach to assessing the value of new medicines under VBP" according to Leela. "We know that the idea is that this wider value assessment will look at the Burden of Illness and the impact on patients and carers and society, primarily in terms of the impact on consumption and production. That's narrow but perhaps better than we had before" she adds. "But we still don't know how price will be linked to that value assessment. My worry is that this could lead to long negotiations. And that comes at a cost; to patients who wait to access treatments, and in some cancers there is a dwindling window of opportunity for treatment to offer benefits, and to companies who see their effective patent life reduced."

Dave added: “We don’t know, but we can only hope, that patients really will be part of the new NICE process in assessing value. That we are allowed to put forward evidence on the wider value of new medicines and that it will be genuinely part of the deliberative process. But we don’t know yet how this will really feel and be like to work within.”

Does VBP matter to patients with rarer cancers?

On this all three agree: yes it does. Eric said: “VBP, particularly via the Wider Societal Benefits, could mean that some patients are less likely to get access: those who aren’t likely to get back to work, or are elderly, or female, or all three, might lose out. And that’s on top of the particular challenges in generating evidence on the benefits of medicines to treat rare diseases. It is just difficult to get enough patients in phase 3 trials, which in turn means less robust evidence of benefit.”

Dave saw some potential opportunities: “VBP could allow new and different evidence to be part of the decision making process. I‘m hoping it means we can make a better case for the benefits of treatment. In particular individuals who happen to be patients will not be confined solely to that status within the evaluative process.”

Leela sees it from a different point of view, that “The public and patients are directly affected by decisions about access to medicines. They either lose out when a promising medicine is not recommended, or lose out when a product that offers poor value is recommended and more could have been done with that money. I want the NHS to get the best value out of every pound spent, so that we can all get the care and medicines we might need if we are ill now, or we get ill in the future whether that’s treating a common or rarer disease. And that includes getting the best value for money from new medicines and creating an environment when innovation in medicines can continue. VBP is part of that environment.”

What’s new with the Cancer Drugs Fund (CDF)?

Leela said: “Decisions are about to be taken on the future of the CDF. The fund was set up in 2010, but promises to ring fence funding for drugs that NICE has said no to, or has not yet come to a decision on, ends in 2014. What we’re waiting to find out is whether the CDF will continue, I predict yes, but also whether it will evolve. Scotland has a fund for treatments for rare diseases and we’re already seeing calls for something like that here too. Or maybe a return to an old idea of an innovation fund”.

Dave also noted that: “The fund is limited, it’s just £200million a year. With new products coming out there is going to be some decisions taken about what the fund can no longer cover.”

Eric picked up that theme and said: “The fund has a limited amount of money and there is a risk of overspend given the pipeline of drugs that will need to get on the fund. The only way to get on is to take a product off. Given that inclusion is based on a score, there is a category of drugs with the lowest scores. It’s likely that the drug with the lowest score will come off provided that the new drug has a higher score. This is going to create a moving target about what is good enough. And that’s not good for patients, clinicians, it’s just not good for anyone. It’s running the risk of creating even more controversy and uncertainty”

Does the CDF matter to patients with rarer cancers?

Eric said: “The fund has provided access for thousands of patients so it is making a difference. But it’s not tackling the underlying problems in access. It’s simply the best current option, but we need to work harder to make changes so that we don’t actually need a fund at all.”

Dave highlighted that: “The fund is essentially a political creation and politics is intrinsically linked with the NHS. It does provide funding and it has made a difference to patients with rarer cancers. Ultimately it will be overwhelmed by its contradictions and narrow agenda. However I think the NICE HTA process, even with the addition of a VBP component, will never represent a complete solution to access. For that to even begin to occur will require all those with an interest to take seriously the paradigmatic shift implicit in the concept of personalised medicine.”

Leela again took a different view: “I’d rather see improvements to how we make decisions about access than have a fund which does little to solve the uncertainties in the evidence base that often coincides with more cautious decisions from NICE, and which is simply unfair to those patients who may experience just as distressing diseases which don’t happen to have the cancer label”.

Find out about Cancer52’s positions on both VBP and the CDF here.

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