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BY:

Medicines Australia Taskforce: Deloitte Report into Cancer Care Access

General comments

The Report represents a broad (though not comprehensive) listing of many of the problems and challenges facing cancer care access in Australia, particularly those relating to drug approvals. It does not provide any solutions, or attempt to do so.

No one-size-fits-all healthcare system can meet all needs, still less desires; at least two systems ("public" - tax-funded - and "private" - consumer-driven) are needed. As A/Prof Gary Richardson is quoted as saying, the existing system is simultaneously "suboptimal" (not generous enough) and "unsustainable" (too generous). This paradox reflects the reality that no single system can function without problems.

The evolution of the present system can be traced to Australia's short-term political culture in which fiscal cutbacks to healthcare support have proven to be electoral suicide. Hence, a tendency to "pork-barrelling" healthcare largesse for political reasons, as distinct from medical or health-based or fiscal rationality, has prevailed. The "path of least resistance" has been to inflate relevant healthcare budgets to however high a level the government of the day can (briefly) manage to support.

Compared to the public medical systems of the UK, US, and Far East, the Australian public medical system provides clearly superior care and support (e.g., drugs) to cancer patients. The US system provides private (insured) care which is clearly superior to all the other private systems, though at an increased cost which proportionately exceeds any measurable improvement in outcomes; it is the experience of cancer care, not the objective outcome, that is superior in the US.

Despite this, the Australian healthcare consumer remains ignorant of international comparisons, and has long accepted the status quo as a basic level of human rights. The Australian cancer care consumer lacks any knowledge or insight by which to compare the quality of care offered in the local system, and now perceives such care quality (or lack thereof) as an absolute, rather than a relative, concept.

In other words, there has been a gradual upward migration of expectations such that only "Rolls-Royce care" has become "good-enough care"; indeed, the concept of "good-enough care" no longer seems to exist in the public's view of Australia cancer medicine, consistent with the idea that health and longevity are priceless consumer commodities that justify any price being paid. Presumably, this central problem can only be realistically addressed by a painful process of political and cultural change.

Co-payment offsets to PBS drug costs are misleadingly low for cancer drugs, with patients receiving upwards of $5000 per month drug value for $36.50. Despite this, many patients complain about having to absorb even this trivial co-payment cost.

The historical generosity of the Australian system to its patients (read, voters) has been defrayed in part by cutting corners in other respects. One of the most egregious impacts has been that affecting the public-sector medical oncology workforce which must now be viewed as one of the most academically depleted in the developed world. This research weakness reflects a multiplicity of contributing weaknesses:

- An extremely weak University-based career track for clinical academics;
- Markedly low after-tax base salary incomes for full-time staff specialists relative to other Western countries, coupled to high living costs;
- An intrusive and demoralising burden of bureaucracy (both Government and Hospital), pursued in the names of equity and cost-efficacy, that drives many to find refuge in the private sector, even when less income is the expectation;
- A lack of authority, reporting lines, and support staff (whether junior medical officers, trainees, oncology-trained nurses, research support, or secretaries);
- High levels of burn-out due to the nature of the specialty field, leading many to abandon full-time employment in favour of more fragmented (but more psychologically sustainable) part-time work, thus damaging Departments;
- Frustration at not having sufficient (or any) protected public time to pursue research, including writing competitive grant applications - given that the desire to pursue research is a key attraction of an oncology career for many;
- An unwillingness by Governments to expand staff specialist numbers with the aim of improving care, based in part on the chicken-and-egg argument that the present system is coping, therefore any increase would be wasteful;
- An historical anti-intellectual cynicism of Australian governments, who see little short-term political reward in creating Centres of Excellence in cancer care and research, but only costs, egos, impenetrable hot air, and more costs.

From a clinical service perspective, the advent of the internet has worsened the problem of matching public services to public expectations. Third-party payers are conservatively focused on evidence-based medicine, whereas the media are keen to publicise the latest (potential) research-based advances, whether proven or not. Discussing this growing 'grey area' of cancer therapeutics is an increasing time-waster for medical oncologists, who often feel obliged to spend even more time requesting free or discounted drug samples to ease the worry of distressed patients.

Clinical cancer research is becoming ever more difficult to pursue in Australia, for the reasons stated in the Report, thereby depriving patients of opportunities to participate in trials of ethically-sanctioned new treatments. Trial participation levels may well be as low as 1% over the country, whereas 5-10% participation would be considered desirable. Mistaken government initiatives in seeking to improve clinical research "quality" over "access" may well have contributed to this shortfall in NSW.

From an industry perspective, the refusal of the PBS to approve Zelboraf™ may well have been a trigger for the present Report. This refusal, based as it was on the price demand by Roche *vs.* modest survival gain, was probably inevitable at some point.

There appears to be a bias in the Report reflecting the composition of the Taskforce members - all pharmaceutical companies. Clearly there are genuine problems facing pharmaceutical companies in Australia, all of which are mentioned in the Report, but these represent only one facet of the "cancer care access" problem in Australia.