Use of expensive new drugs or formulations in WA public hospitals

The Western Australian Drug Evaluation Panel assesses the efficacy and cost-effectiveness of expensive new drugs or formulations for use in WA public hospitals. This is an evidence-based assessment and as such is reliant on the existence of high quality 'gold standard' randomised controlled trials looking at relevant outcomes in the group of people (population) for which the drug is to be used in WA.

As most of these drugs are new, such evidence is not always available or is very limited. Some drugs are very expensive for the often small possible benefits over existing drugs and treatments. Clinicians put forward applications for the drugs that are considered, as they consider them to be useful in their practice.

For a cancer drug, for example, from a patient point of view it is not simply that the new drug will prolong life (sometimes in terms of months), but that life will be more bearable. For someone with mesothelioma this may mean less difficulty in breathing. Sometimes treatment options are extremely limited (for example for chronic pain) or those available may have debilitating side effects that limit their use by some people. Few new drugs dramatically change life for people with a disease but 'biologics' have been an example of this, for rheumatoid arthritis sufferers. Cancer therapy has improved dramatically over the last few decades and drugs are available that markedly reduce metastatic cancers for some.

WADEP looks purely at drugs and formulations for public hospital pharmacy formularies (each hospital has its own formulary, decided by its own therapeutic committee) with differing levels of restrictions on use. Other types of treatment options are administered separately with very different budgets (psychosocial support, counseling, education, physical therapies etc).

Medicare was introduced in Australia to ensure that all citizens have access to health care. Australia prides itself, justifiably, on its provision of quality health care. We are unique in our balance of public and private health care. Clinical specialists are able to work in both systems and in this way to keep themselves on the cutting edge of new treatments and healthcare developments. Now we also see private (fee paying) and public patients in our public hospitals. This is aimed at helping with the rising costs of health care, largely driven by the increasing costs and use of medicines. Both types of patients receive their drugs from the hospital pharmacy.

With increased availability of healthcare information and knowledge about new drug developments (indirectly through the pharmaceutical industry), people are becoming more and more aware of what therapies are available globally. Patient and doctor are on the look out for new, more effective treatments. Patients are often vulnerable – they are sick and want to feel better. They find themselves in a world (the healthcare system) that they are not at ease in and do not understand a lot about.

The Pharmaceutical Benefits Advisory Committee (PBAC) assesses new drugs and formulations as to whether or not they should be available to Australian healthcare consumers at reduced or no cost (on the PBS). This system operates outside the public hospitals, mainly in community pharmacies. The PBAC also determines any restrictions on the use of a drug. These drugs have been approved by the Therapeutic Goods Administration (TGA) for use in Australia. As soon as a drug has TGA approval the pharmaceutical industry is able to provide the drug to doctors, generally specialists working in hospitals. This is a way of enabling the doctors to familiarise themselves to the drug, to give it to patients (sometimes termed seeding trials). Some patients may really benefit from the new drug. However, this can pre-empt the availability of the drug under the subsidy scheme of the PBS. Some of the new drugs becoming available are very expensive. What this means is that they may be approved for subsidy but with very clear restrictions for their use, such as when other treatments have failed. This happened with the biologics and restrictions on their use for rheumatoid factor-positive rheumatoid arthritis. One of these was infliximab (Remicade) that has to be given directly into a vein (by intravenous infusion) and so required a visit to an outpatients' clinic.

In the past, people were selling their houses, or paying for private health insurance that they could ill afford, so that they could have a new hip or knee (joint replacement). They were living with severe pain and restricted mobility but the waiting lists in the public hospital system were (and are) so long that timely treatment was not available. Now, are we heading down a similar path with expensive new drugs? How clear is the guidance to patients that these drugs are necessary and will achieve appreciably more than cheaper treatments? This is a complex situation with potentially many vested interests. If people manage to pay for the drug, where is it to be administered – in public hospitals as a public patient where they have no private health cover? Already people bring in with them the medications they are currently on, including their complementary therapies.

Equity is a difficult philosophy to address and that is why the PBS is in place.

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