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Policy & Resources Committee

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Dear Sir

Letter of Comment – Committee for Health & Social Care - P.2019/141
Review of the Funding of Drugs, Treatments and Devices

The Policy & Resources Committee acknowledges that a significant amount of work has been completed by the Committee *for* Health & Social Care in a relatively short period of time to bring forward these proposals which are in response to the *"Drug Funding"* Requête approved by the States in December 2018.

Decisions regarding the extent of health care provision where cost-effectiveness becomes a key issue are by their very nature uncomfortable and highly emotive. Nevertheless, as a government, the States are responsible for ensure the wellbeing of the community as well as individuals and doing so within finite resources. In this role the States are being asked to make a value judgement regarding the point to which the investment of resources in improving of the quality of life and wellbeing of potentially small groups of individuals represent an effective use of resources in achieving the vision of becoming the *"happiest and healthiest place in the world"* for the community as a whole.

Whilst achieving parity of provision with the UK and Jersey is undoubtedly attractive, it must be considered whether this decision is appropriate for Guernsey. The States are facing unprecedented fiscal pressures and debate on how to address these has already started. It must be clearly understood that the approval of the recommendations in this policy letter will have material fiscal consequences and impact on future taxation.

In order to assist the States in making an evidence-based decision, the Policy & Resources Committee wishes to comment on some key areas of this policy letter.

Many of these drugs are not life-saving treatments

The incremental cost effectiveness ratio (ICER) value measures the cost-effectiveness of drugs relative to the best available alternatives. The lower the ICER value, the higher the gain in terms of additional life years or quality of life for the patient relative to the additional cost of the drug. As a result drugs which offer a cure, thus offering substantial additional years of life typically have lower ICER values, even if in monetary terms they are very expensive.

The drugs with higher ICER values such as those under discussion may offer some extension of life or an improved quality of life by reducing side effects but many of them are not curative treatments. The higher the ICER value the higher the cost of achieving a "comparable" outcome relative to drugs with a lower value. The social return on investment in terms of achieving the desired policy outcomes of greater health and wellbeing therefore reduces the higher the ICER threshold is pushed.

An objective approach is needed in order for government to set policies that seek to *"achieve the greatest good for the greatest number".*

The majority of patients who might benefit from the extension are captured within the first two years

Table 1 of the Policy Letter (reproduced below) suggests that an extension to an ICER threshold of £100,000 would benefit 3,141 "backlog" patients and 737 new patients each year. Of these 98% (3,073) of backlog patients and 92% (678) of new patients would be captured by the proposed extension to an ICER value of £40,000 in the first two years of the proposed phasing at an annual cost in year 2 of £8.3m (£4.7m plus £2.5m plus £1.1m of additional running and project management costs) - a cost in the region of £2,200 per patient benefited.

Table 1: A summary of six possible options for the implementation of TAs

		Number of TA recommendations/TAs		Number of patients		Net cost impact	
Option	ICER banding	TA recommendations	TAs	Backlog	New patients per annum	Backlog	New patients per annum
1		160	145	3,348	782	£7.6m	£5.5m
2		88	84	114	98	£3.3m	£3.2m
3		51	49	74	62	£1.8m	£1.8m
4		44	40	3,221	679	£3.6m	£1.3m
5	<20k ICER	27	24	1,928	338	£1.3m	£0.5m
	<30k ICER	71	67	2,769	630	£3.1m	£1.5m
	<40k ICER	93	88	3,073	678	£4.7m	£2.5m
	<50k ICER	124	119	3,120	721	£5.9m	£3.8m
	<100K ICER	138	130	3,141	737	£6.7m	£4.4m
6		0	0	0	0	£0m	£0m

While there is still some significant uncertainty about the ongoing costs beyond the second year, the extension to an ICER threshold of £100,000 to benefit the remaining 2-8% of patients increases the annual cost estimates by 46% to more than £12m. Based on these estimates the cost per patient for those patients benefited by the further extension averages £27,000 per patient per year for the extension from <£40,000 to <£50,000 and £38,000 per patient per year for the further extension to <£100,000.

Year	ICER range	Backlog patient benefited	New Patients benefited	% of backlog patients benefited	% of new patients benefited	Total annual cost estimate	Estimated annual cost per patient (all patients captured)	Estimated annual cost per patient (additional patients captured)
1	<£30,000	2769	360	88%	49%	£5.6m	£1,790	£1,790
2	<£40,000	3073	678	98%	92%	£8.3m	£2,213	£4,341
3	<£50,000	3120	721	99%	98%	£10.75m	£2,799	£27,222
4	<£100,000	3141	737	100%	100%	£12.15m	£3,133	£37,838

The intention of this analysis is to demonstrate that the vast majority of the benefit of this policy is achieved within years 1 and 2 and beyond this point it becomes increasingly resource intensive.

The Policy & Resources Committee therefore considers a phased approach with the provision of a second decision point after the first two years of the practical operation of this policy to review the success of its implementation and assess the ongoing costs as essential. This is necessary, both to review the initial implementation, and to revise the ongoing cost estimates which are subject to a significant but largely unavoidable degree of uncertainty for a variety of reasons outlined in the policy letter. It also provides the States with an opportunity to consider whether the further commitment of substantial resources to this policy on an ongoing basis is appropriate.

This policy is explicitly presented as requiring new funding

Throughout the process of developing this policy, the Committee *for* Health & Social Care has been clear that it is not willing to pursue it in preference to investing in other areas of policy development which is considers to be a higher priority, offering wider and longer term benefits to the community as a whole. As set out in paragraphs 11.1 and 11.2:

"The Committee has carefully considered the relative merits of an increased investment into a wider range of drugs and treatments versus investing in other areas of the health service, such as prevention, early intervention and other new service developments that would equally give rise to improvements in patient care.

The CfHSC recognises the benefits of adopting TAs and considers that the disparity with England has become too great and is not justifiable. However, it does not wish for such a significant long-term investment into a broader range of drugs and treatments to be at the expense of HSC's plans for the wider transformation of health and care that will have longer-term and far-reaching benefits to improving the overall health and wellbeing of the population."

The Committee *for* Health & Social Care also makes it clear that it would not be possible to fund additional drugs and treatments from within its existing general revenue budget without significant cuts to other services it provides which it considers would be a highly unsatisfactory solution and untenable.

Therefore, **if this policy letter is approved a long-term funding source will need to be found.** Whilst interim funding can be made available from the Guernsey Health Reserve (formerly the Guernsey Health Service Fund), this is only a short-term solution.

To give an indication of the scale of this requirement to fund this item of policy alone at an on-going cost of between £8m and £12m per year, it would require an increase in revenues equivalent to a 0.5% to 1.0% increase in the headline tax rate, or a 50% increase in all TRP rates.

Yours faithfully

Deputy G St Pier
President
Policy & Resources Committee