HealthManagement
Promoting Management and Leadership

There Might Be Too Much Money In Healthcare

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> Inspire2Live has been created to empower people to convert the sense of powerlessness, caused by cancer, into one of strength. Inspire2Live is founded on the absolute belief that one can attain the greatest possible satisfaction by putting their heart and soul into helping others. Its motto is “Never, ever quit!”.

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I was struck by a press announcement of the United States Food and Drug Administration of 23 May 2017: ‘ *FDA approves first cancer treatment for any solid tumour with a specific genetic feature*’

This is good news. Because it means that the knowledge that science has given us many years ago now is accepted by the regulator for the first time. Cancer is not a disease of the organs alone. One might have colon cancer, but from now on this means that we no longer need a protocol that describes what to do and which drug to give for this type of cancer. This is what we thought for many years and it was logical with the knowledge that we had about cancer until then. It was in the last century that discoveries on genes began and it was at the beginning of this century that science discovered more about the influence of genes on the development of cancer and taught us that a particular genetic defect can be the cause of cancer in different organs. ‘The tissue is not the issue’ is not true, but it says that one must not only look at the tissue but also at the defects in our genetic material for the cause(s) of cancer. A defect in the BRAF gene might be the cause of cancer in the colon but also in the skin, causing melanoma. This has been known for many years, but the protocols for approving new drugs and the reimbursement of these new drugs was not aligned with these new findings. This is a bit strange, because in an academic setting there has been ‘basket trials’ for many years. These are trials based on the molecular defect that appears in different organs. With one drug (or a combination of drugs) we attack certain molecular defects (for example Imatinib with chronic myeloid leukaemia (CML) and Gastrointestinal Stromal Tumour (GIST) based on the presence of the Philadelphia chromosome). Trials were set up for ovarian, breast, prostate, and pancreatic cancer. And guess what: the drug (Olaparib) was effective. Not for all the patients with a BRCA1 mutation but it was successful enough to register the drug. For ovarian cancer alone however. Because the regulator told us that we first have to prove it in all the organs that we want to treat with Olaparib. Therefore it’s good news that ‘*FDA approves first cancer treatment for any solid tumour with a specific genetic feature* ’. Because the consequence of this is that we can work on a different approach, and can take care that drugs like Olaparib immediately after registration for treating cancers that are BRCA1 mutated, can be given to patients with the same defect. Or is there another hurdle to overcome? Yes, there is.

Hospital laboratories make a lot of money with trials. Phase 3 trials in particular are very lucrative. For many laboratories in academic hospitals the money spent on these trials and paid by industry is the biggest part of their income. Therefore patients will be confronted with unwilling boards. It’s the medical-industrial complex (the complex of patient organisations, doctors, scientists, regulators, health insurance companies and industry) that will block the new approach initiated by the FDA for many years if we patients don’t take a step forward and together with the regulators force the national authorities to alter their way of work. And these national authorities also include the health insurance companies. Because if a drug is approved it also has to be reimbursed when given. Otherwise the doctor has to say: ‘We have the drug, it is approved but we can’t afford it as a hospital to treat you with it. We’re terribly sorry but you’ll probably die in a couple of months’. Don’t think this is exaggerated. This is what we patients are confronted with every day, and it’s because of this medical-industrial complex that we don’t execute what we already know and what we want to implement. Because of the way we work many patients die. And please don’t call it ‘The system’. It’s how *we* (‘you and I’) work that means we are distracted from the essence in healthcare: the patient. And because it’s the way *we* work, *we* can change it. If *we* start with the question of what is good and bad and answer that with the deepest honesty we are able to define the rules and the

protocols. It starts with morality and then comes the law. Not the other way around. When we see that money is the cause of not changing the way *we* work, morality will make decisions easier.

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