WECAN SmartStart in Cancer Patient Advocacy

WECAN MASTERCLASS in Cancer Patient Advocacy

Basics of Health Economics

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Definition (and privileged approach for WECAN)

Health economics: The application of economic theory, models and empirical techniques to the analysis of decision making by individuals, health care providers and governments with respect to health and health care.

Economic Analysis in Health Care by Morris, Devlin and Parkin © 2007 John Wiley & Sons Ltd

« The role of economics is not to make a decision,
but to identify the recurring patterns structuring our economies,
and to convey economic science's current state of knowledge »

Jean Tirole, Nobel Price in Economy 2014

Basic (Health) economics applied to the healthcare sector

- 1. Health expenditure and the overall economy
  - Panorama
- 2. Resources allocation (Efficiency/inefficiency)
  - Answering needs, planning
  - Cost-effectiveness studies
- 3. : The economic sustainability of HC systems and other issues
  - Financial and fiscal sustainability
- 4. Issues at stake
- 5. Discussion

1. Health Economy and overall the economy

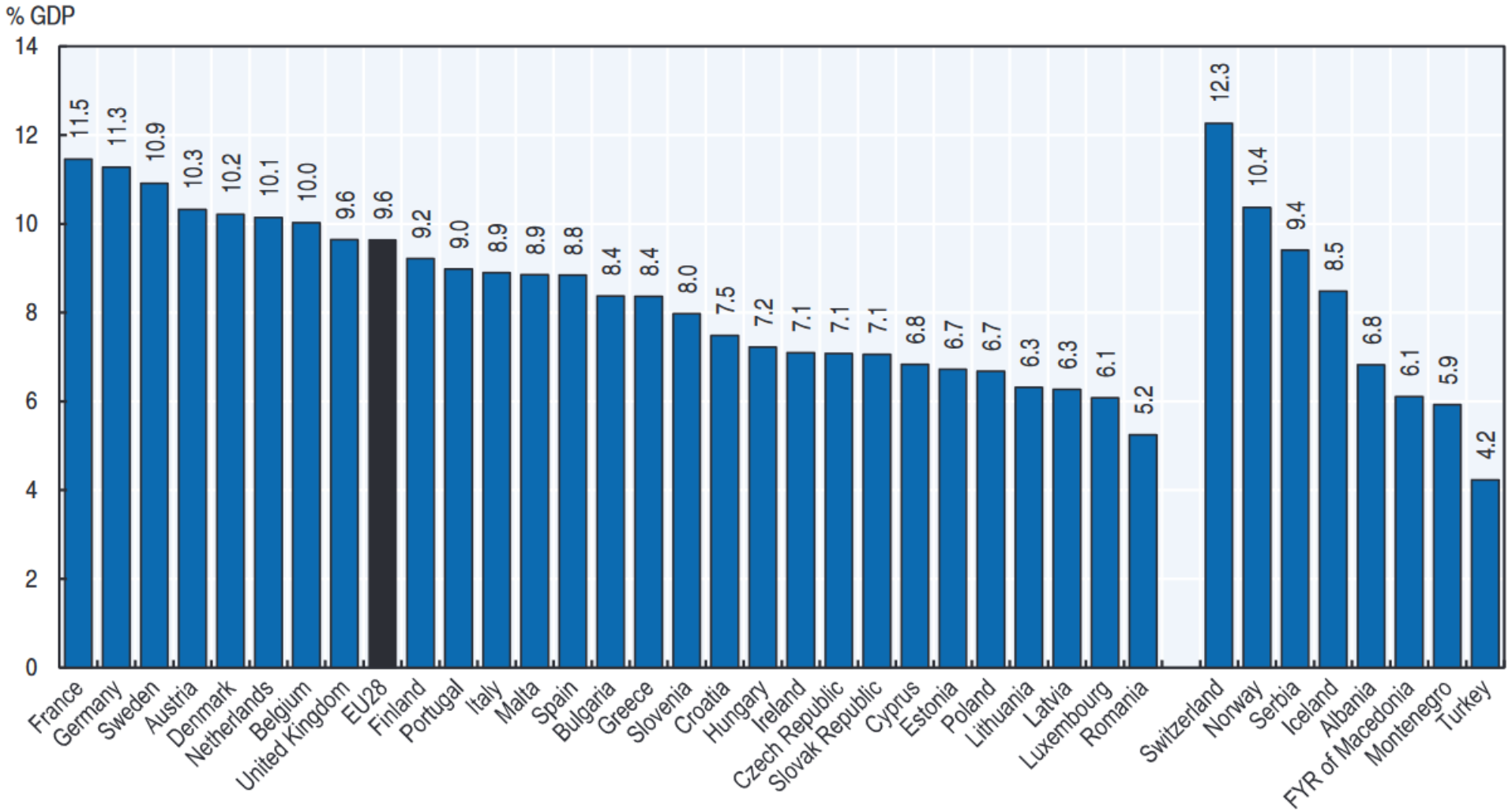
- Health expenditures are growing faster than the global GDP (but is contributing to the GDP)
- 8000 B$ worldwide (x3 since 1995), 10% of WW GDP, OECD countries spend 6000 B$)
  - US 3500 B$ (43% of WW spending)
  - Europe 1400 B$ (17,5% of WW spending)
- Human health and economic well being are aligned (health as a human capital)
- Health is considered as an investment (not only healthcare)
- Healthcare spending related to health status and indicators of the population (to a certain point)
- Healthcare may certainly nowadays be the largest human activity (considering human resources knowing that there is a global shortage of health workers)

Good health: a key pathway to economic growth and development

Economic growth and development depend on a healthy population. The Lancet Commission on Investing in Health, led by former United States Treasury Secretary and Chief Economist of the World Bank, Lawrence Summers, reported that around one quarter of economic growth between 2000 and 2011 in low- and middle-income countries resulted from the value of improvements to health. The return on investment in health was estimated to be nine to one.[10]

Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. WHO 2016

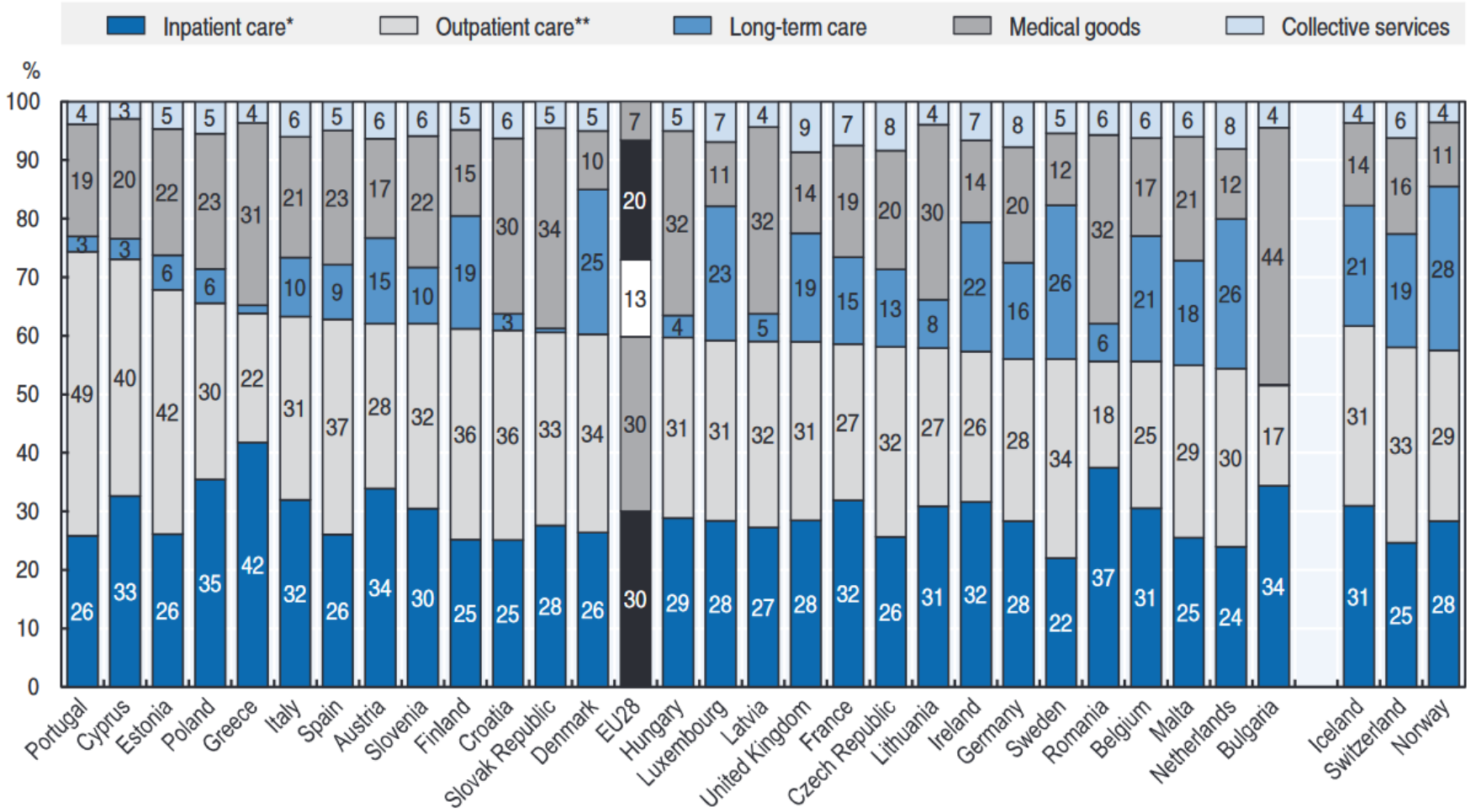
5.3. Health expenditure as a share of GDP, 2017 (or nearest year)



Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*; Eurostat Database; WHO Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888933835383

5.6. Health expenditure by function, 2016 (or nearest year)



* Refers to curative-rehabilitative care in inpatient and day care settings.

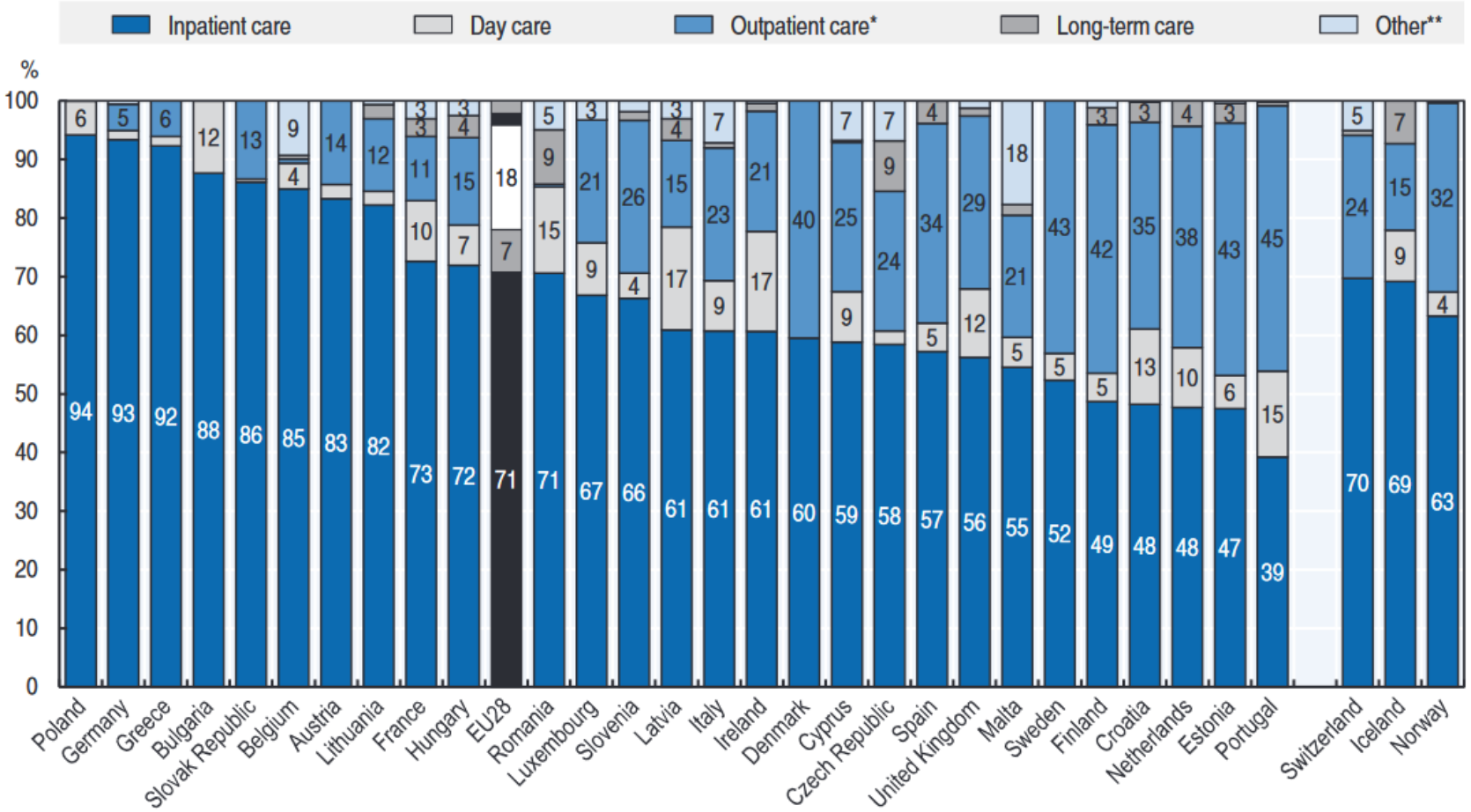
** Includes home care and ancillary services.

Note: Countries are ranked by the sum of inpatient and outpatient care as a share of current health expenditure.

Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*; Eurostat Database.

StatLink http://dx.doi.org/10.1787/888933835440

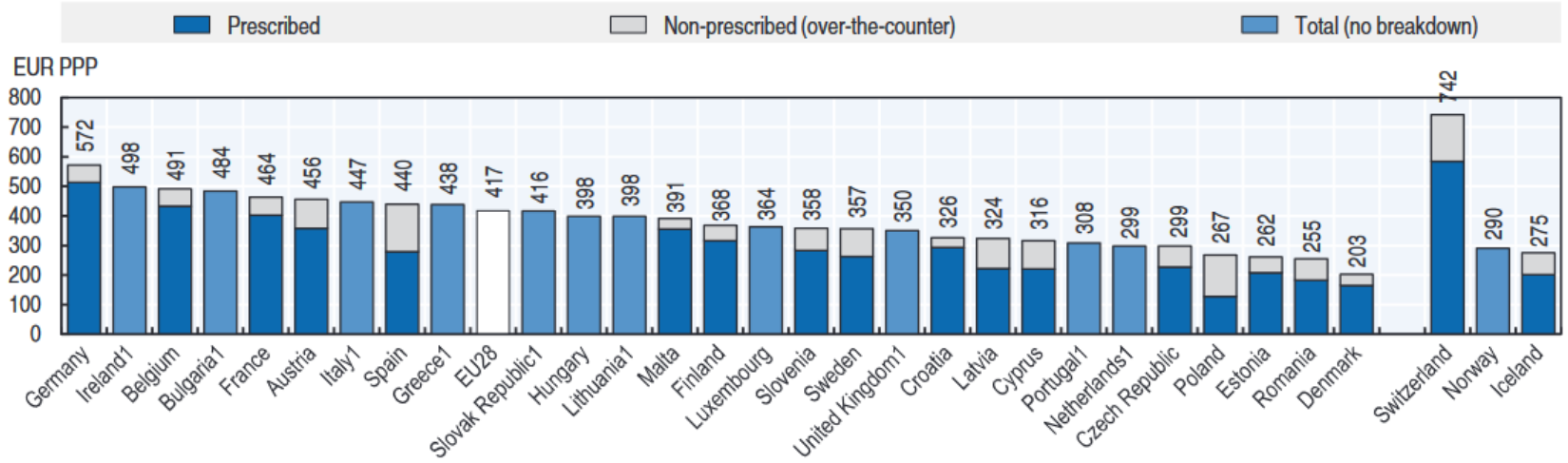
5.9. Hospital expenditure by type of service, 2016 (or nearest year)



* Refers to curative-rehabilitative care in outpatient and home-based settings and ancillary services.
** Includes medical goods and collective health services.
Note: Countries are ranked by inpatient care as a share of hospital expenditure.
Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*; Eurostat Database.

StatLink http://dx.doi.org/10.1787/888933835497

5.10. Expenditure on retail pharmaceuticals per capita, 2016

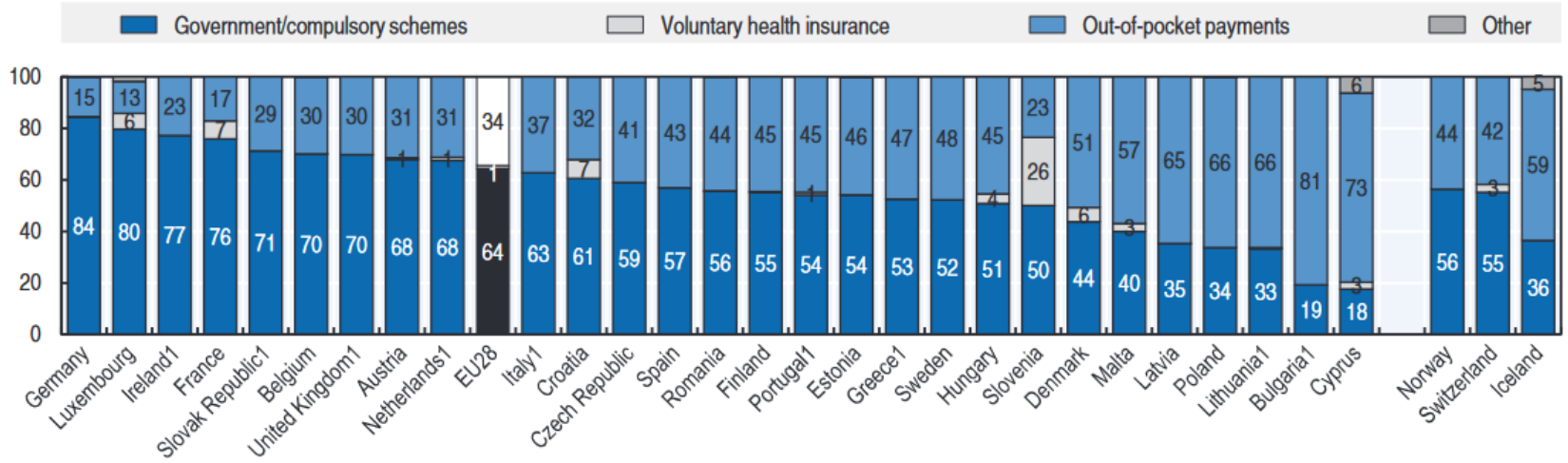


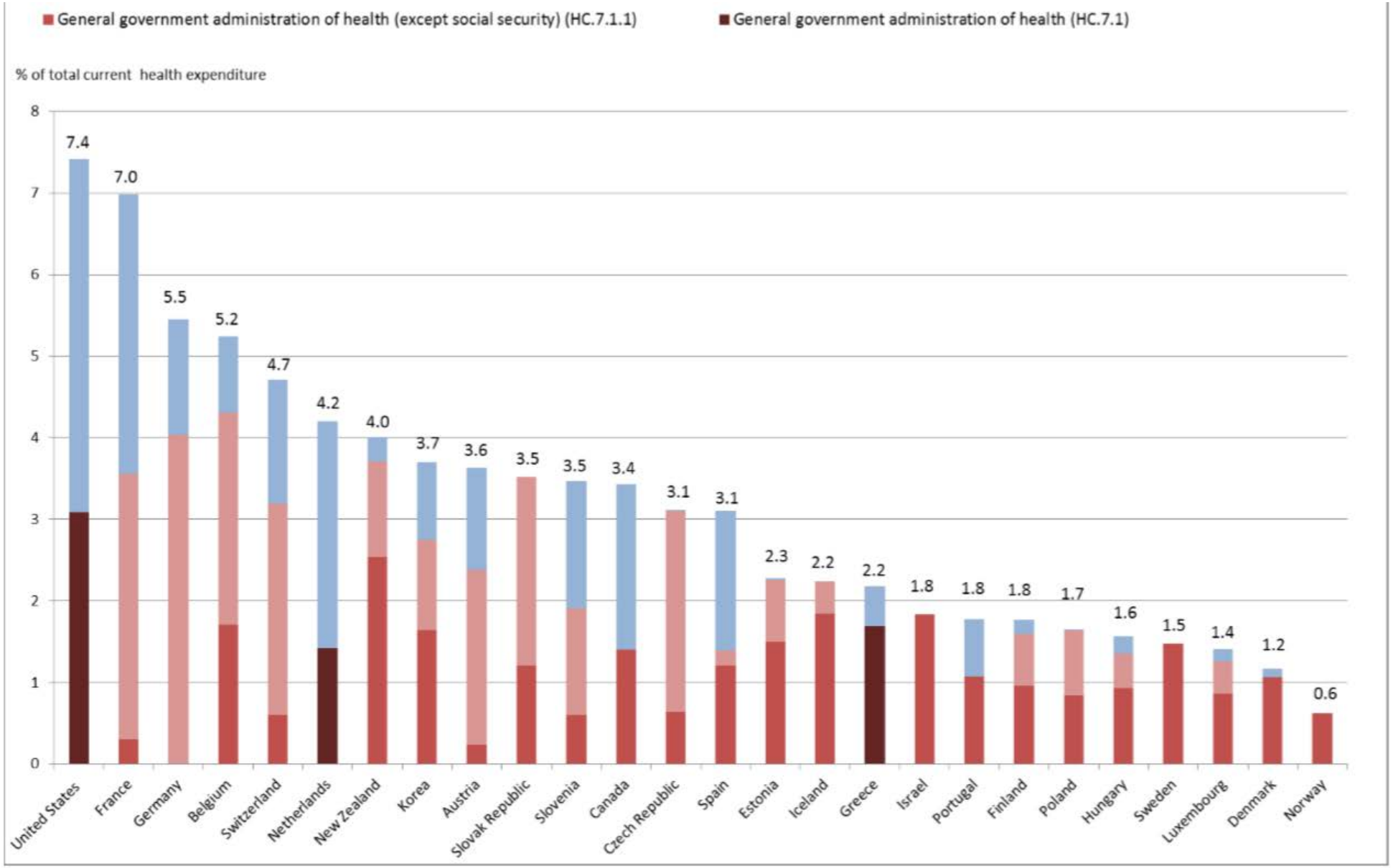
1. Includes medical non-durables (resulting in an overestimation of around 5-10%).

Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en*; Eurostat Database.

StatLink http://dx.doi.org/10.1787/888933835516

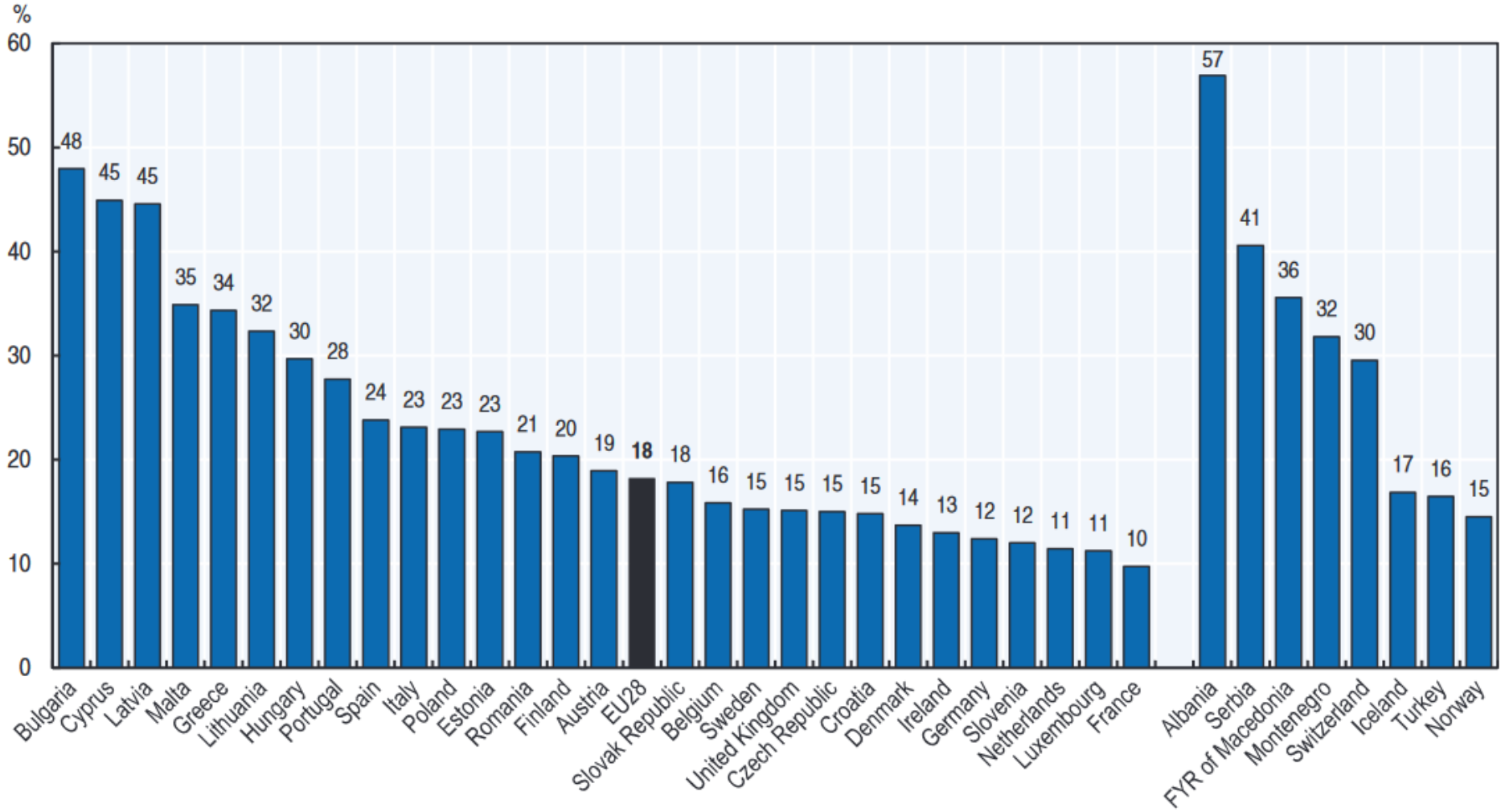
5.11. Expenditure on retail pharmaceuticals by type of financing, 2016





Source: OECD Health Data 2013

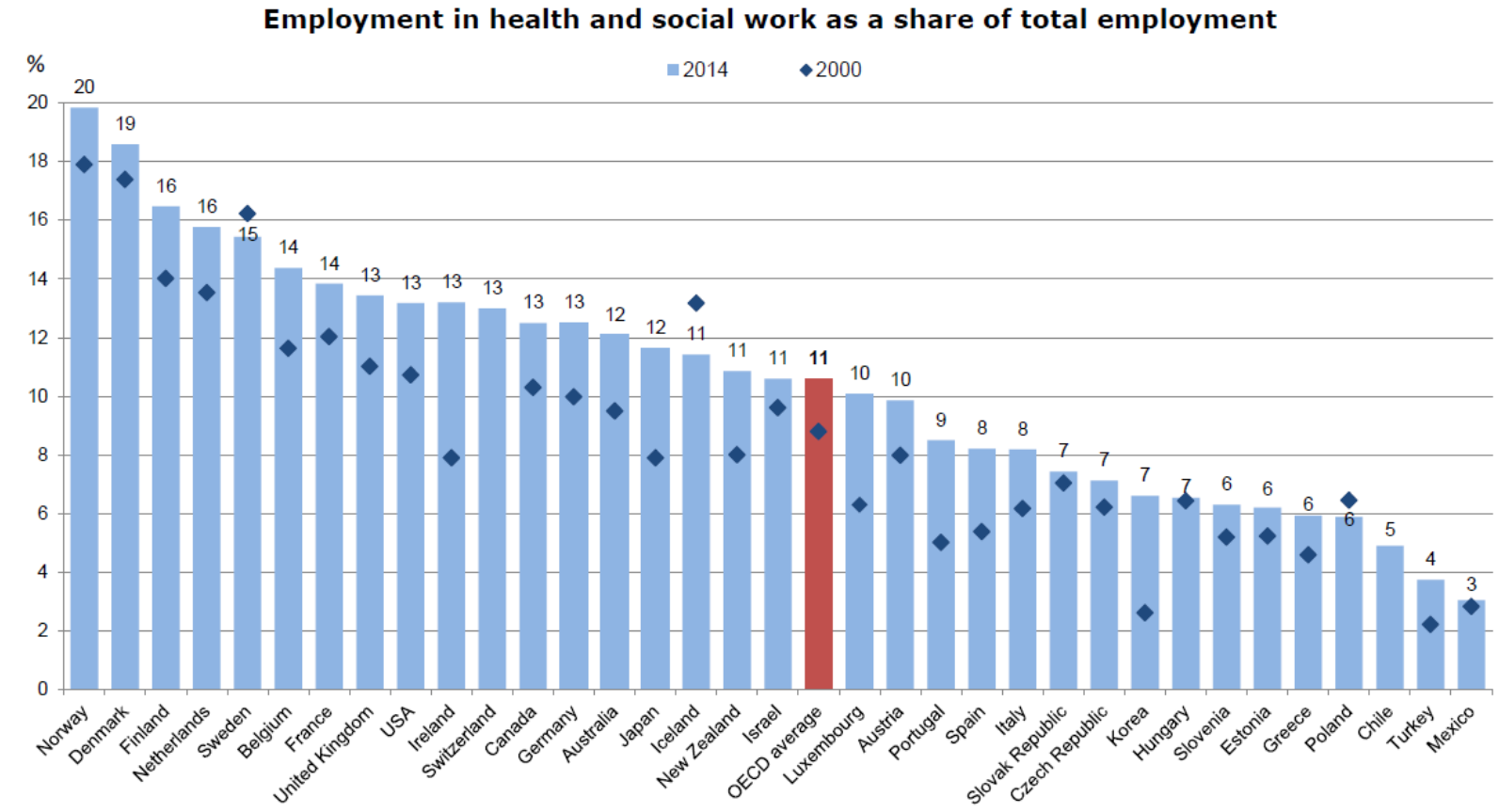
7.5. Share of total health spending financed by out-of-pocket payments, 2016 (or latest year)



Source: OECD Health Statistics 2018, *https://doi.org/10.1787/health-data-en.*

StatLink http://dx.doi.org/10.1787/888933836276

Jobs in the health and social sector now account for more than 10% of total employment in most OECD countries

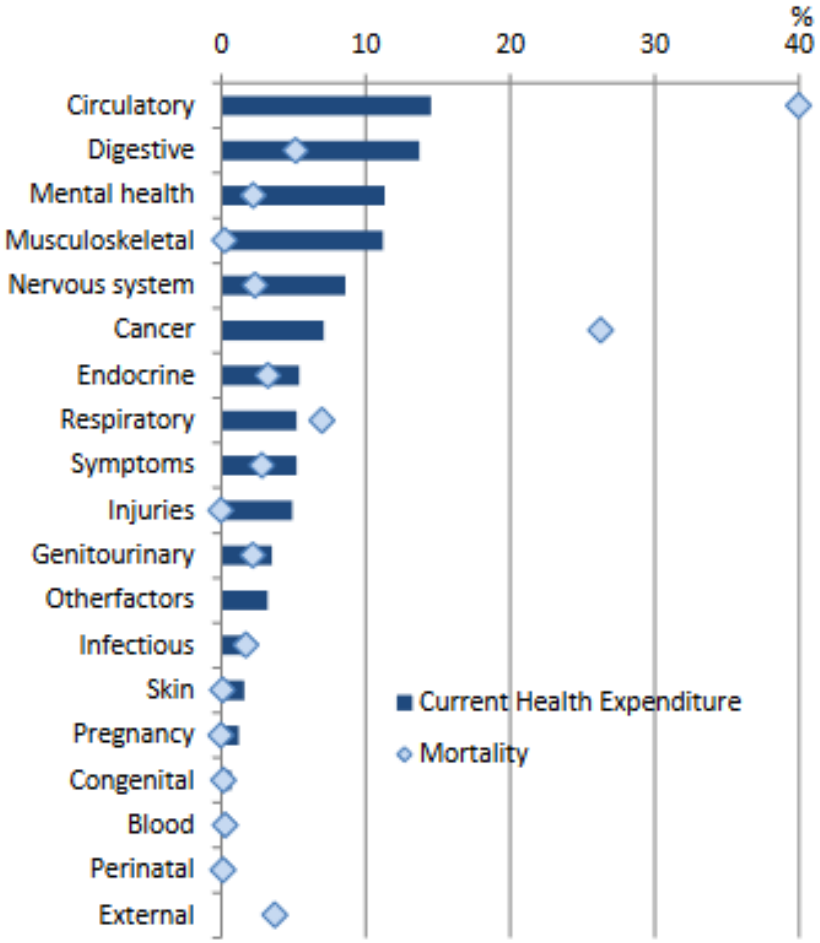


Source: Source: OECD.Stat, Annual Labour Force Statistics (ALFS) and National Accounts, OECD (2016)

2. Resource allocation

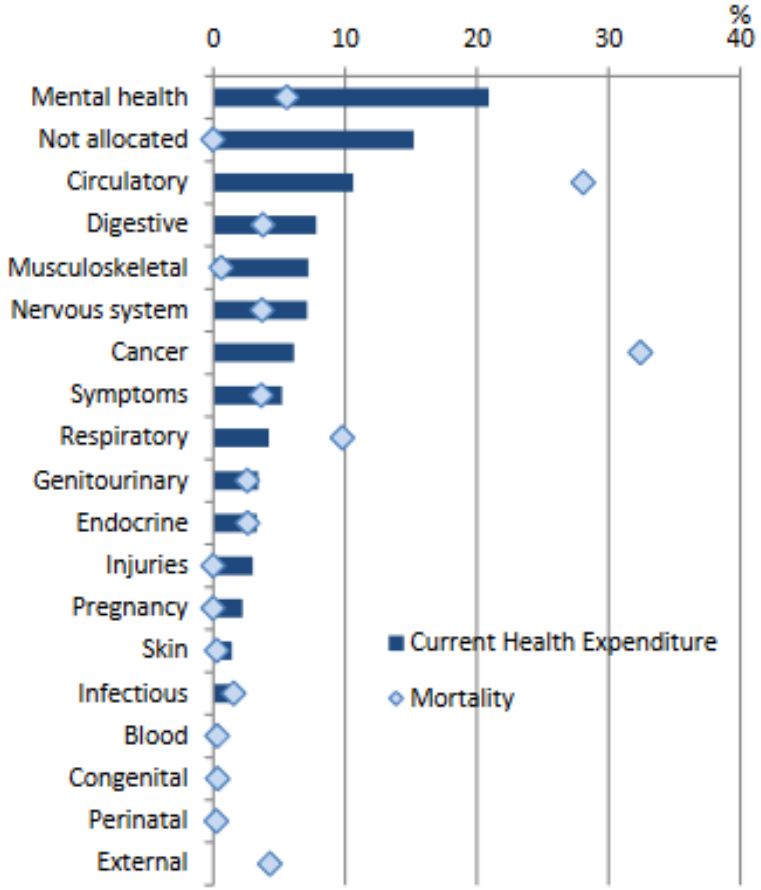
- Evolution of needs
  - Based on epidemiology (incidence, impact on mortality and morbidity)
  - Current and future threats
- How to optimize resource allocation (Health economy most visible field of interest)
  - Also a way to address the issues of marginal returns to medical care vs Health status
  - Opportunity cost comparisons

Figure 1. Health spending and cause of death, by disease, Germany



Source: "Health expenditure and financing: Health expenditure indicators", *OECD Health* Statistics (database).

Figure 3. Health spending and cause of death, by disease, the Netherlands



Source: "Health expenditure and financing: Health expenditure indicators", *OECD Health Statistics* (database).

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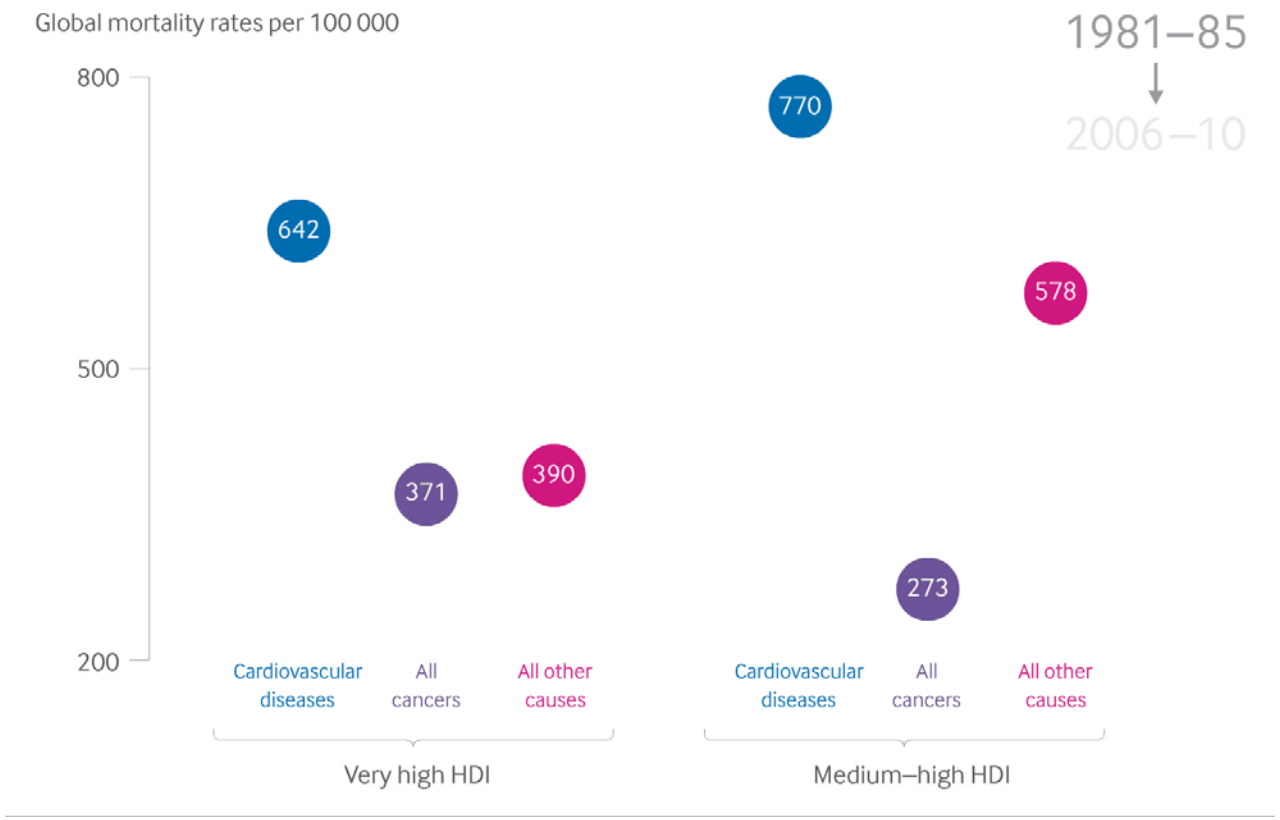
2. Resource allocation: epidemiology

Cancer is surpassing cardiovascular disease (CVD) as the leading cause of death in many high income populations and is projected to become a leading cause of morbidity and mortality worldwide in the coming decades.

In 2012 there were 8.2 million deaths from cancer worldwide, and in 2035 such deaths are predicted to rise to 14.6 million



Benchmarking life expectancy and cancer mortality: global comparison with cardiovascular disease 1981-2010
BMJ 2017; 357 doi: https://doi.org/10.1136/bmj.j2765 (Published 21 June 2017) Cite this as: BMJ 2017;357:j2765

2. Resource allocation: new threats

WHO : Change Can't Wait. Our Time with Antibiotics is Running Out

2. Resource allocation: marginal return (macro)

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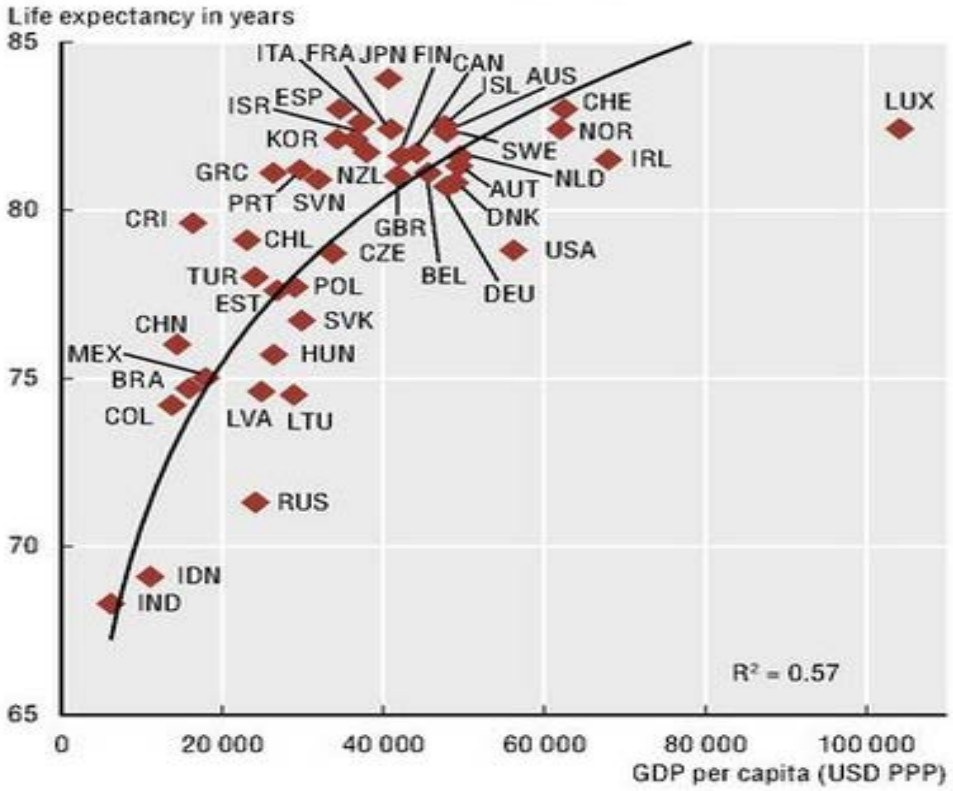
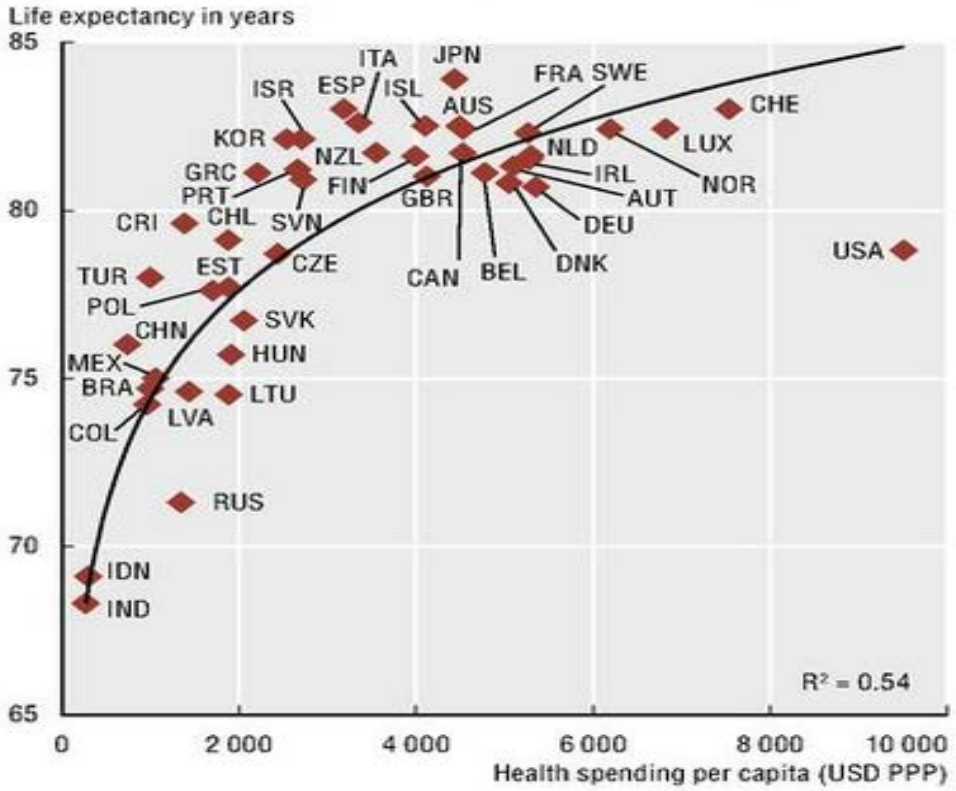
3.2. Life expectancy at birth and GDP per capita, 2015 (or nearest year)



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933602253

3.3. Life expectancy at birth and health spending per capita, 2015 (or nearest year)



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933602272

2. Resource allocation: marginal return

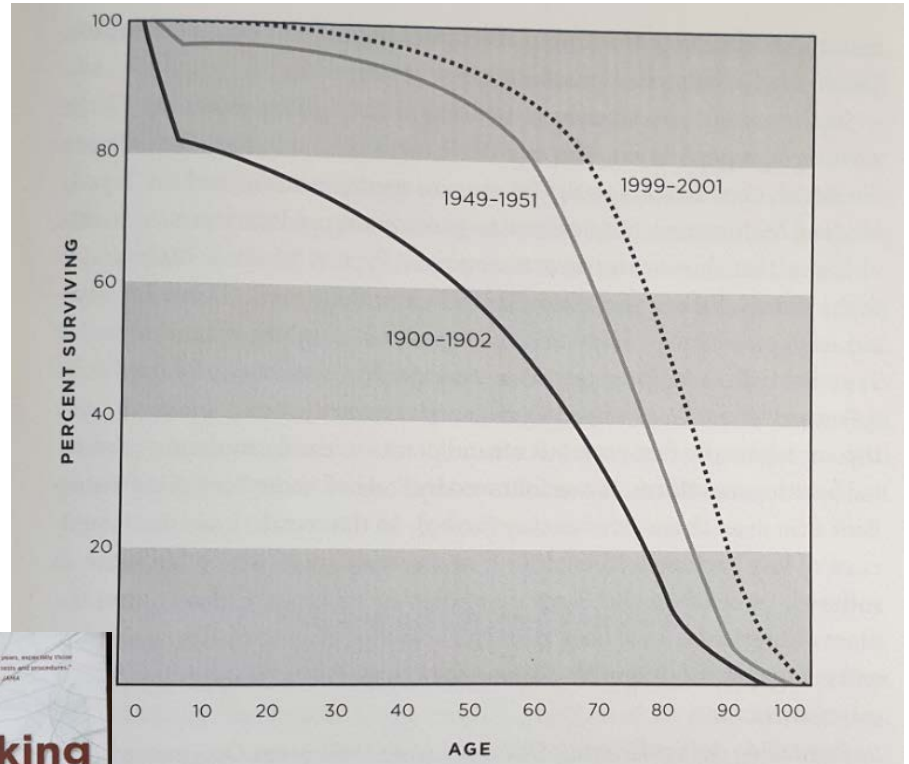
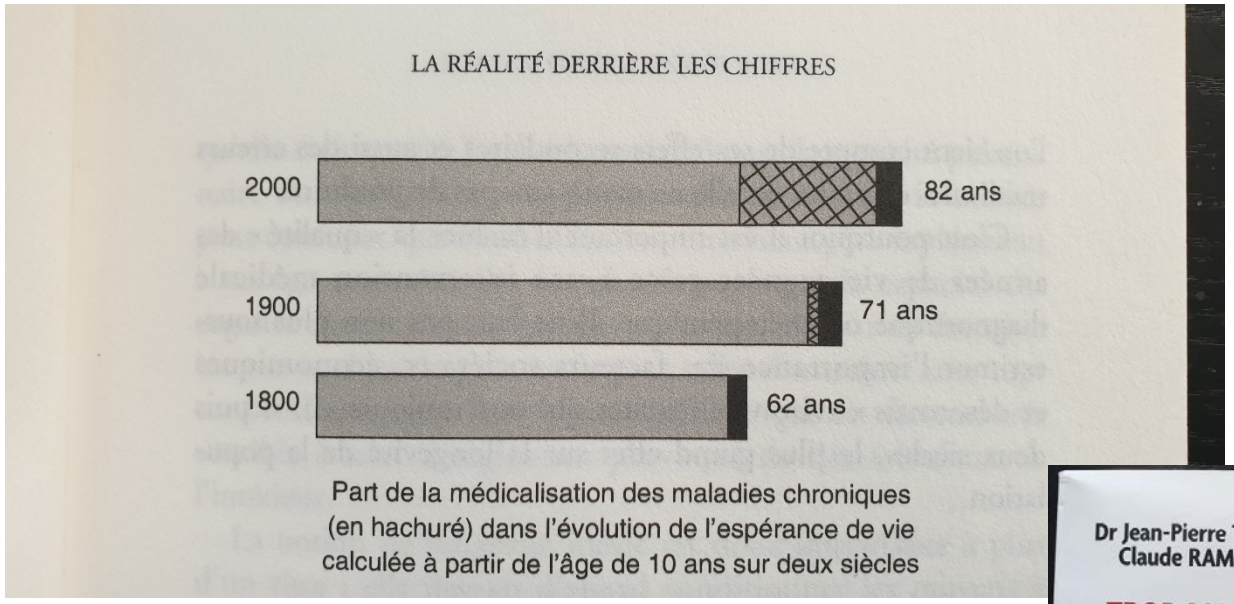
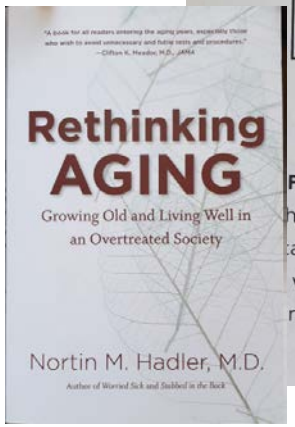


Figure 1. Changes in U.S. longevity rates during the twentieth century. he survival curves over the twentieth century have become increasingly angular. This trend is obvious and dramatic prior to 1950. More and more, we are likely to become octogenarians, at which point the curves are ncreasingly vertical. (U.S. Public Health Service, *National Vital Statistic Reports*, vol. 57, no. 1, August 5, 2008)



Part de la médicalisation des maladies chroniques (en hachuré) dans l'évolution de l'espérance de vie calculée à partir de l'âge de 10 ans sur deux siècles



2. Resource allocation

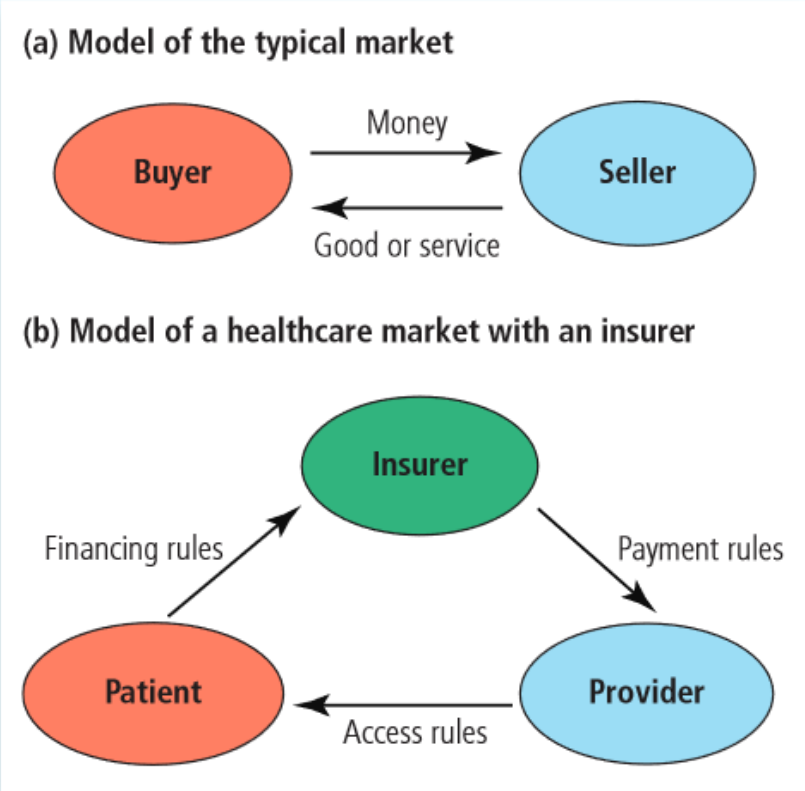


FIGURE 1

How an Insurer Changes a Market

In a typical market, shown in panel (a), a seller delivers a good or service to a buyer, who in exchange pays the seller a market-determined price. In a healthcare market, shown in panel (b), the provider delivers healthcare to the patient, but the provider is paid by an insurer (either the government or a private company). This arrangement requires rules for financing, access, and payment.

https://scholar.harvard.edu/files/mankiw/files/economics_of_healthcare.pdf

2. Resource allocation

- Manpower (e.g. MDs, Nurses, Allied Professionals, management, IT specialists, etc)
- Infrastructure (e.g. Buildings, transportation)
- Medical equipments (e.g. CT, MRI, Speciality beds and capacities, OR, ER, etc.)
- Drugs
- Medical devices
- Healthcare Information Technology (aka eHealth)
- Public Health Programs (housing, nutrition)
- Administration and management (providers and third parties, i.e. Insurances)

2. Resource allocation: Health Technology Assessment

- **Choices are always made facing a scarcity of resources**
  - Implicit choices : trade-offs based on collective preferences, ideology, ethical issues, religion, etc…
  - Explicit based on comparative studies based (economic rationnality based on models)
    - Cost-Benefit analysis
    - Cost-utility analysis : **Cost-effectiveness analysis (Health Economics and HTA)**

- **Cost-effectiveness analysis use health constructs such as QALY or DALY (Quality-Adjusted Life year, Disability-Adjusted Life Year).**

  - **Referred also as ICER: Incremental Cost-Effectiveness Ratio :** the cost per life year gained, that enables decision-makers to judge the value for money of a new technology relative to other technologies and interventions

2. Resource allocation: Health Technology Assessment

- **Cost-effectiveness analysis QALY in Oncology / Immunotherapy**

Article ID	Publication Year	US$/QALY *	Ratio Description
2017-01-25303	2017	100000	All histology: Programmed Death-L1 1% Pembro VERSUS Standard/Usual Care- All histology: Docetaxel IN Specific disease- Lung cancer; Age- Adult; Gender- Both; Country- United States of America (USA); Other- Treated with immunotherapy.
2017-01-25303	2017	160000	Squamous tumors: Programmed Death-L1 unselected Nivolumab VERSUS Standard/Usual Care- Programmed Death L1 unselected Docetaxel IN Specific disease- Lung Cancer; Age- Adult; Gender- Both; Country- United States of America (USA); Other- Treated with immunotherapy.
2017-01-25303	2017	190000	Non-squamous tumors: Programmed Death-L1 unselected Nivolumab VERSUS Standard/Usual Care- Programmed Death L1 unselected Docetaxel IN Specific disease- Lung Cancer; Age- Adult; Gender- Both; Country- United States of America (USA); Other- Treated with immunotherapy.
2017-01-25303	2017	220000	All histology: Programmed Death-L1 Unselected Atezolizumab VERSUS Standard/Usual Care- All histology: Docetaxel IN Specific disease- Lung Cancer; Age- Adult; Gender- Both; Country- United States of America (USA); Other- Treated with immunotherapy.
2017-01-24889	2017	150000	Nivolumab VERSUS Everolimus IN Specific disease- Advanced Renal Cell Carcinoma; Age- 19 to 40 years, 41 to 64 years, >=65 years; Gender- Both; Country- United States of America (USA).
2017-01-24889	2017	230000	Nivolumab VERSUS Placebo IN Specific disease- Advanced Renal Cell Carcinoma; Age- 19 to 40 years, 41 to 64 years, >=65 years; Gender- Both; Country- United States of America (USA).

http://healtheconomics.tuftsmedicalcenter.org/cear2n/search/ratio0.aspx

Treatment	Condition	Incremental cost–effectiveness ratio (£/QALY)
Rituximab	Aggressive non-Hodgkin's lymphoma	6100
Paclitaxel	Metastatic ovarian cancer	8500
Gemcitabine	Metastatic pancreatic cancer	12 500
Vinorelbine	Metastatic breast cancer	14 500
Trastuzumab	Early breast cancer	18 000
Temozolomide	Recurrent glioma	25 300
Imatinib	Inoperable or metastatic gastrointestinal stromal tumour	32 000
Temozolomide	Newly diagnosed glioma	35 000
Bevacizumab	Metastatic colorectal cancer	62 860
Cetuximab	Metastatic breast cancer	72 210

https://www.sciencedirect.com/topics/nursing-and-health-professions/incremental-cost-effectiveness-ratio

2. Resource allocation: Health Technology Assessment

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- **Cost-effectiveness analysis QALY in practice: the NICE (NHS, UK) model**

  - **NICE uses a cost-effectiveness threshold range between 20,000£ and 30,000£ since 2001**
  - **The rationale behind a common threshold :** Positive decisions above the threshold on the grounds of innovation reduce population health (https://www.ncbi.nlm.nih.gov/pubmed/18767894)
  - **In 2011, the English government introduced the "Cancer drugs Fund" allowing for the payment of cancer drugs wih ICER above the common NICE Threshold**
  - **100,000 people had access to treatments accessible through the Cancer Drugs Fund.**

  - **In Oct 2015,The CDF was temporarily closed and reinstalled in 2016 with more stringent objectives to control the prices of drugs and its overall budget through a new "managed access" scheme. The new CDF is also covering access to new radiotherapy and surgery innovations.**

2. Resource allocation: Health Technology Assessment

- **Cost-effectiveness analysis QALY in practice: the NICE (NHS, UK) model**

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ESMO / PRESS OFFICE / PRESS RELEASES / England's Cancer Drugs Fund 'Failed to Deliver Meaningful Value to Patients and Society'

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- Press and Media Affairs Committee

Annals of Oncology Press Release: England's Cancer Drugs Fund 'Failed to Deliver Meaningful Value to Patients and Society'

Date: 28 Apr 2017
Topic: **Bioethics, legal and economic issues**

Analysis of the drugs that were approved for use by the NHS Cancer Drugs Fund (CDF) in England has shown that the fund was not good value for patients and society and may have resulted in patients suffering unnecessarily from toxic side effects of the drugs.

Results

Of the 47 CDF approved indications, only 18 (38%) reported a statistically significant OS benefit, with an overall median survival of 3.1 months (1.4–15.7 months). When assessed according to clinical benefit scales, only 23 (48%) and 9 (18%) of the 47 drug indications met ASCO and ESMO criteria, respectively. NICE had previously rejected 26 (55%) of the CDF approved indications because they did not meet cost-effectiveness thresholds. Four drugs—bevacizumab, cetuximab, everolimus and lapatinib—represented the bulk of CDF applications and were approved for a total of 18 separate indications. Thirteen of these indications were subsequently delisted by the CDF in January 2015 due to insufficient evidence for clinical benefit—data which were unchanged since their initial approval.

2. Resource allocation: Health Technology Assessment

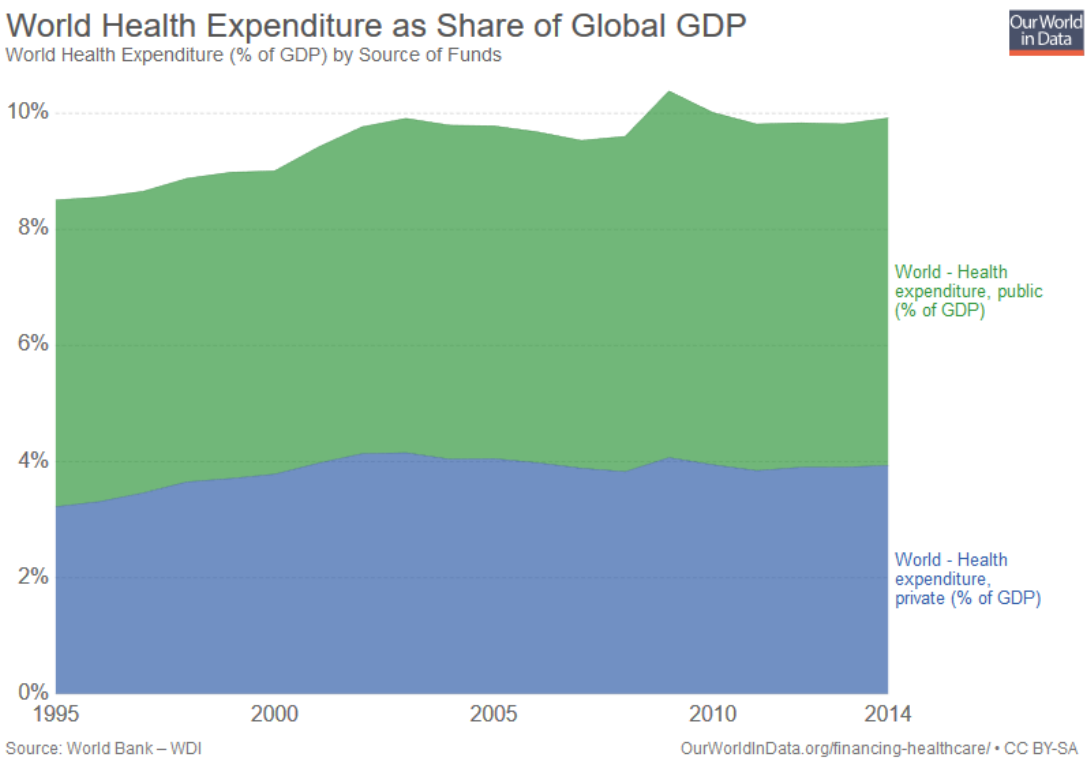
- **Cost-effectiveness analysis QALY in practice: the NICE (NHS, UK) model**

Five things £1.27bn can pay for in the NHS (over five years)

- 10,000 nurses
- 2,500 hospital consultants
- One of England's 10 regional ambulance services
- A one-off pay rise of 2.5% for every member of NHS staff
- An extra 200 GP surgeries

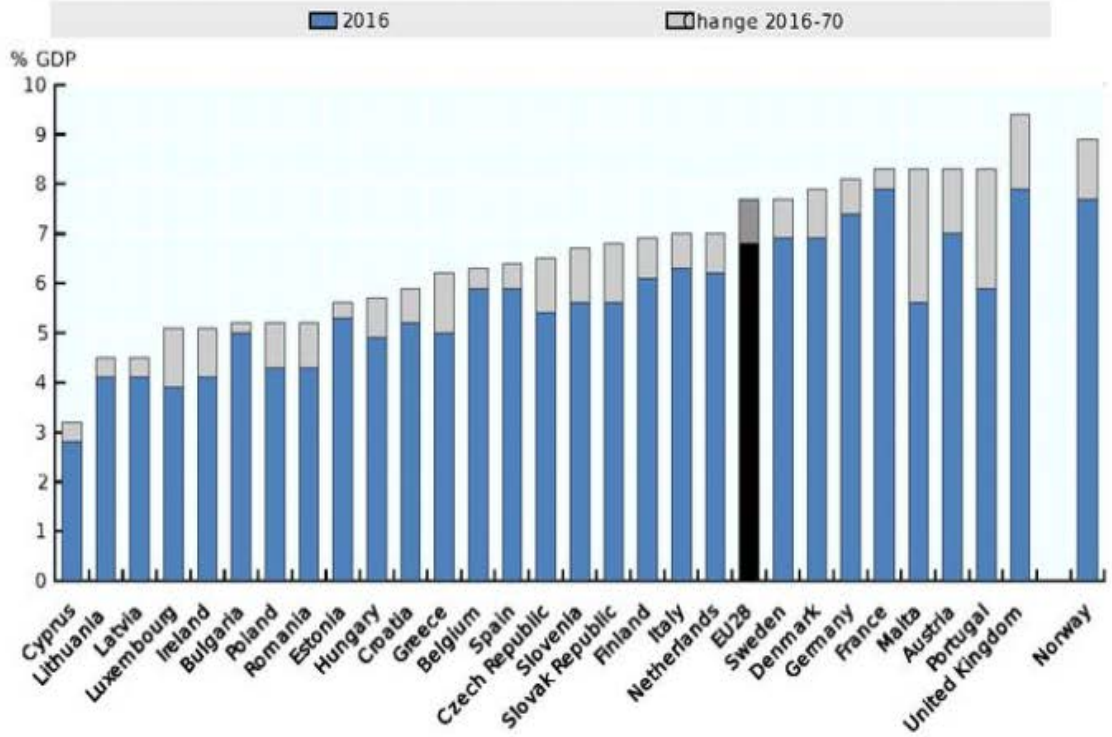
3. Healthcare systems sustainability

Despite a dramatic slowdown in spending on health and long-term care in many EU member states following the 2008 economic and financial crisis, more recent estimates show that spending is back on an upward path. Since, on average, around three-quarters of health spending is financed out of public sources, this represents a sizeable share of government spending, meaning that growth in health and long-term care spending can have a considerable impact on a country's budgetary position. In addition, ageing populations will continue to exert pressures on health and long-term care spending while at the same time reducing the size of the working-age population able to finance such expenditures, thereby raising concerns around the fiscal sustainability of health and long-term care systems (OECD, 2015).



3. Healthcare systems sustainability

Public spending on health care as a percentage of GDP, 2016 to 2070 – Ageing Working Group reference scenario



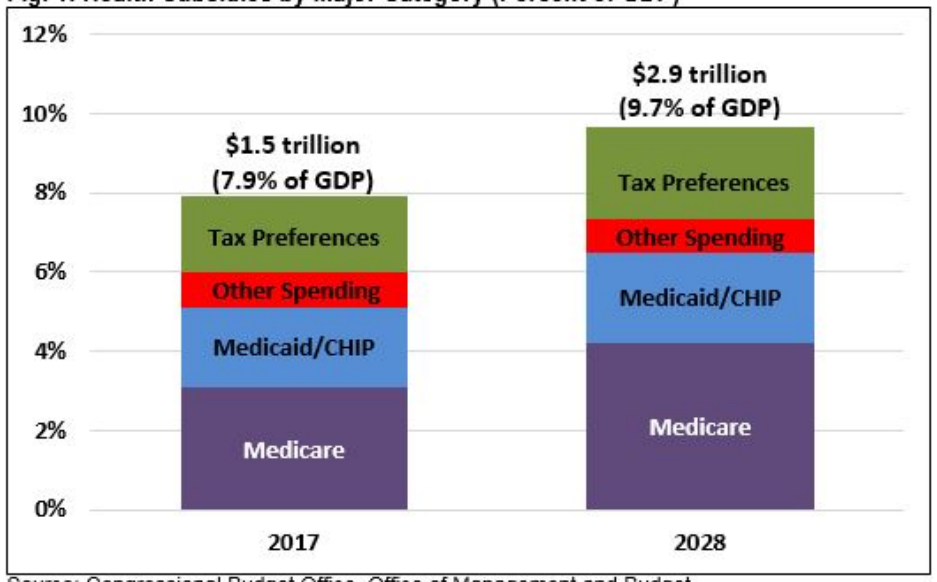
Note: The EU28 total is weighted by GDP.

- The implications of rising costs are particularly important for public finances, since health care is predominantly funded from public sources. Moreover, ageing may lead to shortfalls in payroll taxes to finance health.

OECD Fiscal Sustainability of Health Systems: bridging health and finance perspectives. 2015

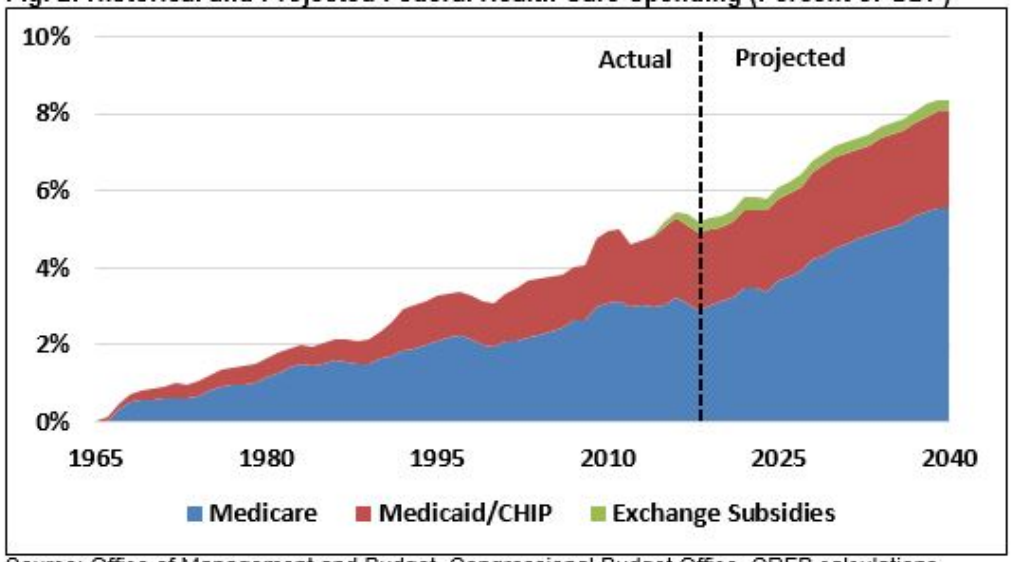
3. Healthcare systems sustainability

Fig. 1: Health Subsidies by Major Category (Percent of GDP)



Source: Congressional Budget Office, Office of Management and Budget.

Fig. 2: Historical and Projected Federal Health Care Spending (Percent of GDP)



Source: Office of Management and Budget, Congressional Budget Office, CRFB calculations.

Over the long term, the rising cost of federal health care spending is clearly unsustainable. Without a course correction, the result will be program insolvency, crowding out of important public priorities, and a growing federal debt.

USA : https://www.crfb.org/papers/american-health-care-health-spending-and-federal-budget

3. Healthcare systems sustainability

IMPRIMER

Social security financing for 2018

The 2018 social security financing bill was presented to the Council of Ministers on 11 October 2017 by Agnès Buzyn, Minister for Solidarity and Health, and Gérald Darmanin, Minister of Public Action and Accounts. With the aim of bringing the social security accounts back into balance by 2020, this bill puts into action the undertakings made before the French people.

- The national healthcare expenditure growth target was achieved once again in 2016. The target of 1.8% growth was the lowest since 1997. (+2.1% en 2017)
- Aim +2% per year.

https://www.gouvernement.fr/sites/default/files/locale/piece-jointe/2017/09/pstab_en_30052017sircom_modif.pdf

France is currently subject to the corrective arm of the Stability and Growth Pact (SGP).

4. Issues at stake: Drivers of healthcare expenditure growth

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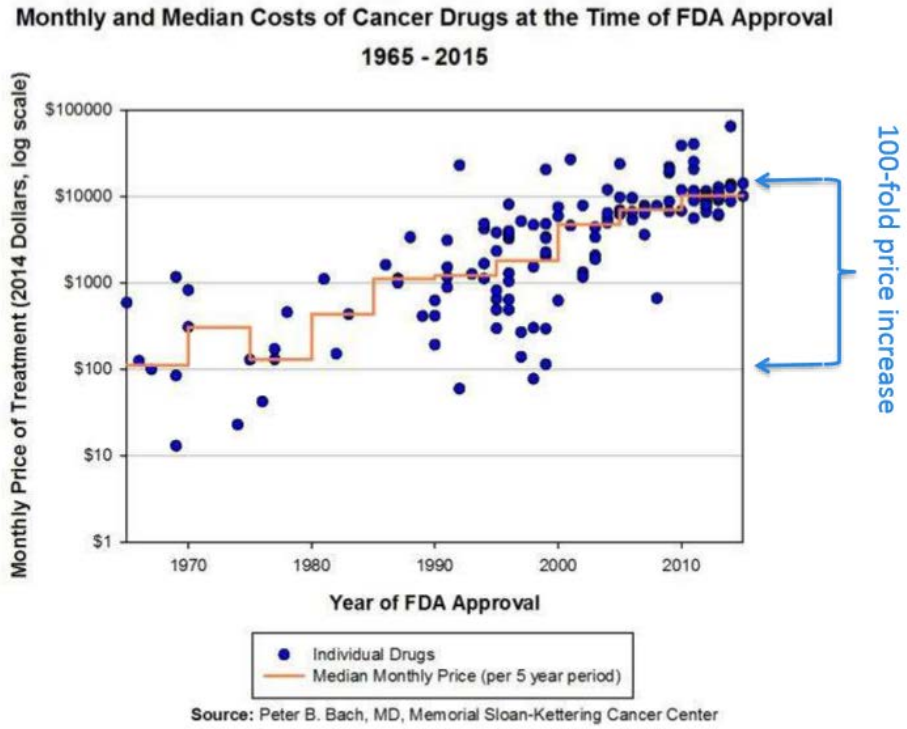
- Innovation
  - **Advances in medical technology**
  - **Drugs (most notably cancer drugs but also rare diseases in the last couple of years)**
- Demographic
  - **Aging population**
- Organization, incentives
  - Fee for service
  - **Overmedicalization**, Low level services, inappropriate care
- Structural
  - Poor productivity
  - Fragmentation of care delivery
  - Waste (administrative costs)
- Poor regulation (regulatory capture by vested interest groups and monopolies)
- Cultural biases and preferences (e.g. End of Life)
- Healthcare as a driver of today's economy/growth/wealth of advanced economies

4. Issues at stake: drug cost explosion

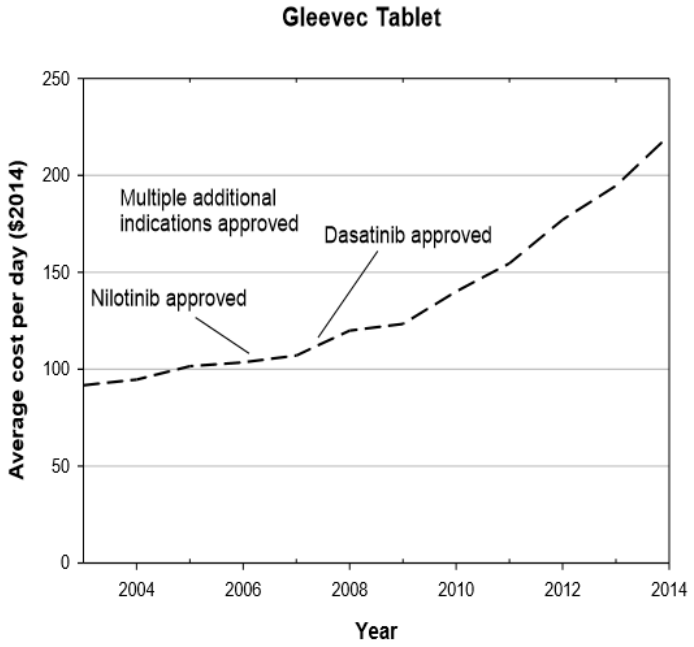
Rising prices of cancer drugs



Memorial Sloan Kettering Cancer Center.

Product prices rise even as:

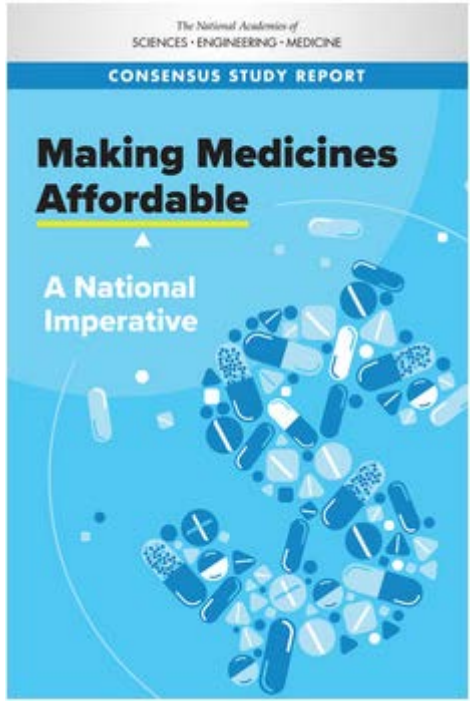
a) competitors enter the market
b) new indications are added

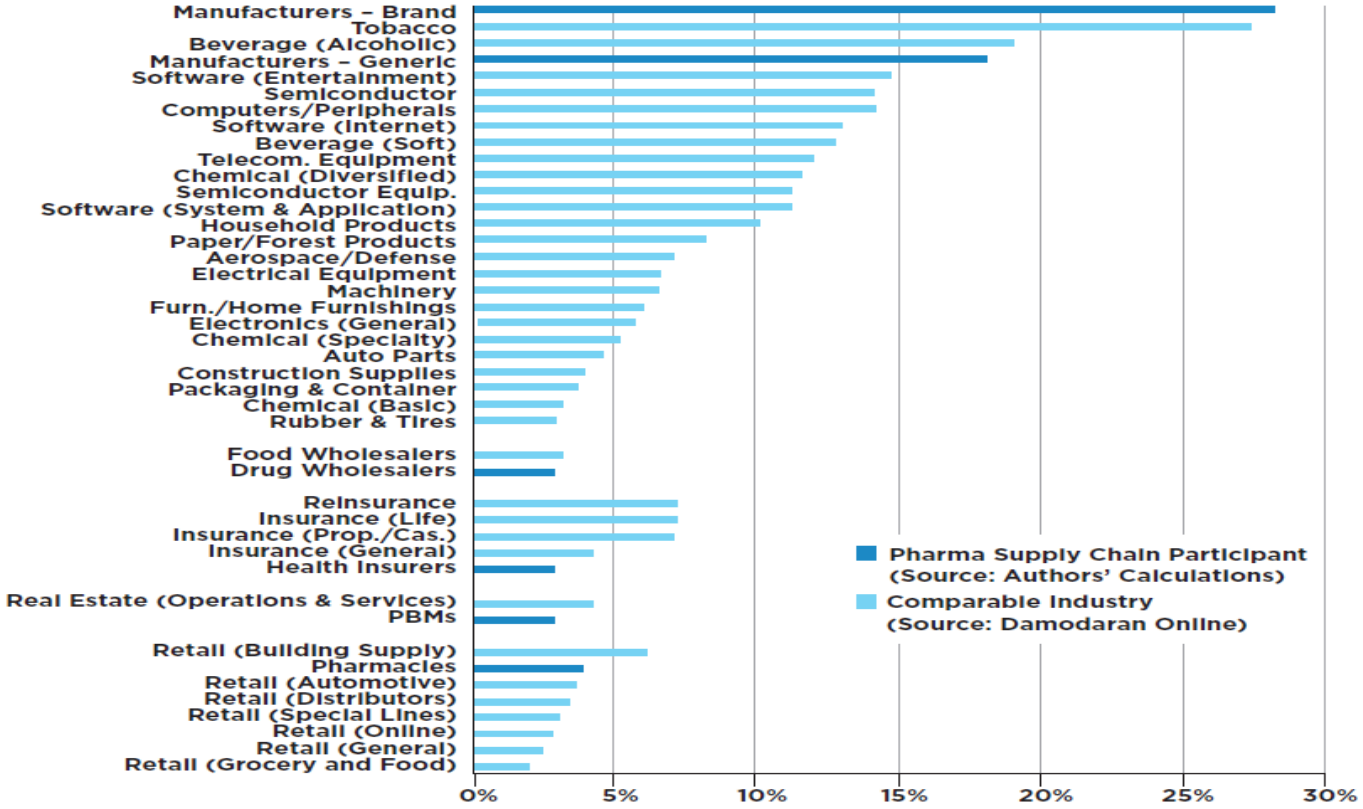


Memorial Sloan Kettering Cancer Center.

https://www.mskcc.org/profile/peter-bach

4. Issues at stake: drug cost explosion

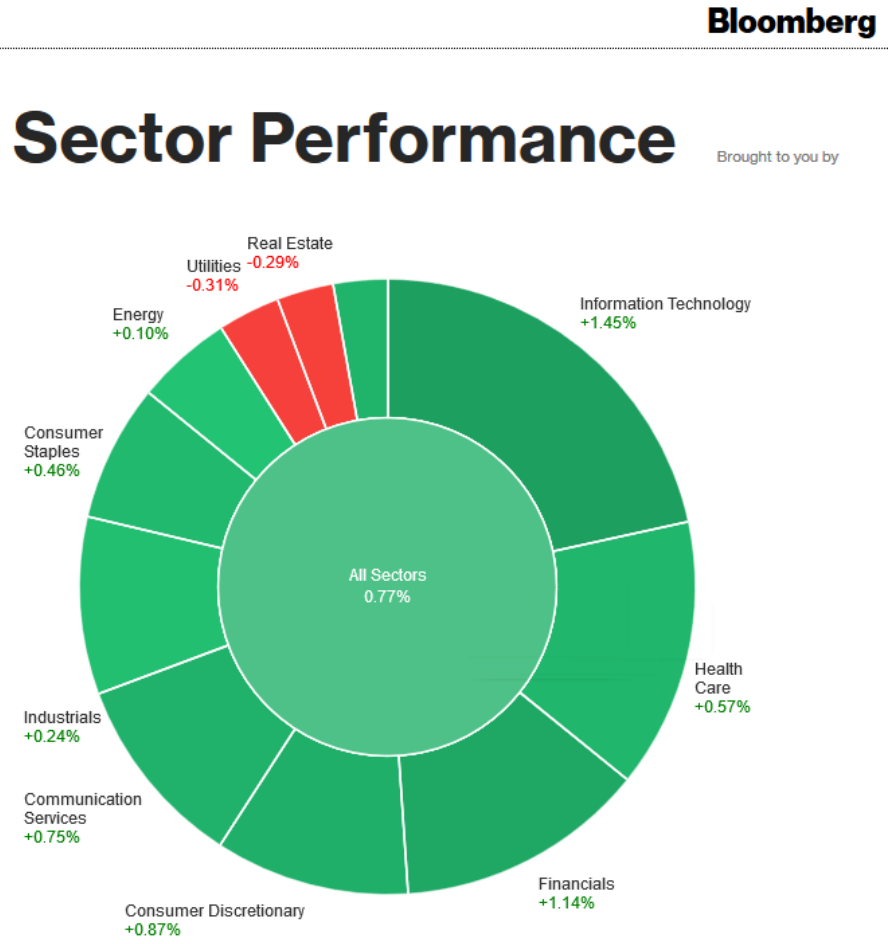




https://www.nap.edu/catalog/24946/making-medicines-affordable-a-national-imperative

FIGURE 2-6 Average sector net margins for companies in the biopharmaceutical sector and comparable industries.

4. Issues at stake: drug cost explosion

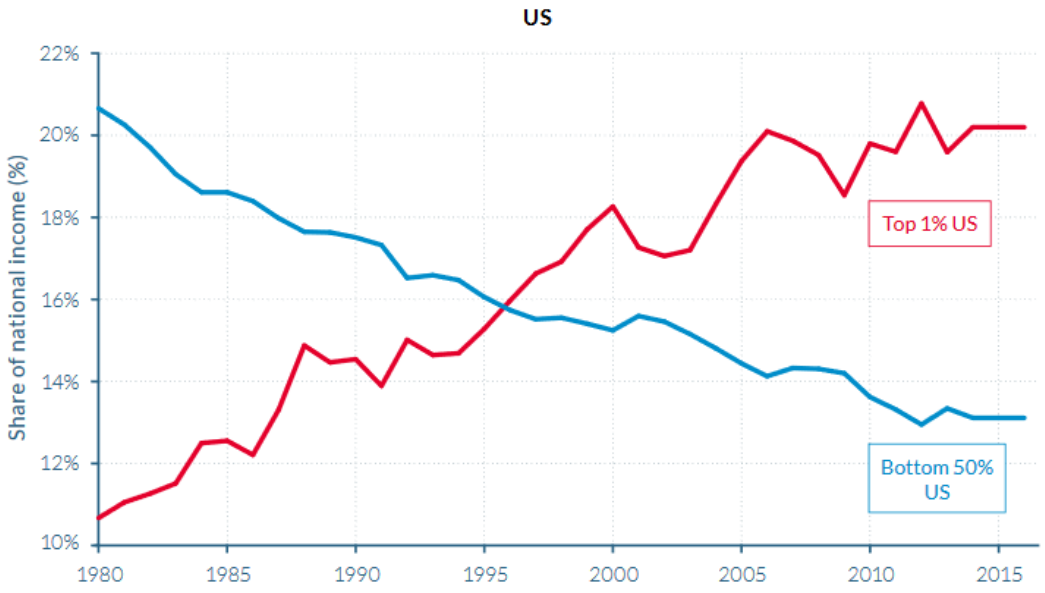


- The rising cost of drugs (20% of HC expenditures paid by HC systems in exchange of goods produced by the pharma industry) is partially explained by the actuel economical ecosystem caracterized by:
  - Negative interest rate and High level of liquidity (M&A reached 400B$ in 2017)
  - Favorable pricing mechanims limiting the risks of poor Return of Investment (rationale was support of R&D and related incentives)
  - Support from industrial policies in some advanced countries
- Assets are overvalued and Innovation price soared (multiplying effect of the true R&D costs through licensing and venture/acquisition based on future prices estimates that could support HC systems and the current stock market… so far).

4. Issues at stake: inequalities

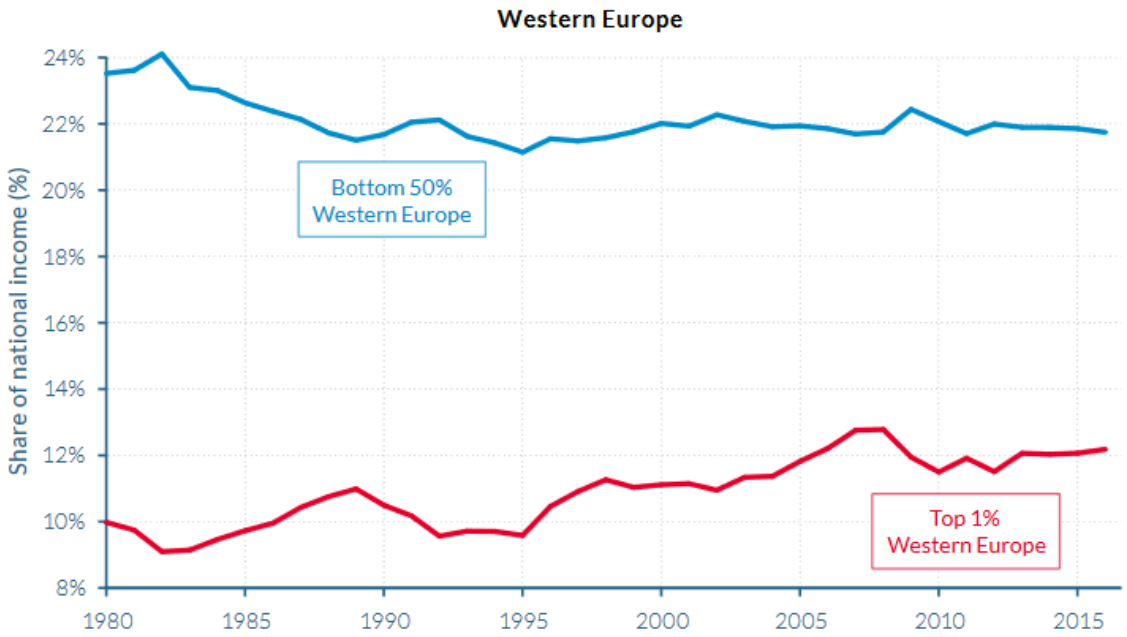
Figure E3

Top 1% vs. Bottom 50% national income shares in the US and Western Europe, 1980–2016: Diverging income inequality trajectories



Source: WID.world (2017). See wir2018.wid.world for data series and notes.

In 2016, 12% of national income was received by the top 1% in Western Europe, compared to 20% in the United States. In 1980, 10% of national income was received by the top 1% in Western Europe, compared to 11% in the United States.



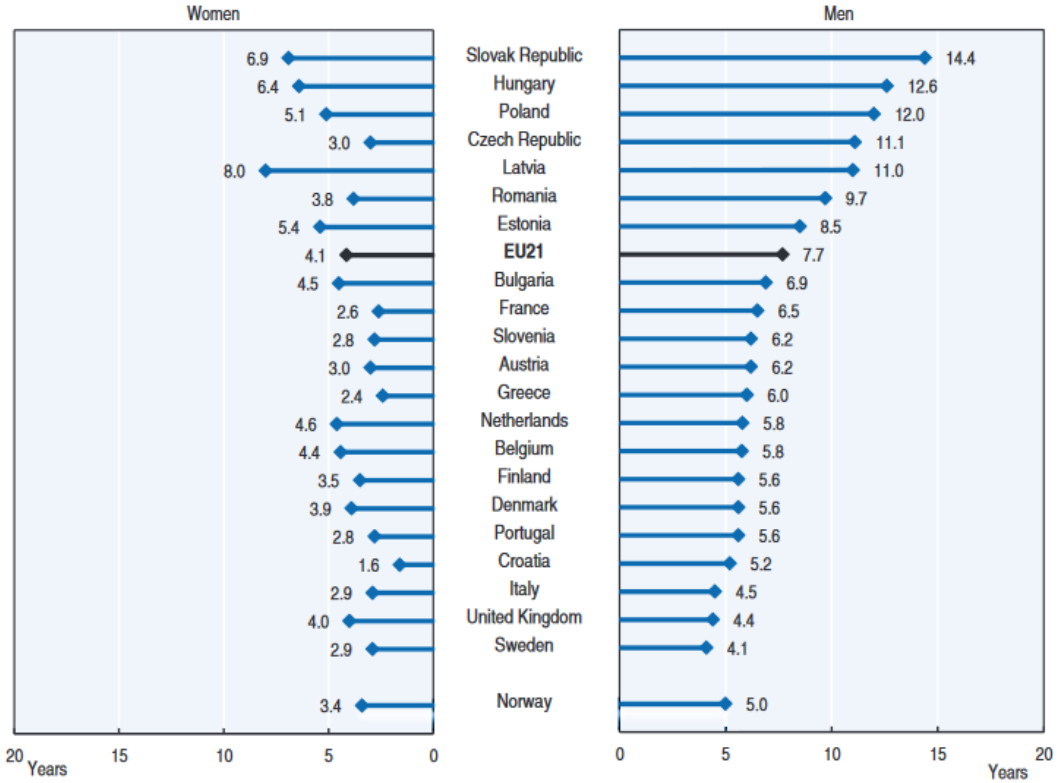
Source: WID.world (2017). See wir2018.wid.world for data series and notes.

In 2016, 22% of national income was received by the Bottom 50% in Western Europe.

https://wir2018.wid.world/files/download/wir2018-summary-english.pdf

4. Issues at stake: financial inbalance

3.3. Gap in life expectancy at age 30 between people with the lowest and highest level of education, 2016 (or nearest year)



Note: Data refer to 2012 for France and Austria and to 2011 for Latvia, Belgium and the United Kingdom (England). EU average is unweighted.

Source: Eurostat Database; national sources or OECD calculations using national data for Austria, Belgium, France, Latvia, the Netherlands and the United Kingdom (England).

StatLink http://dx.doi.org/10.1787/888933834319

The financial inbalance and its impact of the prices of services and goods may increase inequalities through two interelated mecanisms :

- increased out-of-pocket payment (debudgeting)

- Decrease or limitation of public spending in order to control the public debt and deficit.

4. Issues at stake: Access and inequalities

According to data from recent studies from Europe, a large percentage of patients have restricted access to innovative medicines for metastatic melanoma.

The US market offer the fastest market entry and the highest prices compared to the EU but 40% of the patients are without access

L. Kandolf Sekulovic et al. / European Journal of Cancer 104 (2018) 201e209

Table 1
Estimated number of patients without the access to innovative medicines in surveyed countries.

Country	Estimated number of metastatic melanoma patients	% of patients treated with innovative medicines	% of patients without the access to innovative medicines	Estimated number of patients without access
USA	9000	60%	40%	3600
China	4200	10–30%	70%	2940
Australia	3000	>90%	<10%	0
Latin America				
Argentina	600	70%	30%	200
Mexico	NA	NA	NA	NA
Chile	350	<10%	90%	315
Brazil	2000	10–30%	70%	1400
Europe				
Austria	200	>90%	<10%	0
Belgium	350	>90%	<10%	0
Denmark	350	>90%	<10%	0
France	2000	>90%	<10%	0
Germany	3000	>90%	<10%	0
Greece	NA	>90%	<10%	0
Ireland	140	>90%	<10%	0
Italy	2000	>90%	<10%	0
The Netherlands	800	>90%	<10%	0
Portugal	200	30–50%	50%	100
Spain	400	>90%	<10%	0
Switzerland	350	>90%	<10%	0
United Kingdom	2000	70–90%	<10%	200

4. Issues at stake: Financial toxicity of cancer drugs (in the US)

- Financial toxicity is a new side effect of drugs due to Out-of-pocket expenses (OOP)

JOURNAL OF CLINICAL ONCOLOGY | ORIGINAL REPORT

Financial Insolvency as a Risk Factor for Early Mortality Among Patients With Cancer

Scott D. Ramsey, Aasthaa Bansal, Catherine R. Fedorenko, David K. Blough, Karen A. Overstreet, Veena Shankaran, and Polly Newcomb

Scott D. Ramsey, Aasthaa Bansal, Catherine R. Fedorenko, and Polly Newcomb, Fred Hutchinson Cancer

A B S T R A C T

Purpose

More than a quarter of adults aged 18 to 64 years reported they had trouble paying bills because of cancer, according to a report from the CDC. Even those with health insurance went into medical debt or filed for bankruptcy because of cancer.

https://www.ajmc.com/focus-of-the-week/financial-hardship-psychological-distress-hurting-workingage-cancer-survivors-cdc-says

Source: https://pdfs.semanticscholar.org/9e23/cfb7db625ab0b60352241cb4ecc2d1d760bc.pdf

4. Issues at stake: a forthcoming « Trade War »?

WECAN Academy 2019

- Past evolution
  - Trump on drug prices: Pharma companies are 'getting away with murder'», *The Washington Post*, Jan. 2017. https://www.washingtonpost.com/news/wonk/wp/2017/01/11/trump-on-drug-prices-pharma-companies-are-getting-away-with-murder/?utm_term=.140248951d9d
  - Secretary of Health Azar on Europe: foreign countries freeriding off of American innovation https://www.c-span.org/video/?c4729092/socialized-medicine.

- Recent measures considered
  - Introduction of an international price index that would cap U.S. drug payments based on an average of prices paid in an index of developed nations
  - Special 301 submission by PhRMA for 20 countries that are undermining the work of America's biopharmaceuticals innovators ("Biggest threats" includes Canada and "Trouble ahead": the European Union)
  - President Trump on Friday said his administration would soon issue an executive order mandating a "favored nations" policy in which U.S. payments for drugs are capped at the lowest price paid by either a manufacturer or a developed country.

- Likely results (short term)
  - In June 2018 Senate hearing, Azar said that he looked at the idea of giving the U.S. "favored nation" status, but said "I don't think it would be effective" **because companies could simply raise prices abroad to gain leeway in setting prices here"**

4. Issues at stake: a forthcoming « Trade War »?

WECAN Academy 2019

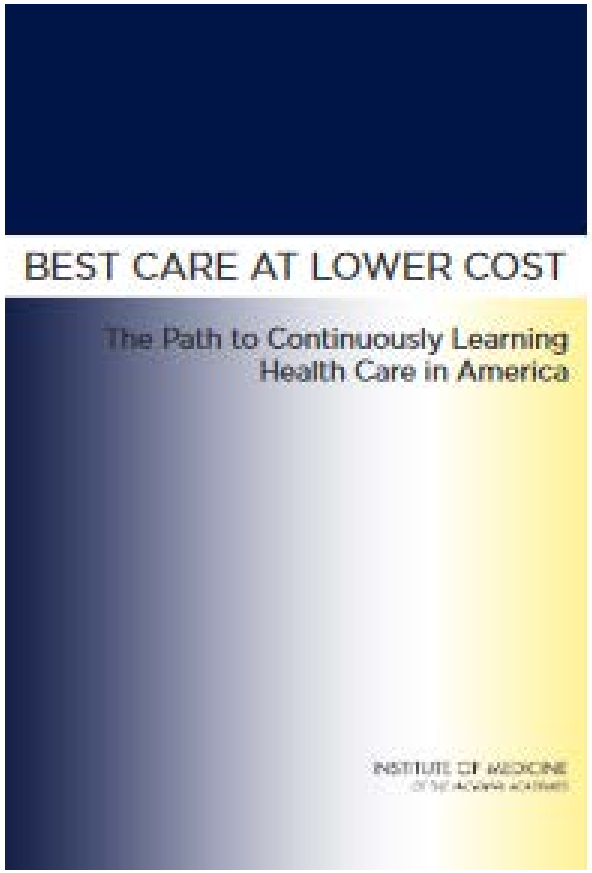
- The Trump Administration and the Pharmaceutical Research and Manufacturers of America (PhRMA) have indicated that in a bilateral trade agreement they would seek radical changes to the ways in which the National Institute for Health and Care Excellence (NICE), which serves the NHS, undertakes assessments of new medical technologies.

  Measuring the value of medical technologies may be considered by the U.S. to be a non-tariff trade barrier.

- Perhaps the impetus for the Trump Administration's calls to restructure key NHS components is the ongoing discussion on prescription drug prices. The Trump Administration wants to lower prices in the U.S. and raise prices in international markets, such as the U.K.

https://www.forbes.com/sites/joshuacohen/2019/06/18/nice-to-be-sovereign-u-k-rejects-trump-suggestion-to-include-nhs-in-possible-trade-deal/#5b7b79576e32

4. Issues at stake: Waste and overmedicalization



The 2012 report of the US Institute of Medicine estimates that 750 B$ is lost due to inefficiencies, medical fraud and other siphons in the healthcare system.

- Unecessary services 210 B$
- Inefficient delivery of care 130 B$
- Inflated prices 105 B$
- Prevention failure 55 B$
- Fraud 75 B$

https://www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning

4. Issues at stake: Waste and overmedicalization

Following for 2.4 million commercially insured residents of Washington state, 1.52 million services were examined in the state of Washington (USA; December 2018):

- 45.7% were determined to below-value
- 47.9%(622,341) received low-value services

36% was spent on low-value services

https://wahealthalliance.org/wp-content/uploads/2018/12/First-Do-No-Harm_December-2018_FINAL11_29.pdf

4. Issues at stake: Waste and overmedicalization

- A significant share of health spending is at best innefective and at worst wastefull
- 1/10 patients is adversaly affected by preventable errors
- 10% of hospital expenditure is allocated to correcting such harm
- Overprescription of antibiotics and other drugs is recorded in most countries
- The potential for generic medicine remains underexploited
- A number of administrative processes add no value.
- Money is lost to fraud and corruption

Overall, existing estimates suggest that 25% of Healthcare spending could be channeled towards better use.

https://read.oecd-ilibrary.org/social-issues-migration-health/tackling-wasteful-spending-on-health_9789264266414-en **OECD January 2017**

Discussion

WECAN Academy 2019

- My recommendation: Prepare for crisis
  - Short term: facing the risk of a **trade war in pharmaceuticals** (cancer + rare diseases)
  - Mid term : considering the risk of a major economical crisis due to debt and speculative bubble (a “great depression” following the “great recession” of 2008)
- Patients organizations should play a key role (high accountability)
  - Importance of reaffirming the core EU value: Universal coverage and Universal access
  - Keep on developing expertise and sharing with all stakeholders (public and private)
  - Embrace Economy, not only specialized « health economics »
  - Don’t get trapped by the most elaborate and complex economics models (different approaches needed, e.g. Looking at balance sheets. Discuss IP and monopolies, social justice and inequalities, trade, business, equity, etc…)
  - Beware of conflicts of interest (real or perceived).
  - Look for new models (e.g. degrowth, triple aim, integrated care, common goods policies)