

The Response from the Breast Cancer Aotearoa Coalition (BCAC)
to the PHARMAC proposal to decline the funding of 12 months treatment with Herceptin
(trastuzumab) for HER2 positive early breast cancer

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1. The PHARMAC Proposal

The Breast Cancer Aotearoa Coalition (BCAC) responds in this submission to the following PHARMAC proposal:

“To decline the funding of 12 months treatment with Herceptin for HER2 positive early breast cancer.”

This submission represents the collective views of our members, namely organisations and individuals affected by the proposal to decline funding for 12 months’ treatment. Some of our members will also be making their own submissions. As a representative consumer body, we also give voice to New Zealand women and their families affected by HER2 positive breast cancer, to all women and their families affected by breast cancer in New Zealand and to those many members of the public who, as consumers and tax payers, are strongly supportive of BCAC’s position on this issue.

An online poll hosted by Stuff.co.nz as part of its Herceptin feature for May, shows that, as of 9 June 2008, 5546 people support 12 months while 1027 do not. This is 84.4% ‘for’ 12 months and 15.6% ‘against’. The poll can be viewed at <http://www.stuff.co.nz/0a27346.html>. While BCAC accepts that Stuff polls are not scientific and reflect the opinions of only those internet users who have chosen to participate, emails, letters and phone calls to our organisation, copies of petitions (3 of which have been submitted to the New Zealand Parliament) and submissions forwarded to us tend to support the trend of greater support for 12 months’ treatment as opposed to 9 weeks. We also say that this trend is consistent with the view of the medical professional body best qualified to provide an expert opinion on this matter, the Breast Cancer Special Interest Group (BCSIG) of the New Zealand Association of Cancer Specialists (NZACS) and with the view of many other medical experts in this country, and is in agreement with international expert consensus (Goldhirsch et al., 2007).

2. Background to this Submission

2.0 The Breast Cancer Aotearoa Coalition (BCAC)

This response to PHARMAC’s proposal to decline funding for 12 months of Herceptin for early stage HER2 positive breast cancer is made on behalf of the Breast Cancer Aotearoa Coalition (BCAC). BCAC is a non-profit, charitable incorporated society, registered with the Charities Commission. It represents twenty-three of New Zealand’s breast cancer organisations and thirty-three individual members (current membership as of 26 May 2008).

BCAC provides a united consumer voice, working to improve the detection, treatment, care and understanding of breast cancer in New Zealand. The BCAC Committee, elected by members at an Annual General Meeting, consists entirely of women who are survivors of breast cancer.

Its members are educated consumers, many of whom are specialists in their fields of employment and who attend workshops, seminars and conferences in New Zealand and abroad, to ensure that they are appraised of the latest data with respect to breast cancer. In addition, a number of its members have been appointed to the boards and advisory panels of bodies and groups charged with making decisions about breast cancer.

Our Māori advisor is Carlene Wolfgram of Ngapuhi and our medical advisors include medical oncologists Dr. Nicole McCarthy and Dr. Marion Kuper-Hommel. This submission is fully endorsed by BCAC's kuia, Rangimarie Naida Glavish, Chairperson of Te Runanga o Ngati Whatua.

The BCAC member organisations are listed below. Further information about BCAC can be sourced from the website at www.breastcancer.org.nz.

2.1 BCAC Member Organisations

Age Concern North Shore	Look Good Feel Better
Boobops Dragon Boat Team	Lymphoedema Support Network
Breast Cancer Action Trust	Mamazon Club
Breast Cancer Network	Pink Dragons
Breast Cancer Research Trust	Pink Pilates
Breast Cancer Support	Reconstructables
Breast Cancer Support Tauranga Trust	Skip for Life
Breast Health NZ	Sweet Louise
Busting With Life	Te Ha o te Oranga o Ngati Whatua
Herceptin Heroes	Waikato Breast Cancer Trust
Kenzie's Gift	Waikato Treasure Chests
YWCA Encore	

2.2 BCAC Mission

'Breast Cancer Aotearoa Coalition will research, educate, support, promote informed choice, represent to relevant authorities, effectively advocate for and network, to optimise the detection, treatment and care of those affected by breast cancer in Aotearoa New Zealand.'

2.3 General Comments

Breast cancer is the most common cancer for New Zealand women. Each year, around 2500 women are diagnosed with breast cancer in New Zealand and over 600 women die from the disease. 20-30% of those women diagnosed every year have HER2 positive cancer. Māori and Pacific Island women have a higher rate of HER2 positive breast cancer and a higher level of breast cancer mortality than European and other ethnic groups. Herceptin (trastuzumab) is currently fully funded for up to 12 months' treatment in New Zealand (via Special Authority) for women with advanced (metastatic) HER2 positive disease and is funded for only 9 weeks for women with early stage HER2 positive disease.

3. The BCAC Submission to the PHARMAC Proposal

3.0 Introduction

The following submission by BCAC supports the funding of Herceptin for 12 months to be administered either sequentially or concurrently with chemotherapy. BCAC's view is that oncologists should be able to decide which treatment regimen is most appropriate for their individual patients, depending on the characteristics of their disease, state of health and so on. BCAC agrees with and supports the view of the BCSIG (Breast Cancer Special Interest Group, a sub-committee of the NZ Association of Cancer Specialists), which unanimously agreed at a meeting held on 9th May 2008 that: *"12 months' duration of Herceptin therapy is the current international standard of care and should be available for all New Zealand women with HER2 positive breast cancer."*

3.1 New information on 12 month treatment regimen

a. Updated trial data

Results of large clinical trials continue to consistently demonstrate the survival and recurrence benefits of 12 months of Herceptin treatment. New data, made available at ASCO 2007 (Perez et al.) showed a 52% relative Disease Free Survival (DFS) benefit (12.8 - 18% absolute benefit) and a 35% Overall Survival (OS) benefit (3.2 - 4.8% absolute benefit) of a 12 month concurrent Herceptin regimen after 4 years follow-up. Similarly, data from the HERA trial of 12 months' sequential Herceptin treatment has shown a 37% relative DFS benefit (6.3% absolute) and a 33% OS benefit (2.7% absolute) after 2 years (Smith 2007). The BCIRG 006 trial at 3 years demonstrated a 51% (AC-TH) or 39% (TCH) DFS benefit compared to AC-T and a 41% OS benefit (4% absolute) (Slamon, 2006).

Data from the smaller PACS-04 study presented at SABCS 2007 showed benefit from 12 months' Herceptin therapy after 18 months that appeared not to be maintained at 3 years. The presenting researcher discussed a number of possible reasons for the results of this study apparently differing from those of the much larger HERA trial, including the fact that 26% of

the 260 patients on the Herceptin arm received either no Herceptin or less than 9 months Herceptin. Another key reason provided for this discrepancy was suggested to be the small size of the trial, thus meaning it was under-powered to reliably show whether there were differences in outcomes between the treatments. We note that this element of uncertainty inherent in small trials is a feature held in common with the FinHer trial. Other suggestions were that the duration of trastuzumab in PACS-04 may have been insufficient; the start time after chemotherapy of 6-7 weeks may have been too long; or perhaps sequential treatment may not be as effective as concurrent.

A conference participant raised the question of whether the French clinical trial (PHARE) testing the efficacy of 6 months vs 12 months Herceptin therapy can now be considered ethical given these results. The presenter commented that the results presented here will “*make it difficult to continue*” the shorter duration trial. The issue of ethics is of course significant and must always be considered in trials involving vulnerable people subject to disease and particularly where they are also in an ethnic minority and/or subject to socio-economic disparity.

3.2 The SOLD trial - timeline and informed consent

The consensus of experts, as stated in the St Gallen International Expert Consensus Guidelines 2007 is that “*The standard duration of trastuzumab therapy was accepted as 1 year. A shorter duration (9 weeks) as used in the FinHer study was not generally accepted*” (St Gallen International Expert Consensus Guidelines, Goldhirsch et al., 2007).

However, in its consultation documents PHARMAC notes:

“*PHARMAC is helping to fund an international clinical trial (SOLD), to help answer the question of whether it is worth adding longer-duration treatment to a concurrent 9 week regimen*”.

The PHARMAC consultation documents do not refer to the St Gallen Expert Consensus Guidelines and neither do PHARMAC’s publications for patients or public statements or releases.

Information provided by PHARMAC on 21st May 2008 in response to an Official Information Act request states that PHARMAC expects to be able to first access data from the SOLD study in 2015, the first date when interim data may be presented at a conference. This relies on the recruitment of 3,000 patients over a 4 year period from January 2008, but it is noted that this is an estimate only and elements influencing the timeframe and beyond the study coordinator’s control include, “... *for example the time needed for a study centre to decide if it wishes to*

participate, the length of time for ethics approval to be obtained, the number of patients presenting with HER 2 positive breast cancer and their willingness to enter the study etc”.

These factors may well lengthen the timeframe for data collection, but even given the ideal, timely recruiting scenario, answers from this study will not be available for another 7 years. Furthermore, women with the aggressive HER2 positive breast cancer do not have 7 years to wait to discover whether the 9 week treatment they have received is as effective as 12 months has proven to be in several large clinical trials.

In addition, Section 10 of the New Zealand Bill of Rights Act 1990 provides that every person has the right not to be subjected to medical or scientific experimentation without that person's consent. The New Zealand Health Council Working Party on Informed Consent in 1989 defined consent as *“granting to someone permission to do something they would not have the right to do without such permission.”* Consent must be informed consent. The Working Party noted that *“informed consent”, “implies that enough relevant information is provided to enable a reasoned decision to be made, and that information has been understood. Without understanding what is involved no one can make a reasoned decision. The consent must be voluntary. There should not be any pressure on the person to give their consent. No undue influence or duress should be present.”*

BCAC notes that Medsafe's declining to register the 9 week indication is information necessary for informed consent but, as with the St Gallen Expert Consensus Guidelines, it has not been provided in publications to patients. Nor is the fact that the 9 week indication is based on the small FinHer study in which only 54 patients received the treatment proposed by PHARMAC and currently funded. Nor is the fact that 33 other countries fund Herceptin for 12 months. We question whether those who will be invited to enrol in the SOLD trial will have available the information and choices that will enable them to do so on the basis of informed consent.

We also note that unlike other countries where women who enter trials have the choice as to whether to receive Herceptin for 12 months or opt for a trial in which they may receive Herceptin for a shorter or longer duration, New Zealand women do not have such an option. If they have the financial resources, they are encouraged to receive 12 months of Herceptin and to pay for it. If not, they receive the funded 9 weeks of treatment. We question whether New Zealand recruits to the SOLD trial will be free from duress and undue influence, especially if socio-economically deprived, unless 12 months of Herceptin treatment is made available to all those needing it. If not, participating in the SOLD trial will be the only way such women might receive 12 months of funded Herceptin which is otherwise inaccessible to them.

We request that PHARMAC establish in New Zealand the 12 months of Herceptin treatment that is now available in 33 other countries. This would offer future recruitment into the SOLD trial in a more appropriate context, where patients are able to freely choose to participate rather than being effectively coerced into participation by the 50:50 possibility of receiving the international standard of 12 months of care.

3.3 Risks and benefits - 12 months vs. 9 weeks

a. Evaluation of cardiac risks

PHARMAC has expressed concerns over the cardiac (heart) risks associated with Herceptin for those women taking the drug for early stage HER2 positive breast cancer.

Indeed there is a proven risk but this is generally reversible (Suter et al, 2007) and longer follow-up data shows the cardiac issue does not increase with the passage of time (Rastogi et al., 2007). One commentator notes, *“while there is cause for concern, perspective is needed: over two years, the risk of cardiac damage seems trivial compared with that of breast cancer recurrence.”* (Hind et al, 2007). This known cardiac toxicity risk can be managed by oncologists through initial selection of an appropriate treatment regimen followed by monitoring of heart function regularly throughout treatment. In cases where a problem arises, treatment may be suspended until the issue is resolved and treatment resumed at a later date. If the problem persists, treatment will stop. For the great majority of patients, the benefits of a 12 month Herceptin course will greatly outweigh the risk of cardiac toxicity.

b. FinHer study

The 9 week regimen currently mandated by PHARMAC and funded in New Zealand is based upon the small FinHer study (Joensuu et al. 2006). Although the study raised interesting questions, the small sample size, wide confidence intervals and thus the high degree of uncertainty in the results have not convinced medical experts in New Zealand and around the world that it will be effective (Goldhirsch et al. 2007). Neither has Medsafe agreed to register this indication, as already noted in this submission, given the insufficient evidence of efficacy. PHARMAC itself has invested in a clinical trial in an attempt to provide additional data to shed light on the effects of this shortened regimen. Funding a 9 week regimen for a population is, in itself, a risk *because it may not work.*

c. 12 months of Herceptin - potential for cure

If breast cancer is caught early the aim of treatment is to cure. If it is allowed to progress, cure is not possible and the life will be lost. Studies examining the impacts of chemo- and hormonal treatments through time have consistently shown that early benefits translate into ongoing, increasing benefits (EBCTCG Oxford Overview, 2005) and the same is very likely with

Herceptin. The economic and social benefits of preventing the advancement of breast cancer are immense. In the New Zealand context, this is a particularly critical view for our Māori and Pacific women, and the impact on them is discussed further at Section 3.8 of this submission.

d. Follow-up results of 12 months - improved survival, less chance of recurrence

Significant overall survival benefits have only been seen in the large scale 12 month trials as one would logically expect. As previously submitted, the combined US concurrent studies show a 35% reduction in death rates at 4 years (absolute 3.2% for the whole study group). HERA is showing a projected 2.7% absolute reduction in risk of death at 3 years. The BCIRG 006 trial has shown a 41% relative risk reduction at 3 years (absolute 4%).

Based on experience with chemo- and hormonal therapies, these early gains are likely to translate into increasing long-term benefits (EBCTCG 2005).

3.4 Consideration of concurrent as well as sequential treatment

BCAC is pleased to note that the consultation documents indicate that PHARMAC is considering both concurrent and sequential treatment and this was confirmed in our discussions with Drs Peter Moodie and Jackie Evans on 30th May 2008. There is substantial data for both concurrent and sequential regimens (Perez et al. 2007; Piccart-Gebhart et al. 2005; Romond et al. 2005; Slamon et al. 2006; Smith et al. 2007), and we believe that oncologists should be able to decide which is best to use for their patients on an individual basis. The St Gallen International Expert Consensus Guidelines 2007 states “A majority of the Panel found both the sequential HERA model (*trastuzumab commencing after completion of all chemotherapy*) and the concurrent model (*trastuzumab commencing concurrently with a taxane following anthracycline*) as equally acceptable” (Goldhirsch et al., 2007).

We note that PHARMAC has already recommended funding for a 9 week concurrent Herceptin regimen for which no party sought PHARMAC funding approval, and which was declined for regulatory approval by Medsafe in 2007 on the grounds of “*insufficient evidence of a regulatory quality*”. This suggests that the absence of regulatory approval or a formal funding proposal should not be an impediment to the funding of 12 months’ concurrent Herceptin therapy, and this also was confirmed in our discussions with PHARMAC’s representatives at the meeting on 30th May.

BCAC believes that the optimal funding scenario that should be recommended by PHARMAC is “funding for 12 months’ Herceptin treatment for those diagnosed with early stage HER 2 positive breast cancer”. The taxanes, docetaxel and paclitaxel, should also be funded for use in conjunction with Herceptin as there is good evidence of the efficacy of combinations of a

taxane with Herceptin (e.g. Hayes et al. 2007; Perez et al. 2007; Romond et al. 2005). This would provide maximum flexibility for oncologists to prescribe the most appropriate regimen for their patients based on the best information available. For example, emerging data presented at SABCs 2007 suggested that while targeted therapies such as trastuzumab and lapatinib have the potential to benefit all those with HER 2 over-expressing breast cancer, only a third of those patients, namely those with the TOPO IIa gene amplification, may further benefit from AC chemotherapy. The FDA has recently approved a taxane-based non-anthracycline-containing chemotherapy in combination with Herceptin for HER2 positive early breast cancer patients, based on positive results showing improved DFS and OS in one of the treatment arms of the BCIRG 006 study (BCIRG 2008).

New research revealing the genetic characteristics of the many “sub-types” of breast cancer is leading to the development of novel, targeted molecular therapies such as Herceptin which are less toxic, more effective, individualised treatments based on the specific biological features of the disease. Gene expression profiling techniques such as OncotypeDX™ and MammaPrint® will enable patients’ risk profiles and optimal treatment strategies to be better understood. As time passes and new information and testing protocols become available, oncologists should have the flexibility to respond in a way that enables them to provide their patients with optimal care by delivering the most appropriate well-targeted array of treatments, rather than being unnecessarily constrained by instructions that lead them to either over- or under-treat.

3.5 Cost effectiveness

BCAC has been informed that Roche has presented a significant new funding proposal to PHARMAC, which includes reduced pricing for Herceptin used in metastatic breast cancer and in the proposed SOLD clinical trial as well as for use in early breast cancer. This suggests a substantially lower QALY value, better value for the DHBs’ current expenditure in treating metastatic HER2 positive breast cancer and potential future investment in treating early disease as well as any investment in the SOLD clinical trial. We urge that this new information be taken into account and that PHARMAC reconsider the new overall cost-benefit scenario resulting from this lower price.

We believe the cost-benefit models (cost-utility analyses) must be run again using the new data showing improved disease-free and overall survival benefits after longer-term follow-up (Perez et al. 2007, Slamon et al. 2006, Smith et al. 2007) to determine the true net additional cost of increasing the level of funding from 9 weeks to 12 months’ Herceptin in early breast cancer.

As any significant new pricing offer will have a large impact on cost-benefit outcomes, it is therefore significant new information that must be fully and carefully evaluated during this consultation process.

We note that information provided under the Official Information Act on 21st May 2008 reveals that a PHARMAC Briefing Paper to the Board dated 21st April 2008 states “*There is currently no evidence that the incremental \$25 million cost per year (on top of the costs to fund a 9 week treatment) for funding a 12 month sequential treatment would result in any health gains compared with the currently funded 9 week concurrent regimen*”. We suggest that the figure of \$25 million is used erroneously here - this was PHARMAC’s earlier estimated cost of providing the full 12 month course, and therefore does not take into account the cost of 9 weeks’ treatment currently funded. Neither does it take into account the funds needed to supply Herceptin for the SOLD clinical trial.

We note this Briefing Paper also refers only to “*concurrent*” treatment and omits to mention the important 12 months’ sequential treatment as an additional option.

Furthermore, reference in this Briefing Paper to the “*lack of evidence of additional health gains of 12 months’ treatment over 9 weeks’ treatment*” is of great concern given the likely timing of availability of data from SOLD, the only trial testing this. As referred to in an earlier section of this submission, the date of first release of interim data is 2015, under a challenging scenario of timely recruitment of 3,000 patients worldwide. Neither the uncertainty of the 9 week data resulting from the small patient sample size included in the FinHer study (Joensuu et al. 2006) nor the absence of overall survival data from this study are highlighted in the Briefing Paper, although this information is needed to provide a balanced picture.

BCAC believes that any new pricing information provided to PHARMAC by Roche is a key element that PHARMAC must seriously consider before reaching its new decision in this consultation. If PHARMAC achieves a significant price reduction in the current negotiations with Roche, this major barrier to providing access to 12 months of Herceptin funding to patients needing this therapy will surely be eliminated or substantially removed.

We urge PHARMAC to run their cost benefit analyses afresh, taking into account new pricing across all uses of Herceptin. The advantages in overall survival and disease-free survival shown in the longer follow-up of 12 month concurrent regimens reported by Perez et al. 2007 and Slamon et al. 2006 should also be used in the modelling.

We also urge that the costs of treating metastatic disease be properly accounted for in these models, including recent data suggesting that these costs have generally been underestimated. Dahlberg et al. (2007) state that total health care costs for patients with disseminated cancer in the era of modern treatments are likely to be three to nine times higher than has been assumed in previous cost-benefit analyses, thus the financial benefits of preventing disease progression by treating to cure in early stage disease have been significantly underestimated.

We note that 33 countries (listed in Section 4 of this submission) have examined the Herceptin trial data, made their economic calculations and are now funding 12 month Herceptin regimens for their populations (figures current as of 1 May 2008).

3.6 The New Zealand Medicines Strategy

The impact on patients of not funding the treatment recommended by NZ oncologists is immense and not in keeping with the objectives of the Medicines Strategy.

New Zealand's Medicines Strategy (Minister of Health, 2007) states Outcomes and Principles relevant to this consultation:

“Health and Disability System Outcomes:

New Zealanders feel secure that the health and disability support system protects them from substantial financial costs due to ill health”

Currently hundreds of New Zealand women face the dilemma of whether to meet the substantial and often crippling financial costs of paying for the Herceptin course their oncologist recommends or taking the chance of a greater likelihood of their disease advancing and ultimately taking their life.

“Medicines New Zealand Outcomes:

New Zealanders have access to the medicines they need, regardless of their individual ability and within the government funding provided”

While 12 months of Herceptin treatment remains unfunded in New Zealand, women with early HER2 positive breast cancer do not have access to the treatment they need and that their specialists recommend. Those with better financial resources are more often treated with a 12 month Herceptin course which has been clearly demonstrated to increase overall survival and disease free survival. This inequity based on financial circumstances is unfair and unpalatable in this country, where citizens expect equal access to medicines for all.

“Guided by Principles:

Equity - New Zealanders in similar need of medicines have an equitable opportunity to access equivalent medicines. Medicines and other resources are allocated in a manner that reduces the inequity of outcomes”

Existing ethnic and socio-economic disparities in cancer mortality continue to be compounded by failure to provide funding for a 12 month Herceptin course in early breast cancer, particularly given the higher rates of incidence of HER2 positive breast cancer among Māori and Pacific women (see Section 3.8 of this submission).

“Effectiveness - The medicines system is effective, people-centred, evidence-based and reflects best practice to ensure safety, efficacy and timeliness”

The professional body representing New Zealand oncologists is the Breast Cancer Special Interest Group (BCSIG) of the New Zealand Association of Cancer Specialists. This body maintains, and BCAC agrees, that the evidence lies with a 12 month course of Herceptin and that this should be made available to those who need this treatment. The St Gallen International Expert Consensus 2007 also holds the view that 12 months is the accepted standard of care (Goldhirsch et al. 2007).

“Confidence - The processes within the medicines system are robust and transparent. Stakeholders (including consumers) understand and have the opportunity, as appropriate, to participate in the decision-making processes used for regulating, funding and managing medicines”

We note that PHARMAC’s counsel in the recent Judicial Review of the 2006 decision to decline funding for 12 months of Herceptin treatment submitted during the proceedings that any intervention by the Court with respect to the requirement to consult on the decision “*would be pointless as the decision not to approve 12 months’ funding, but to fund 9 weeks, has been properly made.... and any decision would be the same*”. However Justice Gendall found that PHARMAC should consult and held that “*Consultation requires open-minded communication and hearing the voice of others who are given the opportunity, and right, to be listened to.*”

BCAC trusts that the views and experiences of consumers - in other words, the affected parties, breast cancer patients and those such as BCAC who represent them - will be considered with respect and genuinely taken into account in this consultation. We also urge that the expert opinion of BCSIG of NZACS be accepted as a key submission in this consultation and given special weight in PHARMAC’s decision-making.

3.7 The PHARMAC proposal: the impact on New Zealand women and their families

BCAC is contacted on a regular basis by women diagnosed with early HER2 positive breast cancer who have been advised by their oncologists that they should access 12 months of Herceptin if they are able to afford it. The impact on these patients and their families is immense. Few are able to meet the costs of treatment, some have the strength and support to be able to engage in fundraising and many simply go without the recommended treatment.

This failure to provide the treatment recognised by New Zealand and international specialists as the standard of care (Goldhirsch et al., 2007) has created stress and suffering within families already struggling to cope with a diagnosis of aggressive breast cancer in a mother, daughter, sister, partner, wife, or grandmother. As HER2 positive breast cancer tends to be diagnosed in younger women, many of those affected have young families and all the associated responsibilities.

3.8 The PHARMAC proposal: the impact on the health needs of Māori and Pacific peoples

A review of the years 2000-2004 showed Māori women have both a higher age-adjusted incidence of breast cancer (66.8 vs. 58.4/100,000 for non-Māori), and higher mortality (21.3 vs. 12.4/100) (Robson & Harris, 2007). The relatively high rates of HER2 positive breast cancer in Māori and Pacific Island women (Courtenay et al., 2008; Metcalfe et al., 2007), suggest the need for early, effective intervention in order to reduce this disturbing inequity in outcomes.

The higher rate of HER2 disease recorded for Māori (29%) and Pacific women (35%) compared to European women (22%) (Courtenay et al. 2008, Metcalfe et al. 2007) results in a greater burden for these groups and adds to the inequity and worse outcomes that these populations tend to experience (Robson et al. 2006; Blakely et al. 2007). Those in lower socio-economic groups also suffer greater cancer mortality (Blakely et al. 2007) and failure to provide funding for high-cost medicines that target diseases prevalent in ethnic groups that tend to have lower socio-economic status will only serve to compound these inequalities.

PHARMAC's key objective as specified by section 47(a) of the New Zealand Public Health and Disability Act 2000 is *"to secure for people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided."*

With regard to Māori health, PHARMAC states on its website (<http://www.pharmac.govt.nz/patients/MaoriHealth>) under the heading of Maori Health that: *"As a Government agency committed to the principles of the Treaty of Waitangi, PHARMAC has developed a Māori Health Strategy to improve the way we respond to the health needs of*

Māori. The Strategy has six key aims, including improving Māori representation within PHARMAC, improving how PHARMAC responds to Māori health needs, and improving information on medicines for Māori.”

We therefore stress PHARMAC’s obligation as a Government Agency committed to the principles of te Tiriti o Waitangi to take the special health needs of Māori patients into account when making its decisions, and we note that the “*particular health needs of Māori and Pacific peoples*” is one of PHARMAC’s nine decision making criteria. We strongly request that the data relating to these more vulnerable ethnic groups be given full attention.

We note that in the Foreword to the PHARMAC’s Māori Responsiveness Strategy July 2002, PHARMAC Chairman Richard Waddell writes: “*We look forward to working with Māori across New Zealand, health professionals and providers, DHBs, pharmaceutical companies and other stakeholders to improve access to medicines by Māori so they can enjoy a positive state of health and wellbeing.*”

Further, in PHARMAC’s document outlining the intended implementation of its Māori Responsiveness Strategy (PHARMAC, 2006) it is stated that (Section 3.1): “*There is a substantial amount of research to indicate that Māori as a population have the poorest health status to any other population group in New Zealand.*”

Health status and its link with socio-economic deprivation is emphasised in a Child Poverty Action Group (Inc) backgrounder paper entitled ‘A Brief Analysis of the Impact of the In Work Payment on Māori and Pasifika Families’ by D. Wynd (CPAG Inc, Backgrounder 01/06, April 2006) which states: “*According to the Ministry of Health (Ministry of Health. (2005). Decades of Disparity II: Socio-economic Mortality Trends in New Zealand, 1981-1999 (No. Public Health Intelligence Occasional Bulletin Number 25). Wellington: Ministry of Health) disparities in New Zealanders’ health outcomes can be linked to the income disparities that have emerged since the late 1980s. Not only have the bottom four deciles’ incomes fallen in real terms, they have fallen relative to others. Moreover, there is increasing evidence that low life expectancy and poor health that cannot be explained by material deprivation alone, can be explained by differences in relative income. Māori and Pacific people are overrepresented in low-income households and have been affected disproportionately by increasing income disparities and this is reflected in their health statistics...*

“*The government’s Opportunity for All New Zealanders (Ministry of Social Development, 2004) ... notes: “Poor child health is linked to poor adult health and also to broader poor outcomes including unemployment and crime.” In other words, today’s low-income children are most likely to be tomorrow’s unemployed.*”

In the Counties-Manukau region, with which some members of BCAC's Committee are familiar because of work and residence, 90% of Pacific families and 72% of Māori families are living in areas of highest need and deprivation according to the United Nations Report 2003 on Child Poverty in New Zealand and to Manukau City Council when launching New Zealand's first action plan to address child poverty in 2003 (<http://www.manukau.govt.nz/default.aspx?id=3661>).

We mention this example because it is well known that more Aucklanders are likely to be living in severe or significant hardship than other New Zealanders - Aucklanders in fact make up 38% of those living in severe or significant hardship but only 31% of New Zealand's population (see the Ministry of Social Development's 2006 report entitled 'New Zealand Living Standards 2004', p 175). In 2006, the poorest 10% of neighbourhoods were made up of 37 census area units comprising 30,000 households, 47% of which were benefit dependant. Of these 37 neighbourhoods, 13 were located within the Mangere Ward of Manukau City, and 8 each in the Otara and Manurewa Wards of the same city.

Women in such neighbourhoods, especially Māori and Pacific women, are acutely affected by poverty. Decisions about their health which are primarily driven by financial factors based on outdated cost-utility analyses will have a significant, detrimental impact on them when health statistics show that they are already at a disadvantage.

One of the whakatauki of Te Kete Hauora, the Māori Health Directorate, is: *He manako te koura e kore ai* or "wishful thinking will not get you a crayfish." It has a wider meaning of needing to have both a vision and the actions to make it happen. Given the greater numbers of Māori and Pacific families who live in areas classified as those of highest deprivation, we urge PHARMAC to give practical and positive effect to the principle of whanau ora when considering its proposal with respect to funding Herceptin.

3.9 Expert opinion

BCAC notes that BCSIG is making a submission to PHARMAC in response to this consultation. We urge PHARMAC to place special weight on the evidence and conclusions of this submission as BCSIG provides the voice of the expert professional body with the most relevant knowledge to the matter at hand.

4. Conclusion

- Data supporting 12 months of Herceptin treatment is strong and derived from large international clinical trials involving over 12,000 women, around two thirds of whom received 12 months of Herceptin. By contrast, the data supporting 9 weeks is uncertain, based upon the small FinHer trial involving 232 women, 116 of whom received 9 weeks of Herceptin and only 54 of whom received the treatment PHARMAC

currently funds. Only the large 12 month studies have shown improved overall survival statistics.

- Both New Zealand and international expert opinion supports 12 months (e.g. BCSIG, St Gallen Expert Treatment Consensus Report 2007). New Zealand's own pharmaceutical regulatory body, Medsafe, registered the 12 month Herceptin regimen as safe and appropriate for use in this country but has not approved the 9 week regimen.
- The St Gallen Expert Consensus Report supports both concurrent and sequential administration of Herceptin. Oncologists should be given the flexibility to determine the most appropriate regimen for their individual patients.
- Funding should also be provided for the taxanes (paclitaxel and docetaxel) in association with Herceptin as these have been shown to be effective in combination.
- Thirty-three countries now fund 12 months of Herceptin therapy. As of 1 June 2008 they are:
Australia, Austria, Belgium, Bulgaria, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Japan, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Republic of Ireland, Romania, Slovakia, Slovenia, South Korea, Spain, Sweden, Switzerland, Ukraine, United Kingdom, USA.

Four of these countries, Bulgaria, Hungary, Lithuania and Romania, have established 'limited reimbursement', i.e. they limit the number of women who can be treated, meaning they fund a full 52 week course but for a capped monetary amount per annum.

- The data from the proposed SOLD trial comparing 9 weeks with 12 months will not be available for at least 7 years (based upon the best recruitment scenario) and the health and wellbeing of New Zealand women should not be risked in the meantime through the administration of a 9 week Herceptin treatment until and unless new, stronger data demonstrates the efficacy of this shortened regimen.
- While there is some cardiac risk associated with 12 months of Herceptin treatment, this is manageable for the majority of patients. If cardiac complications do occur, effects are generally reversible. These risks are considered to be minimal when compared to the risk of the cancer returning.

- Given the higher incidence of breast cancer occurrence and mortality in Māori and Pacific populations, these women should be given access to the proven 12 months Herceptin regimen. One of PHARMAC's decision criteria states that the special health needs of Māori and Pacific peoples must be taken into account.
- Further research into the genetic sub-types of breast cancer will deliver more targeted, individualised and less toxic treatments like Herceptin. PHARMAC should not be too prescriptive in its instructions regarding the use of Herceptin as this could lead to under- or over-treatment.
- A new funding proposal from Roche will significantly reduce the cost of Herceptin in early and metastatic breast cancer as well as in the SOLD trial. BCAC urges PHARMAC to re-run its cost/benefit analyses, taking into account this new proposal, the new longer term follow up data showing benefits in overall survival and disease free survival, and the high cost of treating metastatic disease which recent data suggests may be three to nine times higher than previously thought.
- The provision of 12 months funding for Herceptin sits well with the NZ Medicines Strategy. Such provision would help overcome ethnic and socio-economic inequities and would ensure the evidence-based 'best practice' requirement as stated in the Strategy is satisfied.
- The current lack of 12 months funding has an enormous and detrimental impact on New Zealand women and their families and friends who must either fund raise to pay for the treatment their specialists recommend or go without. This has a particularly devastating effect on younger women who will, in many cases, have young families.
- If breast cancer is treated in its early stages, there is the potential for a cure. Treatment in the advanced stages intends to prolong life but there is no chance of a cure.

BCAC notes that the due date for responses to PHARMAC's proposal falls at the time of Matariki, or New Year, one of the most significant celebrations of the Māori calendar.

Matariki is a time to reflect on and remember the past and to celebrate and create a vision for the future. Many iwi speak of the three baskets of knowledge that Tane-nui-a-rangi obtained when he climbed the vine to the heavens but some add that there was a fourth basket, often

forgotten - te kete hauora, or the basket of health. Matariki is a time when iwi are encouraged to consider health, lifestyle and the steps that need to be taken to enhance both.

This is also, therefore, an ideal time for all of the information now available about Herceptin to be carefully considered from a fresh and open-minded perspective, and for a positive decision to be made enhancing the health and well-being of our women.

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