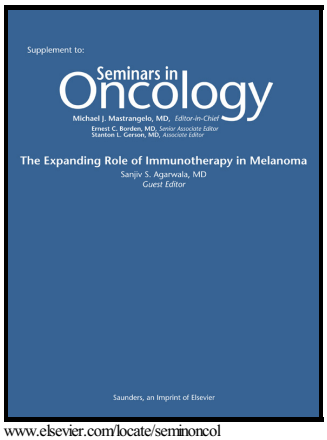

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"Mind the Gap" Revisted

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Dear Sir/Madam,

We note with interest the article by Evans et al recently published in Seminars in Oncology [1]. The authors compared access to cancer medicines in New Zealand and Australia and examined the potential foregone population health gains due to differences in the ready availability of anti-cancer pharmaceuticals in each country. However, we are concerned that the authors have used a flawed methodological approach in making such comparisons and failed to address the potential role of access to pharmaceuticals available in many other developed countries, to the fundamental differences in cancer survival between the two countries.

That cancer outcomes seem to be worse in New Zealand compared to Australia appears to be a reality, based on recent publications that compare the changes in survival between the two countries from 2006-2010 [2,3]. In a pivotal paper published at the end of 2014, Aye et al [2] unequivocally demonstrated that the 5 year relative survival for patients in New Zealand with cancer was 4.2% and 3.8% worse in women and men respectively compared to Australia. Of 18 different cancer types studied, 14 cancer sub-types had an inferior survival when comparing New Zealand to Australia. Whilst the explanation for such findings is likely to be multifactorial, especially given that the major differences occurred within the first year after diagnosis [3], lack of access to modern effective pharmaceuticals for patients who present with locally advanced or metastatic disease is almost certainly to be a part of the explanation. In colorectal cancer for example, in which 20-40% of patients present with metastatic disease, at least some of whom are potentially curable with modern day multi-disciplinary treatment, two effective biological therapies targeting the EGFR (epidermal growth factor receptor) are not available to New Zealanders [4]. In advanced gastric cancer, another tumour type in which outcomes are inferior in New Zealand to Australia, trastuzumab, one of the most effective biological therapies for the 10-15% of patients who have tumours that over express the Her 2 protein [5] is not reimbursed by PHARMAC and hence not available to the general population who cannot afford to purchase this agent. Many other examples of new cancer drugs available in most of Western Europe and Australia, indeed most of the developed world, could be highlighted.

It is disappointing then to see the authors attempt to justify rationing access to new pharmaceuticals, which may be affecting the survival of many patients, using flawed arguments (such as the net improvement in median survival) to support their contention that limited access is not an important contributor to poor health outcomes. As the authors will be aware, measures of differences in the median survival (or median progression-free survival) are not an acceptable basis for measuring the