



Commentaries

How Much Is it Worth?

I HAVE BEEN IMPRESSED RECENTLY WITH THE medical treatment “breakthroughs” being announced in the newspapers. Just the week before I wrote this, a new drug was shown to extend life in men with metastatic prostate cancer by three months. The newspapers, although not quite rapturous, nevertheless were enthralled. Several doctors, undoubtedly world famous experts, judging by their clinical appointments, were quoted about this “major advance.” Not only that, but two other drug companies had similar drugs that would likely show similar efficacy. A month prior I saw an article about another breakthrough, for metastatic melanoma, which, like the prostate drugs, extended life by three months, although only for people whose tumor had a particular genotype.

Last week the *Wall Street Journal* denounced the Food and Drug Administration for denying approval for Avastin for metastatic breast cancer on the grounds that the FDA commissioner was biased, and that the review panel was the same as the one that had recommended a review of the data, hence also biased. Their point seemed to be that drug companies needed protection, not patients. Efficacy and safety were less important than profit.

In a world where the difference between placebo and efficacy may be microscopic, but the cost is increasingly outsized, where will it all end? We have ever-more costly drugs, producing increasingly small benefits. We have come to embrace the drugs for Alzheimer’s disease despite their minimal benefits and costly price tags. We rush to do carotid endarterectomies for asymptomatic stenosis although we have to do about 50 operations to prevent one stroke, and that rate applies only if the surgeon is top rate.

As time passes and advertising campaigns sink in, we become increasingly steeped in the hype, which feeds our egos, that doctors actually can do something in situations we’d previously believed were

hopeless. In the book, *The Thirteen Clocks*, by James Thurber, an apocryphal story is told in which the character explains to his friends that he started the rumor that created a gold rush in some distant land. “But you went, too!” his friend remarked. “Yes. I was convinced that the rumor was true since so many people were going there.” Doctors, who were undoubtedly as smart and talented as those practicing today, practiced blood letting for thousands of years.

These new drugs, as appropriately pointed out, are not cheap. The investment in development may be over a billion dollars. The cancer drugs often cost \$5,000 or more per month. The release of a new drug for multiple sclerosis is actually leading to an *increase* in the cost of its competitors, as each seeks to compensate for its loss of market share. Adam Smith spins in his grave. Of course this doesn’t affect those who lack drug insurance since they can’t afford these drugs anyway. It does make them and their families feel badly, though. Imagine the parents who can’t afford to buy a drug for their terminally ill child, or the adults who can’t afford the payments for the father’s prostate cancer medication?

How much is a life worth? There are standard tables for figuring this out for personal injury suits. If you’re still working and have a high paying job your life is worth a lot, whereas a child’s has no financial value, similar to a retired person. But how can we really attach a value to a life? There is, of course, no way. “Value” and “money” are not interchangeable. Drug insurance varies wildly from plan to plan, and a co-pay of \$40 for a brand name may be a bad deal for cheap drugs, but terrific for a \$5k whopper, whereas a 20% co-pay is good for the cheap drug but prohibitive for the mega-cost drug. Most patients pay a very large percentage of their disposable income, often far beyond their disposable income, to pay



their share for these medications. Everyone feels badly when they can’t afford them but get them anyway, or simply have to decline.

As drugs increase in price and their price to efficacy ratio approaches infinity, perhaps we can propose a deal between the insurer and the patient. If the patient chooses to decline the expensive drug to increase his survival by three months, he gets to keep half the savings in the drug cost. Thus, the patient chooses between a little extra cash to leave his family, if we make the deal contingent on his death, or to use himself. My guess is that a very large percentage of mortally ill people will choose to leave money rather than spend it on medications that delay their exit only a little bit.

— JOSEPH H. FRIEDMAN, MD

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CORRESPONDENCE

e-mail: joseph_friedman@brown.edu