‘ORAL CHEMOTHERAPY IS AS MOBILE AS YOU CAN GET’
– Pierre Fabre supports patient choice

The relentless pressure on the NHS is felt not just in balance sheets but at the frontline of care. By moving chemotherapy out of the hospital, Pierre Fabre can help both patients and the NHS

WITH TIME AND RESOURCES AT A PREMIUM IN THE health system, an ageing population and the longer lifespans achieved through more effective therapies weigh heavily on both budgets and the human resources they pay for – particularly in those parts of the system that need to pay close attention to a fast-growing patient pool.

This is certainly the case in oncology. “When chemotherapy is administered intravenously, that means visiting a hospital and undergoing a procedure that can take around an hour,” notes Santoke Naal, managing director of Pierre Fabre in the UK. Although this may sound simple enough, the situation is far from ideal for either the patient or the NHS.

Chemotherapy suites are “bursting at the seams”, Santoke says. “Many hospitals have capacity issues” as intravenous chemotherapy takes up already-limited chair space in hospital units and stretches nursing and junior staff in particular. There is also added pressure on hospital pharmacies, which need to set aside time for preparing IV solutions.

From the patient perspective, receiving treatment means the inconvenience and stress of regularly travelling to a hospital with a chemotherapy suite, finding and paying for a parking space, and dealing with all the other hassles of an overstretched healthcare institution.

But although chemotherapy patients need to visit a hospital for regular check-ups – and may well do so for initial therapy post-diagnosis – the rest of the treatment cycle is more amenable to approaches that can make life easier for patients and NHS staff alike.

Of course, moving chemotherapy out of the chemo suite, making it more convenient for patients by administering it in settings that suit their needs, also chimes with a broader NHS agenda to shift IV treatments to oral medicines, to expand the use of home care where appropriate and to relieve hospitals and health clinics of unnecessary pressures.

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Finding a creative solution

No-one is suggesting putting cancer patients out on the street but many healthcare providers have found creative ways to deliver IV chemotherapy outside the hospital setting, such as the mobile chemotherapy units run in partnership with the NHS by the charity Hope for Tomorrow (www.hopefortomorrow.org.uk), the first of which launched in 2007.

In one follow-up report, where study participants had previously described waiting in chemotherapy suites for between three and 12 hours, the longest wait for treatment through a mobile chemotherapy unit was 10-15 minutes.

It’s a move in the right direction – and one now entrenched in the standard NHS contract for adult chemotherapy, which states that patients should be treated “at the right time, in the right place, which, where possible, will be as close to home as practicable”. It also recommends inpatient delivery of chemotherapy be kept to a minimum by, among other strategies, “maximising the use of oral medicines”.

Indeed, many hospitals in the UK have now switched IV to oral chemotherapy and have seen rewards both in capacity and cost.

As mobile as you can get

This is where drug manufacturers such as Pierre Fabre can help ease the burden on patients, carers and chemotherapy suites. As Santoke points out, oral chemotherapy is “as mobile as you can get”.

Pierre Fabre has recognised the multiple benefits of moving chemotherapy out of the chemo suites by transitioning from IV to oral formulations. This more patient-friendly capsule formulation testifies to the R&D capabilities of Pierre Fabre’s Oncopole global research centre in Toulouse, France, where around 80% of the company’s oncology R&D is conducted.

As Santoke observes, switching patients from IV chemotherapy to oral formulations saves them time and hassle while freeing chair space and resources in chemotherapy suites. That helps nurses, pharmacists and junior staff working under duress to “do what they do effectively”, he adds.

But making that transition requires budget managers to look beyond immediate cost impact. Using IV chemotherapy may look cheaper on the surface but the trade-off in time and resource is a less compelling value proposition than patients taking capsules at times and locations convenient for them.

Financial managers in the NHS need to shake off the constraints of annual budget planning and “see the bigger picture”, Santoke insists. Upfront cost savings on IV chemotherapy do not translate into the long-term cost-efficiencies that come with more intelligent use of the finite resources available to the NHS in a tough budgetary climate.

At the same time, patients with serious and life-altering illnesses such as cancer need to feel they are in control of their condition as much as possible – but without being pushed to the margins of the NHS by decisions that reduce them to being merely a budgetary component.

One thing that’s clear is waiting for up to 12 hours in a chemotherapy suite is not being in control. Nor does it give cancer patients the respect and freedom to get on with their lives. So transitioning from IV to oral chemotherapy means the best possible use of NHS resources and capacity while sparing patients from elements of the care pathway that can make an enormously challenging condition intolerable.

“We want the best for oncology patients and the NHS,” Santoke comments. “That can only happen if we understand – and help budget-holders to understand – what works for patients, while enabling long-term savings in resources and costs for chemotherapy suites.”