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Sticker Shock

BY LAURA BEIL

Every life is priceless, but Jim Guzzi can tell you almost to the dollar what his costs: more than \$40,000 a year. That's the tab for Gleevec (imatinib), the targeted drug that controls his leukemia. Health insurance and Medicare cover most of it, but he still has to come up with about \$15,000 a year from his own wallet. "It's a heck of a strain. I don't have any choice," the 65-year-old says of the bill. "This is life and death."

Such is the dilemma for many patients who depend on targeted drugs. For some patients, it's a choice in theory only; lacking thousands of dollars to pay a pharmacy up front, they must do without the drug. A recent study from the Kaiser Family Foundation found that 21 percent of Americans surveyed who were given a prescription never filled it because of the cost.

Health care costs are rising, and economists say cancer care is leading the way. For example, Erbitux (cetuximab), which costs around \$10,000 a month, is one of the most expensive cancer medicines in history. Costly drugs aren't just a patient's problem. Insurance companies and Medicare ultimately make up for drug costs through health care premiums and taxes we all pay.

Why are the drugs so expensive? "Once a breakthrough drug is discovered, it's a little bit like winning the lottery," oncologist Lee Newcomer, MD, of UnitedHealthcare told the journal *Health Affairs* in 2007. "The manufacturer can price whatever they want if the drug's good enough and there is no competition."

Pharmaceutical companies cite the time and money it takes to bring drugs to market. "We discovered Avastin in 1989 and it was approved [for colon cancer] in 2004," Walter Moore of Genentech told *CURE* in 2006. "So you have 15 years and \$800 million to get a drug approved. By any stretch, it's a wildly expensive way to get a new therapy into the hands of doctors and into the bodies of patients."

Whatever the reason for the cost of cancer drugs, "it is a monstrous issue," says Eric Nadler, MD, of Charles A. Sammons Cancer Center at Baylor University Medical Center in Dallas. "Every person, doctor or patient, has their own cost-effectiveness ratio."

In a 2006 study published in *The Oncologist*, Nadler reported that in a survey of

oncologists in Boston, 62 percent of the 90 respondents said that a life expectancy gain of just two to four months would justify the use of a drug that cost \$70,000 a year more than the standard of care. If the gain was four to six months, the percentage rose to 82 percent.

With a stalled economy and talk of health care reform, Americans may soon face some uncomfortable questions: Should public money pay for expensive drugs that don't cure? And who is qualified to make that choice? "The issue is, who should be making the decisions, and who should be guiding the decisions?" Nadler says. "Are the people guiding the decisions informed?"

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