The Hon. Greg Hunt MP

Minister for Health

TRANSCRIPT

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DOORSTOP
MELBOURNE

E&OE…

Topics: May 1 PBS listings.

GREG HUNT:
I'm really delighted to be here today at Peter MacCallum. This, along with the VCCC is not just one of Australia's, not just one of the southern hemisphere's, but one of the world's leading oncology centres. As Michael was saying, it's about giving patients access to the best possible treatment and in many cases the first treatment anywhere in the world.

We have the chair of Peter MacCallum, Maxine Morand here today. She's had a distinguished career in her own right. She's now hoping to lead this amazing organisation. Michael and his team are working in lymphoma and haematology and they are extraordinary professionals. Sharon, the head of Lymphoma Australia has been fighting for better access to new drugs for her patients and we have both Boehringer and Merck represented here today, in particular Wes Cook the head of Medicines Australia who's helped deliver so many new drugs to so many patients and of course our patients themselves.

Luke and Alison, who are battling very successfully classical or Hodgkin's lymphoma and Michael who's a non-smoker, who's had to deal with the shock of a diagnosis for lung cancer but he and his wife are here and he's making tremendous progress with his own condition.

Our job as a government is to make sure that we have the best drugs available for new patients. Since coming to office we've listed over 1700 drugs which is one a day, one new medicine a day for patients facing- it could be genetic conditions, it could be contagious disease such as hepatitis and it can be chronic conditions such as cancer. Today, I'm delighted to announce that we will be listing five new drugs as of 1 May that are of particular significance to patients.

They include Keytruda, which would otherwise cost over $200,000 for a patient. And this particular indication will be for more than 120 patients a year that will face particular types of Hodgkin's lymphoma, refractory or relapsed lymphoma. What that means is they have a real chance at a life-saving medicine or a life-changing medicine and $200,000 a year is completely beyond the reach of virtually every Australian.

That will now come down to $6.40 or $39.50 depending on their circumstances. So that's life-changing in terms of the finances but most importantly lifesaving or life changing in terms of the outcomes.

Also, a new drug Gilotrif which will be available for over 220 patients a year, otherwise it would cost more than $33,000 and that is for non-small-cell lung cancer. So, for patients such as Michael it's an opportunity at life which might not otherwise not have been available. New drugs for epilepsy, new drugs for chronic debilitating food allergies for young children.

In fact, I was in contact with a mum in my own electorate today who will benefit from the new drugs in relation to food allergies. And then drugs for chronic inflammation, agonising pain. All up, over 6000 people will benefit and it's these particular drugs, whether it's for Hodgkin's or for lung cancer that can save lives and protect lives and whether it's for chronic food allergies or for epilepsy, a dramatic transformation in the quality of life.

We could only do this with the amazing work of our medical leaders and our medical organisations and with the advocates such as Sharon, so I want to thank and congratulate everybody involved and to make it very clear, today is about saving lives and protecting lives. Michael?

MICHAEL DICKINSON:
We think about Hodgkin's lymphoma as being a good prognosis disease but a proportion of patients can't and won't respond to treatment with chemotherapy or radiotherapy. The availability of Pembrolizumab which is an immunotherapy unleashes the immune system in these patients to attack their lymphoma and improves their chances of responding to treatment compared to further exposure to other chemotherapies or radiations. Pembrolizumab being available is really important for our patients and makes my job a lot easier in providing patients access these treatments.

GREG HUNT:
Sharon?

SHARON MILLMAN:
As of the 1st May, it means Australian patients will have equitable access to Keytruda. This means that patients and their families can now get on with life in terms of fighting their cancer rather than worrying about raising tens of thousands of dollars. It also means now some patients can actually live their lives.

They've been waiting and hoping to live long enough to be able to access this medicine. And I'd also like to mention that there has been an amazing collaboration behind the scenes with the Government, with PBAC, with MSD, with Australian Patients, organisations like ourselves and we wouldn't have been able to bring this to our patients without all of that work together. So thank you.

GREG HUNT:
Okay, so happy to take any questions firstly on the listings and then any other issues of the day.

JOURNALIST:
What was the one thing that compelled you to put this on the PBS?

GREG HUNT:
So an independent process where what's called the Pharmaceutical Benefits Advisory Committee. A committee of medical experts and professionals makes the assessment: is it safe and is it effective? And we have a commitment, every drug that is determined by the PBAC as being safe and effective, we will list.

And it's different to previous governments and I'm really proud of that. And what it's meant is that we've brought on about 1700 new medicines at a cost of about $8.2 billion. But at the end of the day why are you in a role such as this in government? It's to make the space through good economic management, so as every new drug that is recommended, we will list. These are the happiest and proudest moments of my role.

JOURNALIST:
Just one more question on the listing. When you refer to those other five drugs, the ones that treat chronic inflammation, food allergies, are those new from May or are those previous ones?

GREG HUNT:
So, there'll be five new drugs listed as of 1 May. They'll cover over 6000 patients and they will cover conditions such as lung cancer, Hodgkin's lymphoma, we have epilepsy, we have chronic inflammation and we have profound food allergies for small children.

JOURNALIST:
When you say chronic information, what sorts of conditions will that cover?

GREG HUNT:
Intestinal.

JOURNALIST:
I was just going to ask you about the Choice claim that private health insurances are pushing up prices higher than the agreed increase of 3.95 per cent.

GREG HUNT:
Look, this is the amount that has been submitted. It's the evidence that we have. We were always happy to consider any evidence. I understand Choice doesn't like private insurance. They are profoundly opposed to it. That's philosophical choice for Choice. They need to explain why they are so opposed to private health. But for me private health is fundamental which is why we've delivered the lowest change in 17 years.

They have a philosophical opposition to it. They hate private health. We believe in it profoundly and I'll let the editors explain why they are against it, because if you take away private health what you see is that you'll have a collapse in private hospital treatment and a blow out in public hospital waiting lists. So we don't just believe in it, we've delivered the lowest premium changes in 17 years.

JOURNALIST:
And also, are you confident that all the states will sign up to that funding, the hospitals funding agreement.

GREG HUNT:
Well I'm not sure why states would turn their back on a massive $30 billion increase in public hospital funding. What we've seen is already four states, a year ahead of expectations, have come on board, two Labor, two liberal and I'm having very constructive discussions with the others.

JOURNALIST:
And if they don't come to the table?

GREG HUNT:
Well then, they'd be turning their back on extra money and they'd have to explain that to their patients, their doctors, their nurses, all of the people who were involved in the hospital system.

JOURNALIST:
Just on the clinical trials. Can you talk us through what kind of results we've seen and what difference it will make to patients?

MICHAEL DICKINSON:
Do you mean broadly related to this drug approval today…

JOURNALIST:
Yeah Keytruda.

MICHAEL DICKINSON:
So the Keytruda approval- the trials for the patients that you've met are still running. The Keytruda approval is on trials that are completed. And essentially we're talking about having one other treatment option for patients who fail conventional chemotherapy and radiation. Keytruda offers a treatment option that didn't otherwise exist.

In terms of the results the best thing to say here is that it's probably one of the single most active agents ever seen in Hodgkin lymphoma. Somewhere between six and eight out of ten patients will respond to treatment and about a third will have a complete remission. But in that time that offers us the opportunity to provide a follow-on treatment that can then lead to a really good outcome.

JOURNALIST:
We saw somewhere that the studies that one in seven people diagnosed will lose their battle with it within the first five years. Do you think that this will turn that around?

MICHAEL DICKINSON:
Yes, I think it's substantially prolonged the time. I think it's fair to say the translation of Keytruda from a drug in development to a drug that's available to patients has been very rapid. And so the trials that show us that Keytruda is active are still maturing in terms of their data. So how long patients will benefit still remains an open question and one where the early signals are very positive.

JOURNALIST:
For those that chemo has failed, you know, this is the last chance. What difference does this drug make to those patients?

MICHAEL DICKINSON:
Many of the patients who have received treatment with chemotherapy and radiotherapy are a bit exhausted by it. And if offered only treatment with conventional treatments they would find it a pretty devastating treatment option because chemotherapy and radiotherapy come with side effects.

People are prepared to take on those side effects if the outcome is good but if the outcome is poor because the disease is shown to be refractory to treatment, Keytruda offers a treatment which is active in most patients with well tolerated side effects and completely different as an experience compared to being on to conventional treatments. So it's a very welcome option for most the patients that I treat and for most of the doctors who treat Hodgkin lymphoma.

JOURNALIST:
Would it be considered as first line treatment do you think down the track?

MICHAEL DICKINSON:
At the moment no. At the moment there's no evidence that these drugs should be used in the frontline setting, but there are active clinical trials exploring that question and there are patient populations where exploring that question would be a priority if those trials continue. So maybe one of the future.

JOURNALIST:
Are there worse side effects as opposed to chemo?

MICHAEL DICKINSON:
Generally speaking, yes. Generally speaking with chemotherapy and radiotherapy one can tell a patient that you anticipate a particular range of side effects that occur quite often. Pembrolizumab and drugs like it have a range of side effects that occur very infrequently on the most part.

And most patients find they tolerate treatment without any significant side effects. There are idiosyncratic side effects that we see but the overall rate is low and generally patients tell me that they tolerate this class of drugs better than chemotherapy.

JOURNALIST:
Have you treated patients who simply couldn't afford it and what does that feel like knowing that that there's that treatment that they just can't reach?

MICHAEL DICKINSON:
We've been fortunate at this hospital to be running a clinical trial which has meant that patients who had disease that is similar to the PS indication have the opportunity to access a clinical trial and therefore potentially to access the drug within that trial.

So I haven't been in that particular situation for this indication but that's why trials are so important for our patients to access drugs before the Government has the evidence to offer them to patients.

JOURNALIST:
So what was your reaction today to Keytruda being listed?

MICHAEL DICKINSON:
I was delighted. I was delighted. It really makes my job easier and it makes the job of patients getting through treatment easier and it really has changed the quality of life for the patients that I'm (inaudible).

JOURNALIST:
Sharon would have dealt with lots of patients that haven't had access until now.

SHARON MILLMAN:
Yeah, that has been the big thing. I mean patients are connected globally and nationally so they do understand what treatments are available for them and with the Keytruda we've had patients that probably have simply died because they weren't able to access it.

They weren't in a position where they could get to a clinical trial or knew about a clinical trial or they had to sell the house or do a lot of major fund raising to actually receive access. So I think that gets back to the equality of access that we want for Australian patients so that we know these medicines and treatments are working, but we need it to be able to be available to everybody because it's just heartbreaking and devastating when you know that treatment is there and it could work for you but it's just not in your reach.

JOURNALIST:
How long and hard has Lymphoma Australia being trying to get this on the PBS?

SHARON MILLMAN:
This like I indicated earlier it's actually been, Keytruda has been a drug that we've been seeing working overseas where we've seen patients overseas access serious medicine and it did go to PBAC last July and it was a positive recommendation from PBAC at the first meeting. So it's been great that this one has progressed as fast as it has.

So, yeah, it's been wonderful to hear the news today. I know so many patients and their families will be so excited because, like I said before, they can now get on with living and they're not trying to live to get access to this drug.

JOURNALIST:
So is it life-saving? It's not just life-prolonging but life-saving or is that too much of a strong word to use?

SHARON MILLMAN:
That's probably more of a clinical one. Look I think at the moment we're seeing that it is prolonging lives and patients are actually living their lives as well.

Whereas before they may not have had that opportunity. So maybe with future treatments and combining more things then we might actually, we want these patients, quite often very young Australians to live long lives with this treatment.

JOURNALIST:
I just have one more quick question, sorry. I'm just going to say from- can you just tell us about Hodgkin's lymphoma and how prevalent it is in Australia?

MICHAEL DICKINSON:
About 500 patients with Hodgkin lymphoma diagnosed every year. Generally speaking if you're a patient with a new diagnosis of Hodgkin lymphoma you'll be told it's a good prognosis disease and by and large it is. Chemotherapy and radiotherapy cure and most patients, two-thirds some people would estimate higher than that in terms of the cure rate.

Of that about, you know, the remainder will have refractory disease meaning not responding to treatment or not to responding to chemotherapy and radiation and those patients would then require very intensive chemotherapy with a stem cell transplant which is not something that all patients are fit enough to have.

And so those patients who have that treatment about half will be cured and their the patients who really need access to drugs like these, the patients who are not responding to conventional chemotherapy or who relapse after conventional chemotherapy or who are not eligible for autologous stem cell transplantation. And they're the patients who have few treatment options at the moment and this treatment opens up for really prolonged life.

GREG HUNT:
I'll just say one final thing. For me the last word is the best word. It was from Alison, one of our patients, and she described it as very simply a miracle drug that has changed her life.

Okay, thank you very much.

(ENDS)