The Economics of Cancer: Summary and way forward

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Introduction

1. This summary is based on the concluding remarks made at the end of the Economics of Cancer Workshop on 28th October. There was general agreement that the presentations had been enlightening and of a very high standard and that the table-working had been productive. We now need to decide a way forward.

Quotes from the workshop

2. Four quotes from the workshop seemed highly relevant

   - "Cost alone is not very useful, but it is a vital first step" [Marjorie Marshall]
   - "There is a wealth of evidence in some areas, while others are an evidence free zone" [Sarah Willis]
   - "We will always have the problem of uncertain evidence" [Mark sculphis]
   - "We can't say it is too difficult. We have to come to an answer" [Francis Dickinson – speaking particularly from the perspective of an adviser to policy makers]

A reminder

3. This workshop had been convened to address three issues:

   - What do we already know?
   - What do we need to know to drive improvements in outcomes and to get better value for money from services?
   - How might we get there?

Partnership and language

4. The workshop had involved a wide range of stakeholders. These included

   - Health economists

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- Cancer epidemiologists
- Cancer clinicians and researchers
- Patients
- Research funders and charities
- HTA representatives
- NCIN and NCRI staff
- Policy makers

5. There was general agreement that these were the 'right' people to take this forward. New partnerships need to be developed. In future it would also be useful to involve NHS accountants and commissioners.

6. We all need to learn each others language e.g. QALYs, ICERs, Net Health Effects (NHEs). I had been amused to see on one slide that being dead is an 'absorbing state'.

Data and methodologies

7. Linkage of large datasets (e.g. cancer registration, HES, screening) has opened up new opportunities for assessment of the economics of cancer. The datasets are also much more accessible thanks to NCIN. However, there are still gaps (e.g. radiology; chemotherapy).

8. We need to link information on Human Resource Groups (HRGs) to the national datasets – as these are used for billing within the NHS. Some good work on this has been done at network level.

9. We will need to ensure comparability between studies by agreeing on methodologies (or on where methodologies should differ).

Priorities for future work

10. The following suggestions were made, often by several of the working groups [Note: This is not a comprehensive list]:

    1) Collating the work that has already been done on the economics of cancer, particularly from a UK perspective.

    2) Understanding the costs of cancer from a patient and carer perspective, building on the work undertaken in the Republic of Ireland.

    3) Understanding variations in expenditure at a PCT level (Shireland versus Metroland)

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4) Further "costs of illness" studies for individual cancer types. These should build on the top down and bottom up approaches used for skin cancer. [Need to decide which cancers to prioritise.]

5) "Phase of illness" studies. There is very little information on the costs incurred before diagnosis, on initial treatment, on follow up and on progressive illness and end of life care. Identifying where the large elements of cost occur could help to identify where substantial savings could be made – or where further investment may be warranted.

6) Particular emphasis should be placed on prediagnosis costs. This is relevant to the NAEDI agenda, but is largely an evidence free zone (EFZ) as patients do not have a cancer label at this stage.

7) Further whole care pathway modelling should be encouraged, as has been done for colorectal cancer.

8) Areas for potential disinvestment may require more rigorous analysis than areas for investment – in order to bring about change at the clinical frontline.

9) Work on cancer economics should be linked with initiatives on the costs of end of life care and of social care.

Barriers

11. There will doubtless be numerous barriers to taking this forward, including funding, ethics, expertise and coordination. However, all these were felt to be surmountable.

Possible next steps

12. The need for multidisciplinary partnership working to take this forward was recognised throughout the day. The following suggestions were made:

- A network or partnership group should (subject to Board agreement) be established by NCRI, which also comprises NCIN and NCRN.
- The messages from the workshop should be taken back to potential funding organisations
- Next steps should be considered at an NCRI Board meeting.

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