

# Ought Cancer Treatments to be Immune from Socio-economic Evaluation? An Epilogue

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THE PAPERS in this volume all stress that economic evaluations in the cancer field are rare, and proper economic evaluations are nearly non-existent. There are several explanations for this. First, cancer is a life-threatening disease with high mortality, which makes treatment a natural priority, but which in practice may mean that large sums of money are spent pretty indiscriminately, both on treatments that do patients a lot of good and on those that do little or no good. The number of treatment alternatives has also been limited, which appears to make it less relevant to undertake formal and careful evaluations of costs and the probable size of benefits to patients.

However, this situation is changing. New technologies are emerging as a result of investments in research and development. This means that the number of alternatives is increasing. At the same time, we can observe a slower growth of health care resources. As a result, the pressure is on all health care systems to contain health care expenditures and ensure that the available resources really do go where they are expected to do most good.

Even more fundamentally, in all systems of health care there are rival cries that medical care is under- or over-funded. There can be no prospect of resolving such contentious issues until there is greater confidence amongst those who determine major budgets and their allocation that additional resources will be used to their best effect, or that cutbacks occur where they do least harm. This requires much more evaluation of effectiveness and efficiency.

Economic evaluation is not only about alternatives and costs. It is also about consequences and, especially, about the good and bad consequences for patients. There is an increasing demand for relevant effectiveness measures, including patient preferences and quality of life, in evaluations of new medical technologies. This is a challenge for health care in general, but maybe particularly in the cancer field where mortality has been, and still is, the major concern.

The demand for data on costs and outcome of cancer treatments is relevant and understandable. The supply of such information is, however, both complicated and costly. As is pointed out by Professor Rutten, it requires significant developments of the traditional clinical trial methodology to include data collection for costs. The randomised clinical trial is already a sophisticated and complicated process, and the introduction of further criteria to be fulfilled for making studies relevant for economic evaluation further complicates this process. However, it is necessary to have the clinical trial to collect economic information, and the study by Glaspy and his colleagues shows how this can be done.

But clinical data are not enough. We also need better epidemiological data and data about costs of patient management. As

previously shown, the costs of managing a patient with febrile neutropenia events (FNE) vary both within and between countries. We can learn a lot on how to improve health care from studying this variation. We also need better information on epidemiology. The number of FNEs and their distribution across types of cancer and treatments is not known. Neither is the frequency of dose modification due to neutropenia. Epidemiological data are of particular interest since many of the new approaches to cancer treatments involve prophylaxis of adverse events. If it should be possible to generate support and resources for prevention, it is necessary to have a relevant estimate of the size of the problem and how it can be affected by different preventive measures.

Nor, however, are epidemiological and cost data sufficient. In cancer prevention and treatment, symptomatic alleviation and the management of adverse side-effects make mortality an inadequate indicator of outcome or relative success. This is a part of the wider concern, expressed everywhere, for adding not just years to life but also life to years. In the cancer field, as in others, there is an urgent need for the development, refinement and widespread application of valid and acceptable measures of the quality of life of patients under different regimes of care. These are needed not only in the assessment of cost-effectiveness at the broad level at which overall resource dispositions are determined, but also to help inform and guide decisions by patients themselves and their doctors at the individual level.

It may be tempting to conclude that the present state of the art, as well as the future opportunities for economic evaluation, are worse in the cancer field than in other areas of health care. We do not believe this is the case. The demand for cost-effective health care is a challenge for all medical specialities. It is a challenge for those who develop and market new medical technologies, and it is also a challenge for those who have an asset specificity in the old treatment modalities. Change is threatening but also involves opportunities. Economic evaluation is an instrument for assessment of these opportunities, and for helping those concerned to decide which use of health care resources is most beneficial for cancer patients, today and in the future.

A growing demand for cost-effectiveness and economic evaluation is not a threat to patients; properly used it would help us to save and extend more lives, and to improve the quality of more lives than is currently the case. Nor should the application of its methods constitute a threat to doctors' freedom to exercise their best professional judgment in individual cases or to the patients' rights to autonomy. On the contrary, we would argue that these freedoms and rights can best be exercised only in the presence of the sort of information required if a knowledge-based culture of critical evaluation in medicine is to be harnessed in the pursuit of humanitarian ends. Although it cannot provide any final solution, especially at the individual level at which the doctor is responsible to a patient who may be confronting some of the most agonising decisions he or she has ever had to face in

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their life, cost-effectiveness methods, properly and responsibly applied, and what has been learned from their application in previous cases, have a major contribution to make. They can never dictate the professional's decision in specific areas, nor are they a substitute for professional judgment. But they can enable

better-informed decisions—better-informed about risks and personal consequences. Indeed, if they did not enable better-informed decisions, they would scarcely be worth bothering with in the first place.