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Editorial Comment

Food for thought – should we stop doing research?

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Probably the last thing anyone wants to think about in early January is food – but the title did catch your attention didn't it?[1] The question of abandoning research is not as stupid as it first might seem – 'we have a problem' as the astronauts famously said – there is a genuine crisis developing, analogous to a production line where no-one can clear the finished product from the end of the conveyer belt.

The successful results of research over the past 20 years now present us with unparalleled opportunities to improve screening, diagnosis and treatment of patients with cancer – but we cannot afford to implement the new technologies. Examples are plentiful and of course not restricted to oncology, but the introduction of new drugs always catches headlines. The decision by the UK authority The National Institute for Clinical Excellence (NICE) not to recommend Avastin for patients with colorectal cancer last year was a landmark in deciding against the introduction of a drug approved for efficacy and safety for that indication by the UK's own licensing board. I am not criticising that particular decision but using this as an example of modern science outstripping financial resource. It would be absurd to slow down or abandon research but we have to find new ways to facilitate the uptake of successful research or it becomes just an intellectual activity for academia with no commercial profitability (which feeds future research) and of course fails the principle goal of improving health.

The problem of 'Affordability of Health Care' is one of the major social problems facing every community worldwide – the affluent, the poor – everyone. This is all about assessing priorities. The problems in Europe are of particular concern since there is great variability in attitude towards priority setting as well as obvious variability in wealth. The particular problem of variable access to new medicines was addressed in the report from the Karolinska Institute,[2] which is updated in a special issue of EJC soon to be published, but it is essential to embrace the problem in the context of cancer care in its totality and not just to focus on the introduction of new medicines. Within the oncology community we have to accept that the overall results of cancer treatment remain poor with the majority of patients dying from their disease and many within months or very few years from diagnosis. This contrasts with progress in other branches of medicine, but the high incidence of cancer and the devastation that it brings to families preserves its place on the political agenda.

In countries such as the UK where governments attempt to provide healthcare free of charge (from taxation) it is already clear that the status quo is unsustainable – hence the NICE decision on drugs such as Avastin. Under these circumstances what do you do about totally new interventions such as national programmes for bowel cancer screening, or the vaccination of girls against herpes viruses to prevent

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carcinoma of the cervix? Scientifically irresistible, financially unaffordable. So, priorities have to be set – decisions have to be made – the key question is by whom? Certainly not by politicians alone nor in my opinion by doctors and scientific professionals. This is an issue that involves all sectors of society and therefore the priority setting should be informed by the widest possible representation. Patients are a very special group within these discussions, since they are by definition vulnerable and influenced (biased) by their personal circumstances. The ever increasing access to information – particularly via the internet – exposes them to information relevant to, but not necessarily instructive of priority setting. They must take part in the discussion but not necessarily lead or lobby inappropriately for their specific needs. Above all where commerce is concerned – technology transfer, patents, profit and the balance of research and development spend, we must avoid a straight forward fight between industry and academia, but I would urge the academic community to step forward and engage in this vital debate. Academia and industry should foster discussions on how to translate research into practice more efficiently – in this regard time equals money, but time is of the essence for our patients too. We have to find ways to reduce bureaucracy, reward collaboration with recognition as well as finance and argue constructively for the proportion of national incomes allocated to health as opposed to other social needs. Unless we make urgent progress in this important social dilemma our future research will continue to pile up on the conveyor belt and never reach its proper destination – patients.

Food, hopefully not too indigestible, for thought indeed!

On behalf of all our editorial team we wish you a very happy and thoughtful new year.

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