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Ethics, priorities and cancer

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ABSTRACT

Beginning with the ethical case for maximising the impact of health care resources on health, this article examines nine arguments for exempting cancer treatments from rigorous economic evaluation or for relaxing some of the conditions often required if an intervention is to be provided at public expense. Some of these may have validity under particular circumstances but, in general, if these arguments apply at all they apply also to other treatments for similarly placed patients (for example, those near the end of their lives) and so do not constitute an argument for treating cancer patients as such more favourably than others. The arguments need to be more than merely valid. They need also to have quantitative and qualitative significance.

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1. Prioritising

1.1. How ought priorities for public health care spending to be set?

Context always matters, so let us set a context. I shall assume we are thinking about the value of health care interventions – specifically, ones for the benefit of cancer patients, actual or potential (as in preventive interventions) – in a publicly financed health care system. The ultimate payers are therefore taxpayers and the ultimate beneficiaries are cancer patients within that jurisdiction, whether or not they are taxpayers. The ethical issues that arise differ somewhat under conditions of private health insurance financing, but that is not our concern here. The broad questions of prioritisation, chief of which concerns the selection of interventions to be provided publicly and the terms of access to them, are therefore necessarily to be collectively determined and the values embodied in such decisions are, in the same sense *social* values, being made on behalf of a community by publicly accountable “decision makers”.

Let us take it as given that no one is in denial that priorities have to be established. This may be done implicitly or explicitly, in camera or under the public’s gaze. The second is always preferable unless it damages the integrity of the process.¹ Let us also take it

as given that in any period the resources normally² available in a national health insurance system are set by some planning process at a high (say, cabinet) level of government, along with other broad decisions regarding expenditure on education, defence, the environment and so on. We shall consider the question at a slightly less high level – that is, at the level of decisions at the top level of a ministry of health – where the decisions are about the allocation of the “budget” as determined by the higher process.³ Specifically, some of the decisions are about the health care procedures and interventions to be provided. It is these decisions on which we focus. In practice, some decisions may be delegated to a lower or arm’s length agency that either sets the priorities or makes recommendations about them. Finally, let us assume that the main purpose of public health insurance is to enhance the health of the population⁴ without causing anyone to bankrupt themselves, or even to suffer significant financial hardship. Other objectives commonly include reassurance (e.g. “you’re OK”), information provision (e.g. diagnostic utility), certification (e.g. for legitimate absence from work), reduction in uncertainty (e.g. about one’s exposure to health risks), social solidarity (“this is *our* health service”), social or national iconography (e.g. “our system represents the ‘kind of

² That is, excluding those set aside for public emergencies.

³ The private sector analogy is a third party insurer designing a benefits package and anticipating a stream of premium income and co-payments to cover its cost.

⁴ This is commonly treated as allocating resources according to need. For why such an approach is not a good idea see [1,2].

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¹ As when the matter is personal and private, or price-sensitive but public.

people we are”), support for manufacturing and innovation (e.g. in supply chain industries), and sometimes even the provision of ineffective but popularly demanded treatments (e.g. by traditional healers, alternative medicine, religion-driven interventions). Each of these objectives makes a claim on the overall budget. Evidently not all of them directly enhance population health and neither do they all have equal merit. That is not to say that the domination of the impact on health is either automatic or overwhelming, only that it takes a powerful moral argument if a sacrifice of population health is to be made for any other objective. The reality therefore is that all these activities have a specific opportunity cost. If the health budget is spent in part on, say, ineffective traditional medicine, it is necessarily spent at the expense of something else. In considering that part of the budget that is for health itself, the opportunity cost (as economists say) is not any old something else, it is – and only can be – health. Thus adding a new clinical procedure, given the budget limit, necessitates disinvesting in another. Assuming that other procedure also to have been an *effective* procedure, the opportunity cost of the new procedure is the consequential loss of health which the old procedure would have generated. If the old procedure was not effective, it had no business being in the benefits package in the first place.

The father of evidence-based medicine, Archie Cochrane, wrote in 1972, “All effective treatment must be free” [3,p. 1]. This does not mean that effective treatments do not use resources – resources that have other good uses, for the treatments in question are not what economists call “free goods”⁵; even if Cochrane’s slogan certainly does mean that people should not be exposed to the burden of paying for them individually. That burden is a collective one, requiring fairness in the distribution of the financial burden and equity and efficiency in the choices made about the services to be available. Some of these choices are tough. Many concern cancer. So, how should they be made?

2. Prioritising health care spending – the general case

In order to prioritise one needs to be able to compare. We need some acceptable common measure or indicator of the contribution that each intervention makes to health. It must be common, like change in mortality or life-years gained, or SF-36 (36 item short form survey), or QALYs (Quality-Adjusted Life-Years) or averted burden of disease like DALYs (Disability-Adjusted Life-Years), in order for decision makers to be able to make comparisons of the productivity of each across what may be very different sorts of intervention (surgical and medical, many disease categories, chains of supply, imported or home-produced, etc.). Some interventions are disease specific, like the cancer treatments; some are not disease specific, like interventions to improve childhood nutrition; others may be preventive; yet others diagnostic; while others, like community clinics or hospitals, are examples of general delivery platforms or common generic resources available for delivering treatments for many diseases and interventions. A common outcome measure is needed for them all.

If decision makers cannot make reasonable comparisons they can hardly make reasonable choices. This may seem a self-evident point. However, nearly all (or at any rate a very large number of) the studies of the effectiveness of interventions for health have measures of outcome (e.g. biological, physiological, symptomatic, physical functioning, mental functioning) that ensure comparisons *cannot* be made other than amongst a restricted set of options. Selecting an appropriate outcome measure is no minor task and will

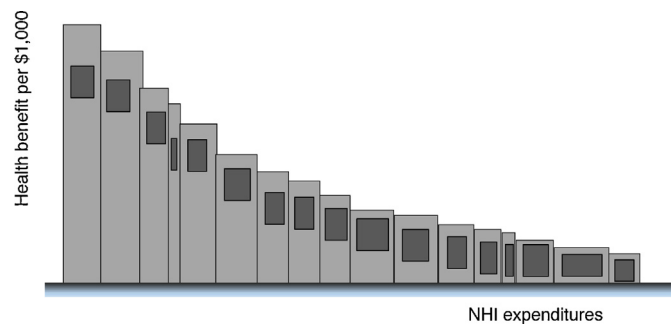


Fig. 1. Health care interventions arranged like books on a shelf.

be contingent on contextual factors like the quality of the available database, the precision required for policy decisions and ethnic and other traditions, for example as to what is understood by “health”. What is appropriate in Canada may not be appropriate (or even feasible) in Malawi. I shall assume, however, that these major matters have been settled.

It is helpful to analyse the main issues by use of a model. A model is a simplification of reality which, if it is to be useful, removes all inessentials (i.e. elements that are irrelevant for immediate purposes) enabling one to focus on key issues and relationships. Consider a bookshelf analogy [5] as such a model. Imagine a bookshelf like that in Fig. 1 – a very long bookshelf – of health care interventions, each like a book, and ranked according to its effectiveness per \$1,000 (its height), with the most effective on the left and the less effective stretching away on the right. The effectiveness is the discounted expected net improvement in health over the full period for which it endures.⁶ The fatness of each book represents the estimated (discounted) cost of providing it. This is a combination of the costs of a specific technology, like a drug, the costs of associated procedures (other medicines, diagnostic services, community services, etc.) for as long as the treatment continues, and the estimated number of people using the intervention in question. The area of each book’s spine is evidently a measure of the total health generated by use of that intervention. The maximum possible total health generated by any given rate of expenditure is the entire area under the roofscape of the books up to the given expenditure.

Consider now Fig. 2. A population health promoter will select the first book on the left and add books (that is, further interventions) moving along the shelf until she exhausts the budget. At that point (B) all the interventions selected will be effective and only the most effective of those that are effective will have been selected. The only services offered under public health insurance are those to the left. The least cost-effective intervention that is included indicates a “threshold” of t_0 , a measure the effectiveness-cost ratio of the least effective procedure included in the insured bundle. Any new candidate for inclusion in the insured bundle must be at least as cost-effective as this. At the budget limit, and with only cost-effective interventions being used, the total health generated is area under the roofscape of the books up to the budget limit.

The reason why the interventions on the right are not included is not because they are ineffective. On the contrary, they are all effective. One would have to go a long way to the right before hitting zero productivity or slipping into the zone of iatrogenesis. The trouble

⁶ A simplification in this model is that each intervention (book on the shelf) has a constant cost and a constant productivity in terms of health. In practice one might expect the marginal cost of rolling out an intervention to rise (as for example, one reaches out to patients groups that are harder to reach) and its marginal benefits to fall (if one prioritizes those most capable of benefiting first). Those assumptions would be inappropriate in a model for analysing the ideal speed and extent of roll-outs but do not affect any of the conclusions reached here.

⁵ “Free good” is used in economics to describe a good that is not scarce; more of which is not demanded than is already available at a zero price: as much is available as anyone wants.” [4]

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