

Short communication

A personal viewpoint against the motion that breast cancer patient advocacy groups unfairly distort the cancer budget

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Voluntary sector organizations in the UK have an enviable and successful track record in influencing health care for people affected by breast cancer, and it is entirely refutable that they in any way distort (that is, misrepresent) the cancer budget unfairly in favour of breast cancer.

Investment in terms of cancer budgets will inevitably always be somewhat biased toward the most significant health problems, and probably justifiably so. Breast cancer has the highest incidence of any cancer in the UK, with more than 44,000 new cases diagnosed each year [1]. The same goes for its prevalence. At any one time in the UK there are an estimated 172,000 people living with breast cancer, as compared with 77,000 with colorectal cancer, 32,000 with lung cancer and 31,000 with melanoma. Thus, if breast cancer attracts a higher proportion of expenditure, then arguably this represents logical health economics relative to the scale of the problem. The significance and prevalence of breast cancer as a major health problem within the UK is also reflected in government targets and plans, which commonly cite breast cancer as a priority area [2].

Mortality rates from breast cancer are improving and have fallen by more than 30% in recent years [1]. Breast cancer is no longer the biggest cancer killer in the UK, but it is also not alone in terms of such improvement. Testicular cancer mortality rates have also fallen by approximately 30% and colorectal cancer mortality is down by 18% [1]. It is highly questionable to suggest that reductions in breast cancer mortality result from a disproportionate slice of the cancer budget when mortality is also improving in clinical areas alleged not to have benefited from this so-called distortion.

A key influence in allocation of cancer drug budgets is the perceived efficacy of those drugs. Distortion, or misrepresentation, of the cancer drug budget by voluntary sector organizations, or whoever, would suggest other cancer drugs receive less funding regardless of efficacy. However, efficacy is determined by formal bodies (for example, the National

Institute of Health and Clinical Excellence and the Scottish Medicines Consortium) and not by voluntary sector groups. Interestingly, a review of National Institute of Health and Clinical Excellence (NICE) appraisals within cancer reveals an equivalent number of reviews for breast and gastrointestinal cancers, with lung and urogenital cancer close behind [3].

The emerging pressure to ensure fast and favourable appraisals has been evident within the UK, and access to trastuzumab is a pertinent recent example. In this case, however, the key players equally responsible for instigating change were as much the high profile legal battles that patients engaged in, the incitement and repeated calls of injustice by the media, and thinly disguised political gaming. Voluntary sector organizations played a role too, but in ensuring equity and speeding up access, not in distorting cancer budgets. Cancer charities have been rightly vocal in criticizing the interval between creation of a new drug, release of data, licence application and formal approval. Cancer charities have also rightly called for funding to accompany approved drugs, concerned that no new money is attached to facilitate implementation after positive appraisals.

Importantly, voluntary sector organizations have been visible and assertive in condemning the postcode lottery within cancer care and specifically unequal access to new drugs. Their message was not one that, for example, merely demanded access to trastuzumab for all, but rather was one of socially responsible campaigning that deemed the vast geographical variations in access to both HER2 testing and receipt of the drug in different areas of the UK as unethical and unacceptable. It was for similar reasons that they were also instrumental in making public the fact that aromatase inhibitors were approved in Scotland a whole year before they were in England. It is also why these organizations called for a national audit of uptake of NICE guidance to be published annually, in order to put an end to wildly inequitable and all too variable spending on cancer drugs and response

times to implementation of appraisal findings by Primary Care Trusts.

It is important to think beyond the obvious consideration of drug expenditure when exploring the cancer budget, otherwise there is a danger of selling short the bigger picture. For example, within lung cancer expenditure a major focus has been on prevention, not least because lung cancer has a far greater potential for primary prevention. Considerable funds have been devoted to smoking cessation campaigns over the past 10 years, regrettably with uncertain efficacy because female incidence and overall mortality rates from lung cancer have both increased [1]. In addition, drug costs represent only about 10% of total cancer spending, meaning there are many other areas of inequity and a worrying prediction of a massive future short fall [4]. Breast cancer groups have led highly visible campaigns on, for example, adjuvant radiotherapy waiting times and excessive delays for patients referred as nonurgent to be assessed.

Probably, teamwork, collaboration and strength in numbers will strengthen campaigning in the future. There is now a coalition of 34 UK cancer charities of differing sizes and remits whose jointly produced white paper [5] calls for efficient distribution of resources and reducing postcode and pan-European inequalities, because every person deserves high quality cancer care and treatment regardless of location, sex, age, ethnicity, financial status, or type of cancer.

One public misconception about cancer spending that is worthy of correction is the belief that cancer care gets the majority share of the health budget overall. In fact, an analysis of the total amount spent on different diseases by Primary Care Trusts provides a top-level view of the way in which the

majority of the National Health Service (NHS) budget is spent and reveals that in 2004 to 2005 twice as much was spent on mental health services than on cancer care. This could be said to reflect decisions about the priorities that the NHS gives to different services [6].

It would certainly be ludicrous (not to mention a waste of valuable time and resources) for breast cancer voluntary organizations or clinicians to feel apologetic for the improvements in breast cancer treatment and survival, just because not all cancers have benefited to the same extent. Breast cancer charities have been enviably successful at campaigning, influencing health policy and keeping breast cancer at the top of the agenda. As such, their model should be presented as one that other cancers groups can learn from, follow and hopefully reap the rewards from too.

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