

Cancer survival in Britain

Is poorer than that of her comparable European neighbours

Collecting cancer statistics is a dry business. Much effort, dedication, and skill have been put into developing an effective network of cancer registries around Europe. Further work to standardise the datasets and provide efficient quality control now makes the comparison of cancer survival between European countries realistic. Britain does not do well in such a comparison.¹

The clearest outcome indicator for the quality of cancer care is the percentage of patients surviving five years after diagnosis. Most patients can be considered cured after this time, having actuarial survival curves exactly parallel to people of similar age and sex without cancer.² The current analysis comes from 33 cancer registries in 17 countries. The figures cover the period 1978-89 and represent the most recent available, to allow for a five year maturation period and for the subsequent collection, analysis, and quality control. Because data come from cancer registries, they do not always cover the entire populations of all the participating countries. Within the United Kingdom data were available for the whole of Scotland and for almost half (46%) the population of England.

The conclusions for Britain are stark. For all the common cancers—lung, breast, colorectal, and prostate—the British survival figures are well below the European average. If Britain could achieve the survival rates of the best country in Europe for each cancer over 25 000 lives a year would be saved. Even if it could just reach the European average, nearly 10 000 lives would be saved. For no cancer does Britain hold top position in the league table. Indeed, it is closer in survival figures to Poland, Estonia, and Slovakia than to countries of similar economic prosperity, such as France, Germany, and Sweden. The reasons underlying Britain's poor performance are not clear. Can we discredit these conclusions as some sort of artefact? Apparently not, as confounding factors have been carefully considered.

The first problem could be delay in diagnosis. This seems unlikely to be a major factor as the stage distribution of cancers in Europe is broadly similar. The quality of primary care is high with reasonable access to secondary diagnostic services, so delays in diagnosis are minimal. The second factor could be delay in starting treatment. The cancer patient's journey is rarely streamlined in the United Kingdom. But delays of more than three months from diagnosis to starting definitive therapy are rare and anything less is unlikely to impact on overall survival. *The New NHS* sets targets

for dealing with patients with symptoms that might be due to cancer.³ From next year such patients will have to be seen within two weeks of referral by their general practitioner. This new target is not based on rational evidence and may be tilting at windmills.

The finger has to point at the quality of cancer care and its integration. Surgery, radiotherapy, and chemotherapy are the main modalities. We know that Britain has fewer radiotherapists per head than Poland and fewer medical oncologists than any country in western Europe.⁴ A study by the Association of Cancer Physicians has shown that 40% of cancer patients never see a specialist oncologist.⁵ Tumour site specialisation has been slow to develop, and is still practised effectively only in the largest cancer centres. Britain is a significantly lower user of chemotherapy than its neighbours. Rationing cancer drugs is commonplace and the lottery of some health authorities being willing to fund certain drugs while others are not leads to patients being treated by the same cancer centre for the same cancer in different ways. A wide variation in clinical outcomes for common cancers in different hospitals has been documented. In some cases this may be due to a volume effect, with some clinicians treating a very small number of patients with a particular cancer type and getting poor outcomes.⁶

Change is taking place, but its pace is slow and variable. The Calman-Hine report led to the concept of a series of interlinked cancer centres and local units covering the entire country.⁷ Although heralded as the way forward by both the previous government and the current administration, central resources to implement the plan have been pitifully small. Semantic changes and endless rounds of discussions with healthcare purchasers will not cure cancer. There is no central audit system for the quality of care. Innovative approaches under way in the United States, such as the widespread use of common care guidelines by the National Comprehensive Cancer Network, have minimised disputes between those who buy and provide care. Evidence based guidelines have been produced by the NHS Executive for breast, colorectal, and lung cancer, but their lack of specificity makes them poor tools for the busy clinician. There is no formal dialogue between cancer centres in the UK and no central control. The National Cancer Forum—a derivative group of the Calman-Hine team—meets every six months but has no executive role or resources.

Improving Britain's position in Europe's cancer league will require further investment. The

exploitation of recent advances in our understanding of molecular biology is likely to revolutionise chemotherapy. Unless there is an effective organisation in place, however, these advances will not be implemented quickly in routine practice. The public fear cancer more than any other illness. Britain's policymakers need to provide the resources to bring cancer treatment up to the same standards as the rest of Europe.

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Evidence based palliative care

There is some evidence—and there needs to be more

In the first decades of the 21st century much health-care spending will be concentrated on the end of life. Predictions for the year 2025 show an ageing population, with more people worldwide dying from chronic or progressive illnesses rather than acute conditions.¹ Indeed, this revolution is already upon us. In the United States end of life expenditure through Medicare consumes 10-12% of the total health budget and 27% of the Medicare budget.² Among older people healthcare expenditure for those in the last year of life was 276% higher than for people of similar age.³ Cartwright and Seale estimated that in England about 22% of hospital bed days were taken up by people in the last year of life.⁴ Although discussion of death is still taboo in our society, all health and social professionals must now be assessing the best way of caring for a person with a progressive illness and their family. This underlines the importance of palliative care.

Palliative care is a person centred approach concerned with physical, psychosocial, and spiritual care in progressive disease. It focuses on both the quality of life remaining to patients and supporting their families and those close to them. Throughout the world specialist palliative care services have grown, though their distribution is uneven. In 1999 there were over 6560 hospice or palliative care services in 84 countries, with 933 services in the United Kingdom, almost 1200 in the other 36 countries in Europe, 3600 in North America, and 350 in Australia and New Zealand.⁵ And within countries the provision of palliative care varies geographically and between patient groups. In some parts of the United Kingdom 70% of patients with cancer are cared for by a palliative care team, and over a third die in a hospice, while in other areas only a few receive specialist care.⁶

Moreover, some sections of the community lose out on specialist care. They include people with progressive diseases other than cancer: in 1995 in the United Kingdom only 3.3% of new referrals to inpatient and 3.7% of those to community palliative care services had a diagnosis other than cancer.⁷ Some data suggest that patients in socially deprived areas, those from minority groups,⁸ and older patients from all sections of the community⁹ have limited access to palliative care. Palliative care services operate in different ways,

varying in funding (voluntary or NHS), team composition, staff to patient ratio, out of hours care, and treatment regimens used. Yet in order to promote greater use of clinical protocols, best practice guidelines within services, and guidance on the most effective models of care we need more research evidence. There are, however, difficulties in applying an evidence based approach to palliative care.

Firstly, an absence of evidence does not mean that a service or treatment is not effective, just that we do not know. Outcomes such as the quality of care, quality of life measures including quality of death, and the best resolution of bereavement are hard to measure, especially when patients are frail and ill. Thus, many studies exclude quality of life as an outcome variable, or include only patients who can complete questionnaires. The challenge is to ensure that those aspects of care that are hard to measure do not become a lower priority than aspects—such as survival or function—that are easy to measure.

Secondly, palliative care presents particular problems for the researcher. While the randomised controlled trial remains the gold standard to determine the efficacy of treatments, some palliative care cannot be investigated by a traditional trial. There have now been three systematic reviews of the evaluation of palliative care services. Rinck et al examined 11 randomised-controlled trials: all had methodological problems.¹⁰ In two studies the problems were so severe that no results were reported. Problems were associated with recruitment of a study population in 10 studies, homogeneity in six, patient attrition in four, defining and maintaining contrast between interventions in six, and selecting outcome variables in four.

Another analysis considered 18 prospective comparative studies, retrospective and observational studies as well as randomised trials.¹¹ When specialist multidisciplinary care was compared with conventional care, four of the five randomised controlled trials and most of the comparative studies indicated that the specialist, coordinated approach resulted in similar or improved outcomes in terms of patient satisfaction; patients being cared for in the place of their choice; family satisfaction; and control of family anxiety, patient pain, and symptoms. Those studies that

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