RESPECT–21

LONDON CANCER NORTH AND EAST

Greater Manchester Cancer Clinical Pathway Boards

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Value for money of large scale changes

? Research: at a glance

1. What we knew

- Centralising specialist surgery for some cancers can improve outcomes for patients.
- But there is only limited evidence of the impact on costs or quality of life.

2. What we did

- We looked at patients' anonymous health records.
- We calculated the **costs** of treatment over 10 years for prostate, bladder, renal, and oesophago-gastric (OG) cancers, for people diagnosed in 2012-2017.
- We also calculated patients' **quality of life** based on diagnoses and treatments, and information from other studies in similar patients.
- We combined all this information to get the **mean differences in costs and quality-adjusted life-years** due to the change itself happening
  - **Quality-adjusted life-years (QALYs)** is a patient outcome measure based on people's quality of life and how it changes over time.
- We did this separately for patients in the London Cancer region (LC) and in the Rest of England excluding Greater Manchester (ROE). The changes happened in 2015-16, so we looked at surgeries done before 2015 and after 2016.

3. What we found

- Centralising specialist **prostate** cancer surgery services was quite likely (80% chance) to have been cost-effective, at the standard threshold of £30,000/QALY gained.
- The "after" period was short (2016-17) so patient numbers were small for the other three less-common cancers, so the results were less clear.
- Centralising specialist **oesophago-gastric (OG)** and **bladder** cancer surgery services had about an even chance of having been cost-effective at this threshold (62% and 49%, respectively).
- Centralising specialist **renal** cancer surgery seems not to have been cost-effective (12% chance). This was partly due to greater improvements in renal cancer patient outcomes in ROE during the study. This made the LC improvements seem less good.

4. What this means

- Prostate cancer reconfigurations had the highest chance of being **cost-effective**, but healthcare delivery in the NHS is highly networked and collaborative, so the result should not be taken alone.
- These reconfigurations also happened at the same time as some **other changes** in cancer care and other system changes, making it difficult to look at only the cancer changes by themselves.
- Collecting standard quality-of-life data using questionnaires in routine care (e.g. EQ-5D-5L questionnaire) would improve future work like this.

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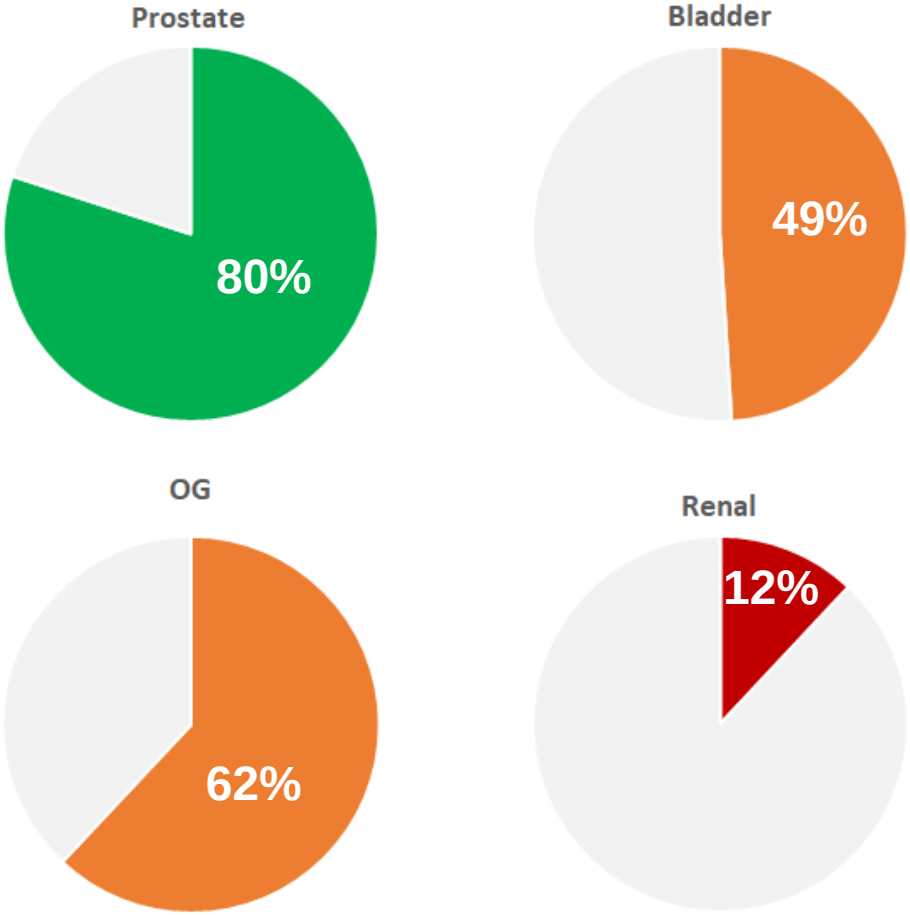
How likely was it that the changes were good value for money?



Reference

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Cost-Utility Analysis of Major System Change in Specialist Cancer Surgery in London, England, Using Linked Patient-Level Electronic Health Records and Difference-in-Differences Analysis Applied Health Economics and Health Policy

Published: 22 July 2022

https://doi.org/10.1007/s40258-022-00745-w

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Our website

https://www.ucl.ac.uk/epidemiology-health-care/research/applied-health-research/research/health-care-organisation-and-management-group/respect-21-0

Acknowledgements

The authors acknowledge the contribution made to this work by Neil Cameron, one of the patient representatives on this study, who sadly died in May 2017. We also thank Michael Aitchison, Georgia Black, Veronica Brinton, Mark Emberton, Patrick Fahy, David Holden, Colin Jackson, Caroline Moore, Michelle Morton, Dipankar Mukherjee, Pei Li Ng, Catherine Perry, John Sandell, Christine Taylor, and Ed Wilson for their contributions to the development of this study. The models and analysis code used in this study were provided to the journal's peer reviewers for their reference when reviewing the manuscript. The authors wish to thank the thoughtful and constructive journal editors and peer reviewers who provided their valuable insights to improve this manuscript

This project was funded by the National Institute for Health and Care Research (NIHR) Health Services and Delivery Research Programme, funded by the Department of Health and Social Care (study reference 14/46/19). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care.

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