Who is bearing the brunt of the increasing cost of cancer care?

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Burgeoning health care costs are a major concern in Australia and throughout the world, straining national budgets and challenging principles of accessibility and equity. In Australia, total health care spending increased by 3.4% per year during 2011–21, and by a further 6% ($13.7 billion) during the financial year 2021–22.[1] The estimated cost of cancer care was the third highest for any disease type.[2] Out-of-pocket health care expenses as a proportion of all health care expenditure in Australia (13.3%) are comparable with those in other countries with universal health care systems (Canada, 14.9%; United Kingdom, 13.9%), but are larger than in European countries with similar health care systems, such as the Netherlands (9.8%), Germany (11.0%), and France (8.2%).[3] Australian data on cancer health care costs at the individual level, and how these costs vary by cancer type and patient characteristics, are limited.

The study by Goldsbury and colleagues[4] published in this issue of the *MJA* adds to our knowledge of cancer treatment costs in Australia. The authors surveyed participants in the 45 and Up Study about their out-of-pocket health care expenses, and linked the responses with New South Wales Cancer Registry data. Strengths of the study included the large sample size (45 061 people), the survey participation rate (53%), and the broad range of cancer types and health care costs covered. As the median age of participants was 70 years (interquartile range, 64–76 years), the respondent sample was fairly representative of people with cancer, although the authors noted selectivity with respect to some characteristics (eg, large proportion with private health insurance; possibility that people with poor outcomes were under-represented). About 43% of respondents reported that their out-of-pocket health care expenses had been more than $1000 during the preceding twelve months, including 55% of those who had been diagnosed with cancer in the past two years. After adjustment for socio-demographic and health factors, people diagnosed with cancer during the preceding two years were twice as likely as people without cancer to report expenses greater than $1000 (adjusted odds ratio [aOR], 2.06; 95% confidence interval [CI], 1.77–2.40), and even more likely to have out-of-pocket expenses exceeding $10 000 (aOR, 3.30; 95% CI, 2.56–4.26).[4] Of particular interest was that people with private insurance and higher household income were more likely to report higher out-of-pocket expenses. Further work is needed to establish how out-of-pocket health costs affect access to care and clinical outcomes.

The Australian health care system is a unique mix of public and private care. Timeliness of care can be an important determinant of health outcomes, and one of the perceived advantages of private care is more rapid access to specialist physicians and interventions. Further, there is evidence that socio economically disadvantaged people, particularly those who do not live in metropolitan centres, may face hurdles to care, including access to general practitioners, which is not determined by insurance status but can be influenced by socio-economic standing and place of residence.[5-7] It has been reported that people with advanced cancer who are privately insured have better outcomes in Australia.[8,9] However, it is a complex relationship, and any survival differences probably have multifactorial causes, confounded by differences in health and socio-economic status.

The study by Goldsbury and colleagues[4] brings into focus the health cost burden borne by people with private insurance and higher socio-economic status, including the substantial and increasing cost of private health insurance, and the out-of-pocket gaps associated with common medical procedures, which are clearly increasing. To have contributed to private insurance and then be faced with major additional costs is confronting, particularly when considering the lower costs for a person receiving the same treatment in a public hospital. Further, in addition to any gap payments, additional costs can be incurred with the use of newer surgical or radiation oncology technology, or medications not readily available to public patients. Such therapies are supported by varying levels of clinical evidence. The strongest association with out-of-pocket costs exceeding $10 000 was a recent breast or prostate diagnosis, which may suggest where higher costs are being incurred.

When emerging treatment options are discussed, informed consent by patients is essential. The evidence base, treatment costs, and details of alternative approaches, including treatment in the public system, should be clearly disclosed upfront to patients. Fully informed decision making is always important, but particularly when highly stressed people are contemplating a life-threatening illness, when disease-related anxiety and the real or perceived urgency of commencing treatment may influence their decisions.

Increasing out-of-pocket health care expenses, particularly for people with cancer, are clearly concerning, especially if they compromise the care of those who are unable to pay. Currently, out-of-pocket costs are more likely to be incurred by those with least disadvantage. Given the inexorable rise in health care costs and the increasing challenge of making the best available treatments accessible to everyone, it is important to discuss cancer treatment costs for all patients. Here, as always, people should be fully informed in advance of costs and treatment alternatives, and efforts are needed to contain out-of-pocket expenses.

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■ See Research (Goldsbury)

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