Acta Oncologica Vol. 33, No. 4, pp. 341–344, 1994

FUTURE HEALTH AND CANCER CARE

Possibilities, hopes and realities

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Cancer care in future will depend on three factors: medical progress, the resources available for health care, the prioritisation of cancer care within that resource frame.

I had the opportunity of working in the care of cancer patients during the 1950s in a highly specialised department—Radiumhemmet, in primary care in a small community—Stenstorp, and in several small, general hospitals and nursing homes.

Cancer care was a relatively small sector of health care. Nobody could foresee the enormous development which it was to undergo during the ensuing decades. There was no specialist training focusing on cancer care—only radiotherapy which in practice was a sub-speciality of diagnostic radiology. And it was from diagnostic radiology that the great majority of future radiotherapists—oncologists—were recruited. The few and relatively small specialised departments, like Radiumhemmet, basically admitted only patients who could be cured by radiotherapy. The small general hospitals, primary care and nursing homes, had no resources for looking after the patients who had been turned away by the specialised radiotherapy and surgery departments. I heard patients screaming in pain, hour after hour. I saw patients slowly suffocated by their tumour—a ghastly, agonising death. I worked in nursing homes where half the patients could have typical, malodorous, disintegrating and painful cancer sores. We laid the foundations of today's widespread terror of cancer through our way of looking after cancer patients, even in the 1960s; through our incapacity, lack of insight, knowledge and interest, through the practice of giving severely ill patients injections of saline and saying that it was morphine.

Accepted 4 March 1994.

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During the fifties we had basically two methods of treatment—radiation therapy and surgery—poor pain relief mostly using salicylic acid preparations, hardly any interest in the emotional needs of the patients. Relatives who came visiting were felt to be a nuisance. In Sweden we had three radiotherapy departments at teaching hospitals and two smaller departments which led an uncertain existence under the constant threat of closure.

Surgery and radiation therapy have developed enormously in the past 30 years. Radiation therapy developed into a method with the greatest accuracy and precision to be found in medical practice today. Surgery has become less brutal, and reconstructive surgery has developed. In addition, cytostatics, hormones, anti-hormones and biological treatment methods have been developed, as well as knowledge in and interest for pain relief, psychosocial care of patients and response to their families. We now concern ourselves not only with the tumour being gone but also with how the patient feels. We have acquired two clinical disciplines specialising in non-surgical cancer care (general and gynaecological oncology), we have surgeons and surgical units with a profile in cancer surgery, we have haematologists and internal specialists with a strong profile in the care of haematological malignancies, paediatric oncologists, oncological centres for regional co-ordination, 15 departments for general and 7 for gynaecological oncology, in the specialised departments and profiled units we retain many patients we are unable to cure. Between 1959 and 1990 the number of cancer cases more than doubled, rising in Sweden from not quite 20 000 to nearly 40 000 (1, 2). We carry out health screenings of healthy persons with the aim of diagnosing cancer before it presents any symptoms. We speak of cancer prevention based on observations with ever-improving scientific confirmation. We understand the nature of cancer—we know the basic change which occurs in a normal cell when it is transformed into a cancer cell; there is no longer any 'riddle of cancer'.

 ISSN 0284-186X

What is going to happen?

Developments will continue to move fast, even if they will be less dramatic. The steep rise in the number of cancer cases since the 1950s has levelled out somewhat. According to the best-substantiated, even internationally, forecast hitherto, 'Prediction of cancer incidence in the Northern countries' (3), by the beginning of the 2010s, Sweden will have upwards of 47 000 new cancer cases annually, affecting 24 000 men and 23 000 women. About half these people will be under 69 years of age. How great the increase actually turns out to be, and whether the age-adjusted incidence of cancer will increase at all, will depend on one factor: the development of smoking habits especially among young women. It was recently shown that the incidence of lung cancer is diminishing among men in big cities but continuing to rise rapidly among women (4). Other preventive measures, relating for example to eating, sunbathing and other living habits, are important and hopefully of great interest in the long term, but will not produce any quantifiable, discernible effect for at least another two decades.

Earlier discovery of cancer in growing numbers of patients is the factor that will contribute most to the ongoing increase in the percentage of patients cured. This is because the general public will be even better informed about early symptoms of cancer and know that cancer can be cured if discovered early. In addition there is the steadily improving education of physicians and other personnel; they will be less likely to miss an early diagnosis in a patient consulting them for early symptoms. The enormous development of diagnostic radiology can also contribute towards earlier discovery of cancer. Screenings for early diagnosis will continue, but their value will be called into question not least in general public debate. We have charted the benefits of screenings for early diagnosis of breast and cervix cancer; mortality is diminishing and more people can be cured with less drastic surgery. The disadvantages—such as the worry provoked by screenings above all in healthy women who are channelled into the medical system by being recalled for re-examination or being operated on 'unnecessarily'—have been less well charted. In the economic climate which health care will have to live with, the cost–efficiency of health screenings will also be called into question.

The most remarkable thing that has happened in the past few years is that we better understand the nature of cancer. This will lead to a development of treatment methods based on our new knowledge—the introduction of substances blocking the expression of oncogenes or counteracting the effects of oncogenic products. We shall find ourselves receiving for clinical use an increasing number of substances which selectively stimulate certain cells and subdue others in the complex immune and tumour defence systems which we are learning to understand better and better. We shall have increasing use for growth factors and monoclonal antibodies. It is essential that we should work on these immensely exciting developments, but in the short term they will make little difference to the results of treatment on patients in general.

What will be of the utmost practical importance is better use of methods we already have today, and better nursing. Treatment will become gentler, the results just as good or sightly better in terms of the percentage of patients cured. But above all, several of those who are not cured will be able to live longer and lead progressively better lives. In growing numbers of people, cancer will become a chronic disease with which they can continue to lead a relatively normal life, with relatively lenient, ongoing maintenance treatment. We are going to see a growth of interest in local methods of treatment, surgery and radiotherapy with the aid of which most cancer patients are already being cured today. At present, according to a report by a group of experts within the European Commission, the greatest achievable improvement in practical cancer care would be from greater precision and accuracy in the application of existing methods of radiotherapy. In this way the proportion of cancer patients cured could be raised by about 5%.

Thus the future for cancer care seems bright. The problem is what resources will be made available to meet the needs generated by this wonderful advance in medicine, what priority will be given to cancer care generally and its various constituent activities within these frames? On these points I am profoundly uneasy.

The great majority of countries aim to provide their populations with good care—for everybody on equal terms—on the principle of 'from each according to his ability and to each according to his need'. More and more countries, however, are experiencing great difficulty in living up to the promise they made to their populations. This today is a universal problem in all countries which had the aim of building up a collectively financed health care system. This is a painful problem to those with political responsibilities, to us as cancer practitioners, but above all to our patients and their families.

Health care in Sweden, as in other Nordic countries, is a county council and/or municipal responsibility. Over the past ten years a highly unanimous parliament has withdrawn immense resources from the county councils and municipalities—40 billion Swedish crowns in annual funding. This accounts for ongoing job cuts, the closure of wards and hospitals, overcrowding, absurdly short lengths of stay in hospitals, and difficulty in admitting patients who are obviously in need of hospital care. And this is only the beginning of the process.

Unfortunately things are going to get much worse before they may get better. For there must come a turning point. But when it comes will depend on how quickly the general public becomes aware of what is happening and affecting all of us: one out of every three people living in the Nordic area today will develop some form of cancer during their lifetime.

Compared with the other OECD countries, the Nordic countries are spending relatively little on medical care in gross national product percentage terms (Table 1). Allowing for age of population, Sweden, Denmark and Norway come at the bottom of the list together with Britain (Table 2).

During the current 15-year period, the number of 85-year-olds in Sweden will rise by about 40%. An 85-year-old uses 38 times as many in-hospital days as people aged 65 or under. Many counties and municipalities in Sweden are in financial trouble. They will be forced to go on reducing their medical funding and the number of hospital beds. This is an equation that will not come out.

What priority will cancer care be receiving when funding frames are shrinking in relation to needs? In Sweden as in many other countries, primary care is receiving priority at the expense of specialised hospital care. For greater efficiency, performance-related systems of remuneration are being introduced. To improve availability, systems are being introduced which facilitate freedom of choice for patients. In a system governed by performance-related payments, the severely and chronically ill are liable to be regarded as unprofitable risk patients. They have little chance of exercising any freedom of choice. What they need is the specialised medical services which are now being so dramatically reduced.

Theoretically speaking, a gap between needs and resources can be dealt with by means of:

Rationalisation and efficiency measures
Delimitation of medical responsibilities
Additional resources
Prioritisation
Reduction of quality

Nobody is likely to have any objections to rationalisation and efficiency improvements, but these have their given limits, not least in care, where there is seldom a fast boundary between efficiency improvement and quality reduction. In Sweden at least, that boundary has been reached and crossed in many sectors.

Table 1

Actual gross national product percentages of health care in 1991. (Swedish Institute for Health Services Development 1993)

Country	Percentages
USA	13.4
Canada	10.0
France	9.1
Finland	8.9
Australia	8.6
Germany	8.5
Austria	8.4
Sweden	8.4
Netherlands	8.3
Italy	8.3
Switzerland	7.9
New Zealand	7.6
Norway	7.6
Japan	6.6
UK	6.6
Denmark	6.5

Table 2

Gross national product percentages of health care in 1991, age-adjusted in relation to Sweden, nursing homes excluded. (Swedish Institute for Health Services Development 1993)

Country	Percentages
USA	14.9
Canada	11.9
Australia	10.7
Finland	10.1
France	10.1
Netherlands	9.5
Germany	9.1
Austria	9.1
Italy	9.0
New Zealand	8.8
Switzerland	8.6
Japan	8.4
Norway	8.0
Sweden	7.2
UK	7.2
Denmark	7.1

If there are treatments which, due to open delimitation of medical responsibilities, are not to be offered to the public, this is noticed and evokes protests. The same goes for sufficiently distinct priorities.

If additional resources are to be committed, this calls for tax increases or the transfer of resources from other activities; these measures too are noticed and cause protests. On the other hand it is perfectly feasible, politically speaking, to reduce quality. Nobody protests! Nobody gets upset on reading in the paper that the State has withdrawn a few billion crowns from county councils or municipalities. Few wax indignant on reading that a county council is to make a few assistant nurses redundant. The severely and chronically ill notice this in a very painful way, but they have little chance of gaining a hearing. They lie there in their beds, in need of help to eat, to dress, to go to the toilet, in need of someone to talk to, in need of a rapid change of sheets and bedding or effective pain relief.

The primary treatment of cancer patients will continue to receive high priority and will be relatively well provided for. But I, and many others like me, am growing more and more apprehensive about the care of those whom we do not cure. Apprehensive as to whether we shall be allowed to preserve the most important development in cancer care during the past 30–40 years—its humanisation through better provision for those who cannot be cured. This costs money, a lot of money, and it involves a weak, very weak, category of people. Those of us who are employed in cancer care and relatively weak organisations of cancer patients are at present their only spokesmen in a world where many vociferous groups are contending for resources which are

shrinking in relation to growing needs—their spokesmen in the face of grim economic reality and faltering political aspirations.

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