Are health-care policies restricting further progress in cancer survival outcomes?

We commend Melina Arnold and colleagues on the ICBP SURVMARK-2 project published in *The Lancet Oncology*,[1] which concluded that cancer survival has improved over the past two decades (1995–2014) across seven high-income countries because of earlier diagnosis and advancements in tailored treatments based on molecular markers.

A noteworthy finding was that survival is persistently lower in the UK and Denmark compared with the other countries for four common cancer types. Potential drivers of international variation in cancer survival include stage at diagnosis; delays in routes to diagnosis due to patient, doctor, and system factors; tumour biology;[2] and differences in registration practices and coding,[1] which cannot be standardised. It is important to consider the effect of inequalities of health-care policy.

Health-care policy reforms in the UK have been instrumental in improving cancer survival outcomes, but the aforementioned disparities raise the question: are further reforms warranted? For example, health-care in the UK is free at the point of use for primary and emergency care services. However, those not ordinarily resident in the UK are billed retrospectively for secondary care services deemed as urgent or immediately necessary under the National Health Service's (NHS) charging regulations. Migrants' poor knowledge of these regulations, aggressive cost recovery systems (including threats of disclosure to the Home Office), and great financial debt might explain their disengagement from health-care services and delayed presentation. Migrants wait an average of 6 years before accessing health-care services, which is important information given the role of delayed presentation in cancer survival. Considering that health tourism has been estimated to account for £50 million to £200 million, approximately 0·15% of the 2016 £116·4 billion budget,[3] which incurs negligible burden on NHS funding, this policy of retrospective charging of irregular migrants merits further review. The cost of NHS Overseas Visitors Teams nationwide has been suggested to exceed that of the recovered charges,[4] and excluding asylum seekers and refugees from unrestricted health-care services in Germany was shown to incur greater health system costs in the long term.[5] Implementation of similar restrictive policies in Spain was associated with 15% increased mortality in migrants. Although migrants account for a small proportion of the general population, we raise the issue of inequalities in accessing health-care imposed by policies, which are amenable to change. Understanding and reforming health-care policies that restrict access to effective life-prolonging or curative treatment to vulnerable patients might not only provide for more benevolent health care, at little or no additional cost, but also contribute to better cancer outcomes.

We declare no competing interests.

*Reena Patel, Wing K Liu, Hiten RH Patel, Lisa Pickering, *Mehran Afshar*

mehran.afshar@stgeorges.nhs.uk

St George's Medical School, University of London, London, UK (RP); Department of Oncology, St George's University Hospitals NHS Foundation Trust, London SW17 0QT, UK (WKL, MA); Department of Urology, University Hospital North Norway & IKM University of Tromsø, Tromsø, Norway (HRHP); and Department of Oncology, The Royal Marsden NHS Foundation Trust Sutton, London, UK (LP)

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