

# Why are we organizing another costing supplement in *Current Oncology*?

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Canadian researchers need an opportunity to describe real-world health system use and costs in their jurisdictions. Reviewers at international journals do not have an appreciation of our unique population size and demographics, and the differences in policies and programs across our country. As an example, a question from the reviewers at a major U.S. cancer journal that we recently fielded asked “Is [Ontario] a major metropolitan area?” Important work conducted from a Canadian perspective might not resonate with non-Canadian audiences. Authors are sometimes hesitant to name a Canadian jurisdiction overtly in an abstract or title for fear that the editor of a non-Canadian journal will not understand the significance of the work.

As cancer-drug costs continue to rise, there is—now more than ever before—a need to understand the Canadian context with respect to costs and health system resource use. Newer targeted agents, immuno-oncology products, and the promise of chimeric antigen receptor T-cell therapies create a greater need to understand how care is managed and used in the real world and to conduct relevant economic analyses. Importantly (to simplify matters), costing occurs in 3 phases:

- Identify the resource used (without identification, costing is impossible)
- Quantify the resource (how much is being used?)
- Apply a value to the resource (unit cost of the resource)

Those three steps allow researchers to determine the burden of disease, the management of the disease, the cost of procedures, and (used as numerator) the inputs into formal economic evaluations.

The supplement you are reading includes seven publications, of which five studies from four provinces use provincial databases. Administrative databases across the country collect and report data about demographics, diseases, outcomes, and health care encounters. Those population-level databases allow the researcher to understand management across the care continuum. From Ontario, Seung *et al.*<sup>1</sup> provide data relating to the real-world management of non-small-cell lung cancer, while Monakova and colleagues<sup>2</sup> use micro-costing and administrative data to establish funding rates for endoscopic procedures. Sam and Cheung<sup>3</sup> use Alberta

Health Services administrative databases to compare the costs of cancer and non-cancer diagnoses, finding that, overall, cancer costs are higher than the costs for other diseases. Tran and colleagues<sup>4</sup> use the Saskatchewan Cancer Agency’s cancer registry to identify cases of non-melanoma skin cancer, examining total and annual health system costs. Finally, Costa *et al.*<sup>5</sup> conducted a costing analysis of diffuse large B-cell lymphoma from a British Columbia provincial perspective.

Other studies included in this supplement use Canadian costs for incremental analyses and risk-based assessments. Cheung *et al.*<sup>6</sup> consider the economic impact of the transition from branded to generic oncology drugs and the incidence-adjusted health care costs for common cancer and non-cancer diagnoses respectively, and Blair and colleagues<sup>7</sup> link census-derived location data and Statistics Canada’s Canadian Community Health Survey to highlight the importance of socioeconomic status and income with respect to the uptake of colorectal screening.

As the need for health services, economic methods, and outcomes increases, *Current Oncology* should be applauded for providing a space for publications that allow authors to use administrative data and costing analyses in unique ways, providing useful insights into various Canadian jurisdictions and representative Canadian applications.

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## CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology*’s policy on disclosing conflicts of interest, and I declare that I have none.

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