

## RESEARCH ARTICLE

# Estimating the Economic Burden of Premature Mortality Caused by Cancer in Iran: 2006-2010

Behzad Karami-Matin<sup>1</sup>, Farid Najafi<sup>1</sup>, Satar Rezaei<sup>1</sup>, Ardashir Khosravi<sup>2,3</sup>, Moslem Soofi<sup>1\*</sup>

### Abstract

**Background:** Cancer is currently one of the main public health problems all over the world and its economic burden is substantial both for health systems and for society as a whole. To inform priorities for cancer control, we here estimated years of potential life lost (YPLL) and productivity losses due to cancer-related premature mortality in Iran from 2006 to 2010. **Materials and Methods:** The number of cancer deaths by sex and age groups for top ten leading cancers in Iran were obtained from the Ministry of Health and Medical Education. To estimate the YPLL and the cost of productivity loss due to cancer-related premature mortality, the life expectancy method and the human capital approach were used, respectively. **Results:** There were 138,228 cancer-related deaths in Iran (without Tehran province) of which 76 % (106,954) were attributable to the top 10 ranked cancers. Some 63 % of total cancer-related deaths were of males. The top 10 ranked cancers resulted in 106,766,942 YPLL in total, 64,171,529 (60 %) in males and 42,595,412 (40%) in females. The estimated YPLL due to top 10 ranked cancers was 58,581,737 during the period studied of which 32,214,524 (54%) was accounted for in males. The total cost of lost productivity caused by premature deaths because of top 10 cancers was 1.68 billion dollars (US\$) from 2006 to 2010, ranging from 251 million dollars in 2006 to 283 million dollars in 2010. **Conclusions:** This study showed that the economic burden of premature mortality attributable to cancer is significant for Iranian society. The findings provide useful information about the economic impact of cancer for health system policy/decision makers and should facilitate planning of preventive intervention and effective resource allocation.

**Keywords:** Economic burden - cancer-related premature mortality - years of life lost - productivity costs - Iran

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### Introduction

Cancer is currently one of the main leading cause of death in both developed and developing countries (Jemal et al., 2011). Based on GLOBCAN databases, an estimated 14.1 million new cancer cases and about 8.2 million deaths due to cancer occurred in 2012 worldwide which 53 % of them accounts for developing countries (Torre, Bray et al., 2015). In Iran, cancer is one of the main public health problem for policy-makers and planner in health sector. An about 53,350 deaths caused by cancer 53,350 occurred in 2012 and is expected to will reach to 58,087 deaths in 2015. In addition, cancer is the third leading cause of deaths after coronary heart disease and road traffic injuries (Naghavi et al., 2009, Kambiz et al., 2011).

Cancer incidence will continue to rise because of the growth in life expectancy, increase in the proportion of the elderly population and size of population over the

world (Jemal et al., 2011). In recent years, deaths due to cancer has decreased in developed countries as a result of improvement in preventive and therapeutic interventions, whereas in developing countries such as Iran, it has significantly risen (Jemal et al., 2010, Khorasani et al., 2014). Then, it is necessary to conduct the preventive and therapeutic interventions in order to reduce the burden of cancer in developing countries like Iran. Due to limitation of health resources, it is necessary for health policy-makers to prioritize the cancer control interventions (Kim et al., 2013).

One of the main ways in this issue is the estimating economic burden of cancer, including healthcare expenditures and cost of lost productivity due to mortality and morbidity. Based on previous studies, the cost of cancer-related premature mortality accounts for 70 to 85 % of the total cost (Insinga 2006, Jonsson and Wilking, 2007; Bradley et al., 2008, Ortiz et al., 2010; Hanly and

<sup>1</sup>Research Center for Environmental Determinants of Health, <sup>2</sup>Social Development and Health Promotion Research Center, Kermanshah University of Medical Sciences, Kermanshah, <sup>3</sup>Deputy of Health, Ministry of Health and Medical Education, <sup>4</sup>Non-Communicable Diseases Research Center, Endocrinology and Metabolism Population Sciences Institute, Tehran University of Medical Sciences, Tehran, Iran \*For correspondence: moslemsoofi@yahoo.com

Sharp, 2014). Majority of conducted previous studies in Iran estimate the direct cost of cancer (Akbarzadehbaghban et al., 2009, Bazyar et al., 2012). Previous studies have estimated the total cost of breast cancer (Daroudi et al., 2015) and the total cost of cancer deaths attributable to smoking (Rezaei et al., 2015).

To the best of our knowledge, no study quantify the costs of cancer-related premature mortality in Iran at the national level for more than one year. The current study aimed to estimate the economic burden of cancer-related premature mortality in Iran over the five years from 2006 to 2010.

## Materials and Methods

Data on deaths caused by top 10 cancers by sex and age groups (under one, 1-4, 5-9, 10-14, 15-19, 20-24, 24-29, 30-34, 35-39, 40-44, 45-49, 50-59, 60-64, 65-69, 70-74, 75-79, 80-84 and 85+) for 29 provinces (data for Tehran province for the studied period is not available) were retrieved from the Ministry of Health and Medical Education (MoHME) over the five years from 2006 to 2010. To estimate the average life expectancy for each age group, Iran life table from the World Health Organization was used. Data on age- and sex-specific wages for the studied period came from the Iranian Ministry of Cooperation Labor and Social Welfare. Also, the data on age and sex-specific employment and housekeeping rate for the studied period were obtained from the Iranian Statistical Center (ISC). Because of there weren't any data about wages for the housekeeping activity in Iran, the minimum daily wage approved by the Iranian Ministry of Cooperation, Labor and Social Welfare was used for the females housekeeping activities.

To estimate the quantify burden of cancers and its impact on society, two measures including years of

potential life lost (YPLL) and cost of productivity loss (CPL) were used. The YPLL was calculated by the life expectancy methods. We assumed that all of deaths in each age group occurred in the mid-point of that age group. So, to calculate of YPLL, the number of deaths in each group was multiplied by the average of remaining life expectancy. Based on previous studies, to estimate the CPL, the human capital approach was used (Insinga 2006, Bradley et al., 2008; Hanly and Sharp, 2014). The CPL was estimated as follow: first, the YPLL according to the previous section was estimated, only in terms of CPL, we disregarded any deaths beyond 65 years and less than 15 years. Then, the estimated YPLL was multiplied by age and sex-specific annual wages from age of deaths until the retirement age. The estimated CPL was adjusted based on the employment and housekeeping rate. In addition, to obtain the present value the future costs were discounted at 3 % per year. CPL for each death were summed across age groups by sex and cancer site (Khorasani et al., 2014; Rezaei et al., 2015).

## Results

During 2006-2010, there were 138,228 cancer-related deaths in Iran (without Tehran province) which 76 % of them (106,954) were attributable to the top 10 ranked cancers. 63 % of total cancer-related deaths were in male. The main causes of cancer-related deathsweregastric, lung and prostate in the males, whereas they were gastric, breast and lung in the females. For the whole of period studied, gastric cancer was the most common cause of death in males, females and both sexes combined. The total number of deaths caused by cancer increased by 10 % in males and by 22% in females (Table 1). There were 42,351deaths between 15 and 64 (working-age range), related to the top 10 ranked cancersduring the period analysed and 56% of

**Table 1. Numbers of Deaths Due to the top 10 Ranked Cancers by Sex in Iran During 2006-2010**

ICD COD	Cancer site	2006	2007	2008	2009	2010
Male						
C15	Esophagus	944	931	849	889	911
C16	Stomach	3,680	3,790	3,777	3,740	3,735
C17	Small intestine	433	413	491	500	513
C18	Colon	499	586	639	684	653
C22	Liver	1,425	1,453	1,505	1,566	1,607
C32	Laryngeal	539	566	595	593	649
C33-C34	Lung	2,353	2,515	2,571	2,514	2,718
C61	Prostate	1,296	1,479	1,510	1,572	1,706
C70-C72	Brain & CNS	792	882	848	863	898
C95-C96	Leukaemias of unspecified cell type	960	869	861	928	821
Female						
C15	Esophagus	619	624	663	614	631
C16	Stomach	1,849	1,905	1,824	1,853	1,889
C17	Small intestine	287	311	313	314	324
C18	Colon	337	433	470	435	461
C22	Liver	923	1,036	1,109	1,029	1,199
C33-C34	Lung	993	1,059	1,068	1,089	1,138
C50	Breast	962	1,086	1,122	1,124	1,283
C53	cervix	23	262	276	267	300
C70-C72	Brain & CNS	564	659	640	612	676
C95-C96	Leukaemias of unspecified cell type	37	552	544	527	519

**Table 2. Estimated YPLL for the Top 10 Ranked Cancers by Sex in Iran during 2006-2010**

ICD COD	Cancer site	2006	2007	2008	2009	2010
Male						
c15	Esophagus	889,295	856,037	3,497,347	808,694	826,658
c16	Stomach	3,452,613	3,556,324	2,484,936	3,474,500	3,460,584
C17	Small intestine	420,430	366,937	1,114,812	480,050	490,382
C18	Colon	495,921	586,502	1,471,622	698,852	649,030
C22	Liver	1,398,365	1,372,498	885,379	1,547,447	1,555,607
C32	Laryngeal	537,868	561,802	789,821	594,637	644,580
C33-C34	Lung	2,302,693	2,434,168	904,506	2,418,865	2,649,259
C61	Prostate	981,995	1,100,270	624,268	1,133,122	1,235,948
C70-C72	Brain & CNS	871,826	950,967	582,424	949,187	990,780
C95-C96	Leukaemias of unspecified cell type	991,608	860,296	477,582	943,521	798,700
Female						
c15	Esophagus	624,943	634,863	651,742	606,873	625,733
c16	Stomach	1,878,272	1,888,272	1,844,118	1,825,545	1,910,794
C17	Small intestine	308,182	318,182	339,567	318,363	339,824
C18	Colon	357,620	367,620	494,694	476,527	492,600
C22	Liver	982,665	986,609	1,151,351	1,083,388	1,231,960
C33-C34	Lung	1,042,846	1,142,905	1,108,167	1,133,017	1,197,345
C50	Breast	1,289,246	1,389,429	1,482,823	1,479,704	1,702,422
C53	cervix	278,494	298,395	322,921	345,702	354,935
C70-C72	Brain & CNS	661,974	691,887	734,790	714,029	801,926
C95-C96	Leukaemias of unspecified cell type	625,941	605,941	595,944	579,956	548,273

**Table 3. Estimated YPPLL for the Top 10 Ranked Cancers by Sex in Iran during 2006-2010**

ICD COD	Cancer site	2006	2007	2008	2009	2010
Male						
c15	Esophagus	413,779	380,630	1,549,353	354,741	374,040
c16	Stomach	1,536,291	1,637,184	1,277,131	1,614,315	1,644,043
C17	Small intestine	222,702	145,923	245,956	263,403	261,927
C18	Colon	280,409	347,638	769,303	404,318	364,789
C22	Liver	734,841	667,203	612,728	857,822	839,350
C32	Laryngeal	283,266	303,039	382,075	332,722	370,831
C33-C34	Lung	1,170,056	1,243,424	626,582	1,263,577	1,463,828
C61	Prostate	215,273	238,627	332,210	226,081	268,677
C70-C72	Brain & CNS	637,152	680,927	320,604	693,068	725,438
C95-C96	Leukaemias of unspecified cell type	673,769	572,183	252,610	631,808	506,860
Female						
c15	Esophagus	307,299	308,198	292,402	290,004	308,165
c16	Stomach	912,641	902,632	908,077	870,992	991,511
C17	Small intestine	170,750	178,754	200,567	180,188	197,293
C18	Colon	206,724	236,754	291,239	296,696	295,711
C22	Liver	562,952	592,831	626,806	617,350	655,315
C33-C34	Lung	571,881	581,321	598,772	629,359	678,045
C50	Breast	1,096,959	1,196,123	1,239,704	1,227,192	1,451,303
C53	cervix	194,641	199,441	222,066	266,564	255,229
C70-C72	Brain & CNS	492,265	530,201	552,133	538,846	600,895
C95-C96	Leukaemias of unspecified cell type	433,472	423,472	409,212	402,124	374,262

them were in males.

The number of YPLL due to the top 10 ranked cancer-related deaths by sex from 2006 to 2010 in Iran is presented in Table 2. These top 10 ranked cancers resulted in 106,766,942 YPLL in total 64,171,529 (60%) in the males and 42,595,412 (40%) in the females. In the period analysed, the highest number of the YPLL was related to gastric cancer, followed by lung, Esophageal, liver and prostate for males, and the highest number of the YPLL for females was gastric cancer, followed by breast, lung, liver and esophagus. From 2006 to 2010, the overall

number of YPLL increased by 8% for males and by 13% for females. (Table 2)

Table 3 shows the YPPLL by sex and type of cancer for the period analyzed. The estimated YPPLL due to top 10 ranked cancers was 58,581,737 from 2006 to 2010 which 32,214,524 (54%) of them were in male. From 2006 to 2010, the total number of YPPLL increased by 9% for males and by 15% for females. Among males, the highest number for YPPLL was gastric cancer, followed by lung and liver. For females, the highest number for YPPLL was breast cancer, followed by gastric cancer

**Table 4. Estimated Premature Mortality Costs Due to TopTen Cancers by Sex in Iran during 2006-2010, (US \$)**

ICD COD	Cancer site	2006	2007	2008	2009	2010
<b>Male</b>						
c15	Esophagus	8,808,830	10,625,327	12,715,898	11,239,553	8,865,640
c16	Stomach	39,136,136	46,647,752	45,482,655	50,260,028	43,152,545
C17	Small intestine	6,861,558	3,471,005	9,669,948	11,004,909	8,881,256
C18	Colon	9,004,471	11,314,383	224,032,229	16,016,603	11,568,005
C22	Liver	24,508,124	20,861,564	28,259,921	31,546,709	23,970,587
C32	Laryngeal	7,805,355	8,209,518	9,961,959	11,549,587	10,080,893
C33-C34	Lung	31,052,671	36,452,553	43,632,251	44,484,194	41,155,198
C61	Prostate	3,931,417	4,406,357	6,724,090	5,470,572	5,451,759
C70-C72	Brain & CNS	30,303,625	34,653,710	36,934,492	41,263,102	35,439,514
C95-C96	Leukaemias of unspecified cell type	41,173,727	37,458,991	47,783,088	44,589,055	34,550,052
<b>Female</b>						
c15	Esophagus	1,778,344	2,921,943	2,698,421	2,447,410	1,968,421
c16	Stomach	6,714,114	9,142,011	9,394,984	9,473,632	8,120,992
C17	Small intestine	1,894,531	1,687,153	2,687,222	2,180,563	1,801,678
C18	Colon	1,766,437	2,827,791	3,090,542	3,860,440	3,104,044
C22	Liver	4,967,920	5,059,156	7,195,292	7,262,528	5,548,064
C33-C34	Lung	4,384,472	6,291,862	7,521,633	7,135,474	6,119,040
C50	Breast	10,309,944	13,543,183	15,347,129	16,396,540	14,639,443
C53	cervix	1,894,531	2,499,836	2,670,796	4,928,843	2,822,108
C70-C72	Brain & CNS	6,997,365	8,534,069	10,313,896	10,040,560	8,235,163
C95-C96	Leukaemias of unspecified cell type	8,303,563	10,413,992	10,134,954	10,957,881	6,720,549

and lung. (Table 3)

The total cost of productivity loss caused by premature deaths because of top 10 cancers was 1.68 billion dollars (US\$) from 2006 to 2010, ranging from 251 million dollars in 2006 to 283 million dollars in 2010. From 2006 to 2010, the CPL increased by 10 % in males and by 18% for females. Among males, the main contributors of total cost of lost productivity were colon, gastric, Leukaemias of unspecified cell type, lung and brain, respectively. For females the highest CPL was due to breast cancer followed by Leukaemias of unspecified cell type, brain, gastric and lung cancer. The percentage of the total costs due to productivity losses for 10 main cancers was 81.2 % in males and 18.8% in female (Table 4).

For the whole studied period, the average premature mortality cost per death for both sexes combined was US \$ 420,842. It was \$ 331,733 for males and \$ 88,748 for females. In this period, the most costly cause per death in males was colon cancer (\$1,113,825 per death) followed by Leukaemias of unspecified (\$454,183), and brain (\$ 363,622). Prostate cancer was the least costly cancer per death in male (\$142,361). Among females, the most costly cancer was leukaemias of unspecified cell type (\$166,563) followed by brain (\$121,016) and breast cancer (\$98,335). The least costly cancer in females was esophageal cancer (\$ 49,652).

Table 5 also shows the average premature mortality cost per YPPLL by sex from 2007 to 2010. The average cost per YPPLL in the studied period for both sexes combined was \$152.9. It was \$244.2 for males and \$ 61.6 for females. Among males, in term of cost per YPPLL, like cost per death, cancer of colon and prostate cancer were most costly and least costly cancer, respectively in case of females the most costly cancer per YPPLL was Leukaemias of unspecified cell type and the least costly cancer was esophageal cancer.

## Discussion

The aim of this study was to measure economic burden of premature mortalities due to cancer-related deaths in Iran between 2006 and 2010. We used number of mortality, YPLL, YPPLL and cost of productivity losses to quantify the burden of premature mortality caused by cancers. Based on previous studies human capital approach was used to estimate cost of productivity losses. [5, 13, 15, 18-20].

There were 138 228 cancer-related deaths in Iran from 2006 to 2010, 76 % of them were attributable to top 10 ranked cancer. The total number of deaths caused by cancer increased by 16% for both sexes combined over the period. A study conducted by frouzanfar et al. to evaluate causes of death and morbidity in Iran, showed that more than 57% of deaths in 2010 were caused by cardiovascular diseases and cancers and the cancer was the second most frequent cause of death (Forouzanfar MH, Sepanlou SG et al., 2014). Another study by naghavi et al. that assessed the burden of diseases in Iran showed that stomach cancer was one of top ten ranked cause of mortalities (Naghavi et al., 2009). At global level, a study for the global burden of disease by Lozano et al. showed that 8 million deaths occurred because of cancer in 2010 which 19% of them were from trachea, bronchus and lung cancer. Their report indicated that lung cancer was one of leading cause of death at global level (Rafael et al., 2013).

In the present study the main contributors to YPLL in males, were gastric and lung cancer, while they were gastric and breast cancer in females. Similarly, in a previous study in Iran stomach cancer was the second highest burden by YPLL. In addition, it showed that most important cancers in Iran are gastric cancer, lung cancer, and breast cancer (Forouzanfar et al., 2014). According to another study in Iran among males and in the both sexes

**Table 5. Premature Mortality Costs per Death/YPLL for the TenTop Cancers in Iran, 2006-2010, (US \$)**

ICD COD	Cancer site		2006	2007	2008	2009	2010
Male							
c15	Esophagus	CPL/DEATH	28,600	37,947	44,774	42,735	32,005
		CPL/YPLL	21.3	27.9	33.2	31.7	23.7
c16	Stomach	CPL/DEATH	34,481	38,776	39,550	41,988	35,575
		CPL/YPLL	25.5	28.5	29.4	31	26.2
C17	Small intestine	CPL/DEATH	42,618	31,844	52,841	57,020	46,256
		CPL/YPLL	30.8	23.8	38.3	41.8	33.9
C18	Colon	CPL/DEATH	44,357	44,898	925,753	54,664	44,152
		CPL/YPLL	32.1	32.5	674.3	39.7	31.7
C22	Liver	CPL/DEATH	45,301	42,401	50,374	50,153	38,850
		CPL/YPLL	33.4	31.3	36.8	36.8	28.5
C32	Laryngeal	CPL/DEATH	37,525	36,813	42,572	47,141	36,657
		CPL/YPLL	27.6	27	3	34.7	27.2
C33-C34	Lung	CPL/DEATH	36,276	39,795	46,417	47,729	38,319
		CPL/YPLL	26.5	29.4	34.2	35.2	28.2
C61	Prostate	CPL/DEATH	24,268	24,210	35,766	31,260	26,855
		CPL/YPLL	18.3	18.5	27.3	24.2	20.3
C70-C72	Brain & CNS	CPL/DEATH	65,029	69,169	80,467	81,709	67,247
		CPL/YPLL	47.5	50.9	58.9	59.5	48.8
C95-C96	Leukaemias of unspecified cell type	CPL/DEATH	80,891	86,112	103,203	94,468	89,507
		CPL/YPLL	61	65.5	77.9	70.5	68.2
Female							
c15	Esophageal	CPL/DEATH	8,233	7,473	13,035	11,880	9,029
		CPL/YPLL	5.7	9.5	9.2	8.4	6.3
c16	Stomach	CPL/DEATH	10,507	13,463	14,795	15,404	11,634
		CPL/YPLL	7.3	10	10.3	10.9	8.2
C17	Small intestine	CPL/DEATH	16,192	15,478	19,332	17,169	13,345
		CPL/YPLL	11	9.8	13.4	12	9.1
C18	Colon	CPL/DEATH	12,527	14,728	15,375	18,831	15,068
		CPL/YPLL	8.5	13.6	10.6	13	10.5
C22	Liver	CPL/DEATH	12,738	12,906	16,390	16,811	12,166
		CPL/YPLL	8.8	8.9	11.4	11.7	8.5
C33-C34	Lung	CPL/DEATH	11016	7626	17994	16107	12909
		CPL/YPLL	7.7	11	12.5	11.4	9
C50	Breast	CPL/DEATH	14,046	30,850	18,446	19,947	15,045
		CPL/YPLL	9.4	12.3	12.4	13.4	10
C53	Cervix	CPL/DEATH	14,352	16,127	17,571	26,933	16,407
		CPL/YPLL	9.7	12.8	12	18.5	11
C70-C72	Brain & CNS	CPL/DEATH	20,282	27,352	26,929	26,703	19,748
		CPL/YPLL	14.2	17.3	18.7	18.6	13.7
C95-C96	Leukaemias of unspecified cell type	CPL/DEATH	26,785	41,490	34,708	38,314	25,265
		CPL/YPLL	19	24	24.7	27.2	17.9

combined, gastric cancer had the highest number of YPLL. (Khorasani et al., 2014) Our Findings showed that during 2006-2010 the total number of YPLL by all cancer site and sex increased except esophageal cancer and Leukaemias of unspecified cell type in males that decreased over period. Over the studied period the total number of YPLL for both sexes combined increased by 10%.

Our findings showed that the total productivity costs from premature mortality caused by top 10 cancer were about US\$ 1.68 billion between 2006 and 2010. And average productivity cost per year was about US\$ 337 million for both sexes combined. This study indicated higher total cost of premature mortality in males (\$1,37 billion vs. \$316 million) during 2006-2010. Higher mortality, employment and wage rate for males are the reasons of this difference. Similarly, The finding of previous study in Iran showed that the total cost of premature cancer-related mortality for males was 67 % higher than females (Khorasani et al., 2014). Furthermore,

in Ireland and the US it was 90 % and 80 % times higher in the males, respectively (Bradley et al., 2008; Hanly and Sharp, 2014). In this study, among males gastric cancer was the most costly cancer in terms of total cost and among females most costly cancer was breast cancer. This finding is in line with that of Khorasani et al. previous Iranian studies showed that incidence and mortality of breast cancer are increasing considerably (Taghavi et al., 2012, Rashidian et al., 2013). Based on findings of these reports combined with our results, these cancers are two main areas that should be considered in cancer prevention programs and priority setting.

An important finding from the study is that the ranking of cancers by type of measures was different, for instance, in females, Leukaemias of unspecified cell type ranked 6th in terms of YPLL and 1st in terms of CPL and CPL per YPLL. In contrast, breast cancer ranked 1st in terms of CPL and 3rd in terms of cost per death and cost per YPLL. These changes depend on age of death for each cancer

and survival rate of that. When a cause or disease with low survival rate results in death in earlier age, generally received higher rank of YPLL per death and cost per death (Bradley et al., 2008; Hanly and Sharp, 2014, Khorasani et al., 2014). It implies that prevention policies to reduce cancer-related death can decrease the higher cost and YPLL per death at younger ages.

This study has some limitation, therefore interpreting of results should be based on this limitation. The first is that our analysis was based on data on 29 provinces of Iran, there is no data on Tehran province in this study. It implies that major percentage of deaths did not enter to study. A second limitation is lack of representative data on death and diseases at national level in Iran. And there is remarkable understimation in data on mortality in Iran (Forouzanfar et al., 2014). Third limitation is that this study estimated productivity losses due to premature mortality and other productivity losses because of morbidity that include absenteeism from work, early retirement and reduction in employment did not consider. (Ortiz et al., 2010; Menzin 2012; Doran 2015; Song 2015)

In conclusion, this study shows that premature mortality attributable to cancer has considerable productivity costs. It was about \$1. 68 billion, during 2006-2010 in Iran. In this period the overall cost of productivity losses for the males was 4.3 times higher than the females. Our results also show that gastric cancer (in males) and breast cancer (in females) were the most costly cancers in term of total cost. This finding provide a good picture of economic impact of cancer on society to health system policy/decision makers. It can help them to plan preventive intervention and effective resource allocation.

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## References

- Akbarzadehbaghban A, Esmaeili M, Kimiafar K (2009). Medical information management and assessment of direct costs of treatment of lung cancer. *Health Information Manage*, **5**, 15-21.
- Bazyar M, Pourreza A, Harirchi I, et al (2012). Medical and non-medical direct costs of cancers in patients hospitalized in Imam Khomeini cancer institution-2010. *Hospital*, **11**, 39-50.
- Bradley CJ, Yabroff KR, Dahman B, et al (2008). Productivity costs of cancer mortality in the United States: 2000-2020. *J Natl Cancer Inst*, **100**, 1763-70.
- Daroudi RA, Akbari Sari A, Nahvijou A, et al (2015). The economic burden of breast cancer in Iran. *Iran J Public Health*, **44**, 1225.
- Doran CM, Ling R, Byrnes J, et al (2015). Estimating the economic costs of skin cancer in New South Wales, Australia. *BMC public health*, **1**, 952.
- Forouzanfar MH, Sepanlou SG, Shahrzad S, et al (2014). Evaluating causes of death and morbidity in Iran, global burden of diseases, injuries, and risk factors study 2010. *Arch Iran Med*, **17**, 304-320.
- Hanly PA, Sharp L (2014). The cost of lost productivity due to premature cancer-related mortality: an economic measure

- of the cancer burden. *BMC Cancer*, **14**, 224
- Insinga RP (2006). Annual productivity costs due to cervical cancer mortality in the United States. *Womens Health Issues*, **16**, 236-42.
- Jemal A, F. Bray, MM. Center, et al (2011). Global cancer statistics. *CA Cancer J Clin*, **61**, 69-90.
- Jemal A, Center MM, DeSantis C, et al (2010). Global patterns of cancer incidence and mortality rates and trends. *Cancer Epidemiol Biomarkers Prev*, **19**, 1893-907.
- Jonsson B, Wilking N (2007). The burden and cost of cancer. *Ann Oncol*, **18**, 8-22.
- Abachizadeh K, Mohagheghi MA, Mosavi-Jarrahi A (2011). Setting research priorities to reduce burden of cancer in Iran: an institutional experience. *Asian Pac J Cancer Prev*, **12**, 2365-70.
- Khorasani S, Rezaei S, Rashidian H, et al (2014). Years of potential life lost and productivity costs due to premature cancer-related mortality in Iran. *Asian Pac J Cancer Prev*, **16**, 1845-50.
- Kim JL, Cho KH, Park EC, et al (2013). A single measure of cancer burden combining incidence with mortality rates for worldwide application. *Asian Pac J Cancer Prev*, **15**, 433-9.
- Menzin J, Marton JP, Menzin JA, et al (2012). Lost productivity due to premature mortality in developed and emerging countries: an application to smoking cessation. *BMC Med Res Methodol*, **12**, 87.
- Naghavi M, Abolhassani F, Pourmalek F, et al (2009). The burden of disease and injury in Iran 2003. *Popul Health Metr*, **7**, 9-15.
- Ortiz-Ortiz KJ, Perez-Irizarry J, Marín-Centeno H, et al (2010). Productivity loss in Puerto Rico's labor market due to cancer mortality. *P R Health Sci J*, **29**, 241-9.
- Lozano R, Naghavi M, Foreman K, et al (2013). Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, **380**, 2095-2128.
- Rashidian H, Davoudi R, Ghiasvand R (2013). Prevalence and Incidence of premenopausal and postmenopausal breast cancer in Iran in 2010. *Basic Clinical Cancer Res*, **5**, 2-10.
- Rezaei S, Akbari Sari A, Arab M, et al (2015). Estimating economic burden of cancer deaths attributable to smoking in Iran in 2012. *J Res Health Sci*, **15**, 228-33.
- Song X, Quek RG, Gandra SR, et al (2015). Productivity loss and indirect costs associated with cardiovascular events and related clinical procedures. *BMC Health Serv Res*, **1**, 254.
- Taghavi A, Fazeli Z, Vahedi M (2012). Increased trend of breast cancer mortality in Iran. *Asian Pac J Cancer Prev*, **13**, 367-70.
- Torre LA, Bray F, Siegel RL, et al (2015). Global cancer statistics, 2012. *CA Cancer J Clin*, **65**, 87-108.