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Advanced cancer care in Europe: Equity and access.

Vision or reality?

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Barcelona, Spain,
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GART
Advanced Radiation Therapy

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OUTLINE

- EQUITY OF ACCESS vs EQUITY OF OUTCOMES
- SOME DATA TO ASSESS THE REALITY OF OUTCOMES
- ADVANCED CANCER TREATMENTS: BALANCING INNOVATION WITH EQUITY?
- SOCIO-ECONOMIC DIFFERENCES ARE A PROBLEM IN EU, BUT COULD HEALTH SERVICES HELP?
- THE ONLY WAY TO COPE WIH THE CHALLENGE IS ORGANIZING BETTER CANCER CARE IN EUROPE:
  - POLICIES IMPLEMENTED IN EU COUNTRIES
  - CCC AND ITS DIFFERENT APPROACHES IN EU COUNTRIES
- CONCLUDING REMARKS

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EQUITY OF ACCESS vs EQUITY OF OUTCOMES

Usually, equity is defined as fair access to health care, but it is relevant to think on two different levels of equity:

- **Equity of access** (to health care to all with equal need)
  - How need is defined: physician or patient.
  - There is a relevant role for health policy and healthcare organization
  - **Timely** access to the diagnostic tools required.
- **Equity of Outcomes**:
  - Strongly dependent on quality of care
  - A realistic approach to this objective may be *less unequal health outcomes* (Oliver, Mossialos, JECH, 2004)

WHO defined dimensions towards Universal Health coverage in 2030

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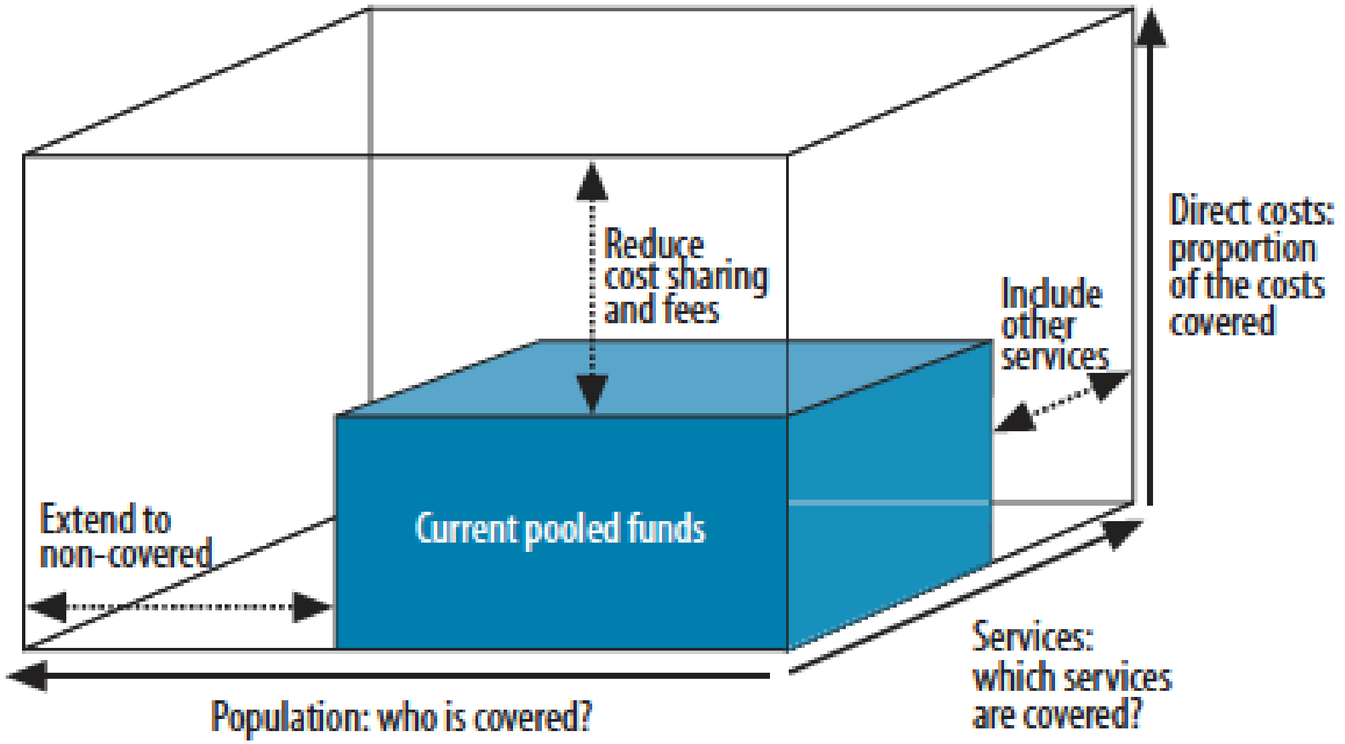
Fig. 1.2. **Three dimensions to consider when moving towards universal coverage**



CHALLENGES TO ACHIEVE A HIGH COVERAGE WITH GOOD QUALITY OF CARE

- **Fragmentation** of health services providers among different levels of care
- **Lack of coordination among specialists** that should be involved in the provision of multidisciplinary cancer care
- **Lack of standards** for the joint (multidisciplinary) treatment of patients
- **Lack of (quality) indicators** that make the quality of treatment transparent, measurable and thus possible to evaluate and improve

SOME DATA TO ASSESS THE REALITY OF EQUITY

Global expenditure in health care

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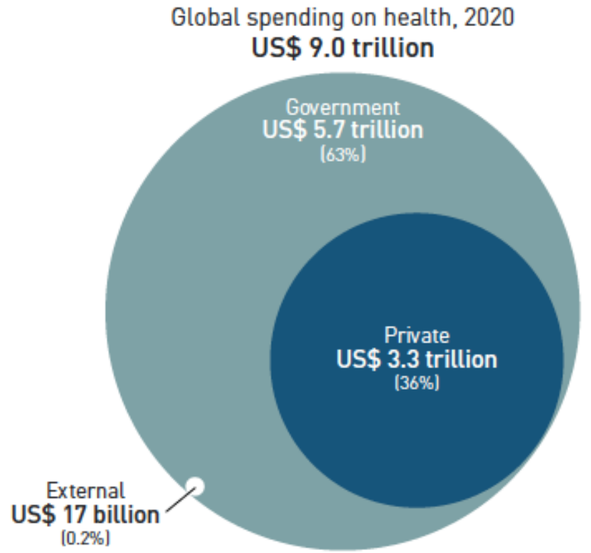
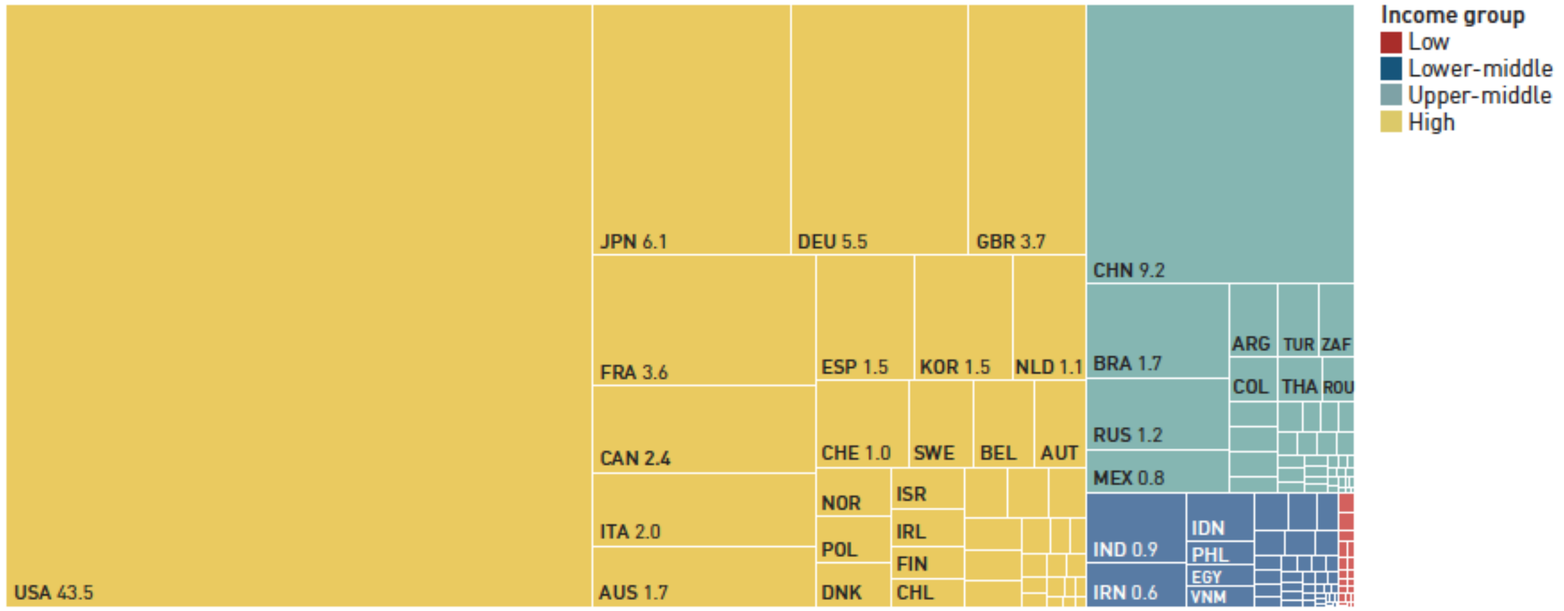
FIGURE 1.1 In 2020, global spending on health reached US$ 9 trillion



Data source: WHO Global Health Expenditure Database, 2022.

FIGURE 1.2 High income countries accounted for over 80% of health spending in 2020



Share of global spending on health, 2020 (%)

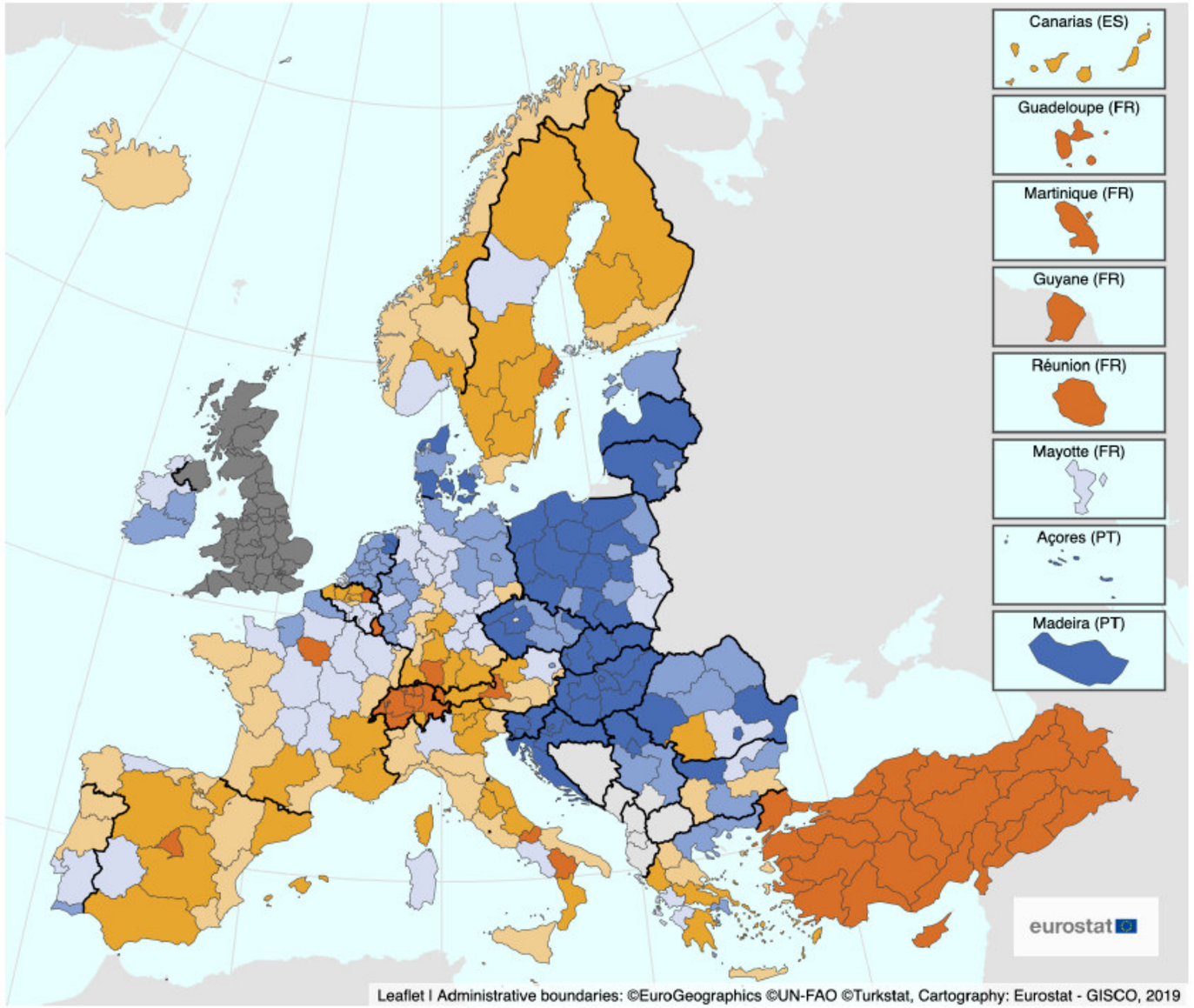
Data source: WHO Global Health Expenditure Database, 2022.

INCIDENCE (2010 and 2022) AND MORTALITY (2010 and 2020)
European countries

Age-standardised incidence (estimated) and mortality (observed) rates per 100 000 population, both sexes

Causes of death - standardised death rate by NUTS 2 region of residence

Geopolitical entity (reporting) / Time: **2020** Time frequency: **Annual** Unit of measure: **Rate** Sex: **Total** Age class: **Total**
International Statistical Classification of Diseases and Related Health Problems (ICD-10 2010): **Malignant neoplasms (C00-C97)**



Legend

- ≥ 107.75 to 205.53
- ≥ 205.53 to 218.86
- ≥ 218.86 to 234.67
- ≥ 234.67 to 250.28
- ≥ 250.28 to 268.56
- ≥ 268.56 to 339.97
- Data not available

OUTCOMES ARE NOT THE SAME, MEASURED BY 5-YEAR SURVIVAL

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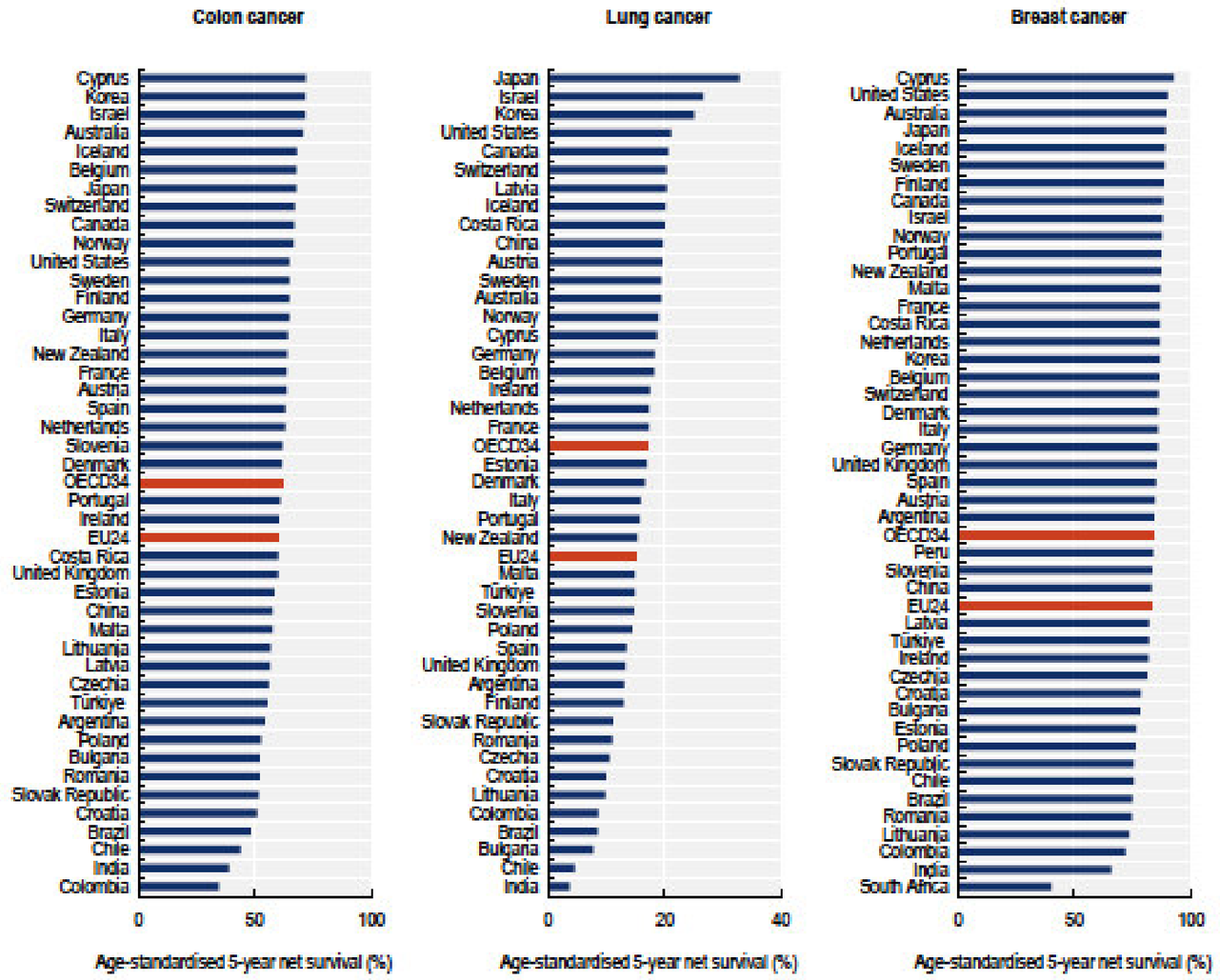
Age-standardised 5-year net survival (%) for colon, lung and breast cancer, 2010-14



Source: Allemani, C. et al. (2018[71]), "Global surveillance of trends in cancer survival 2000-14 (CONCORD-3): analysis of individual records for 37 513 025 patients diagnosed with one of 18 cancers from 322 population-based registries in 71 countries", https://doi.org/10.1016/s0140-6736(17)33326-3. See https://stat.link/pa15yx.

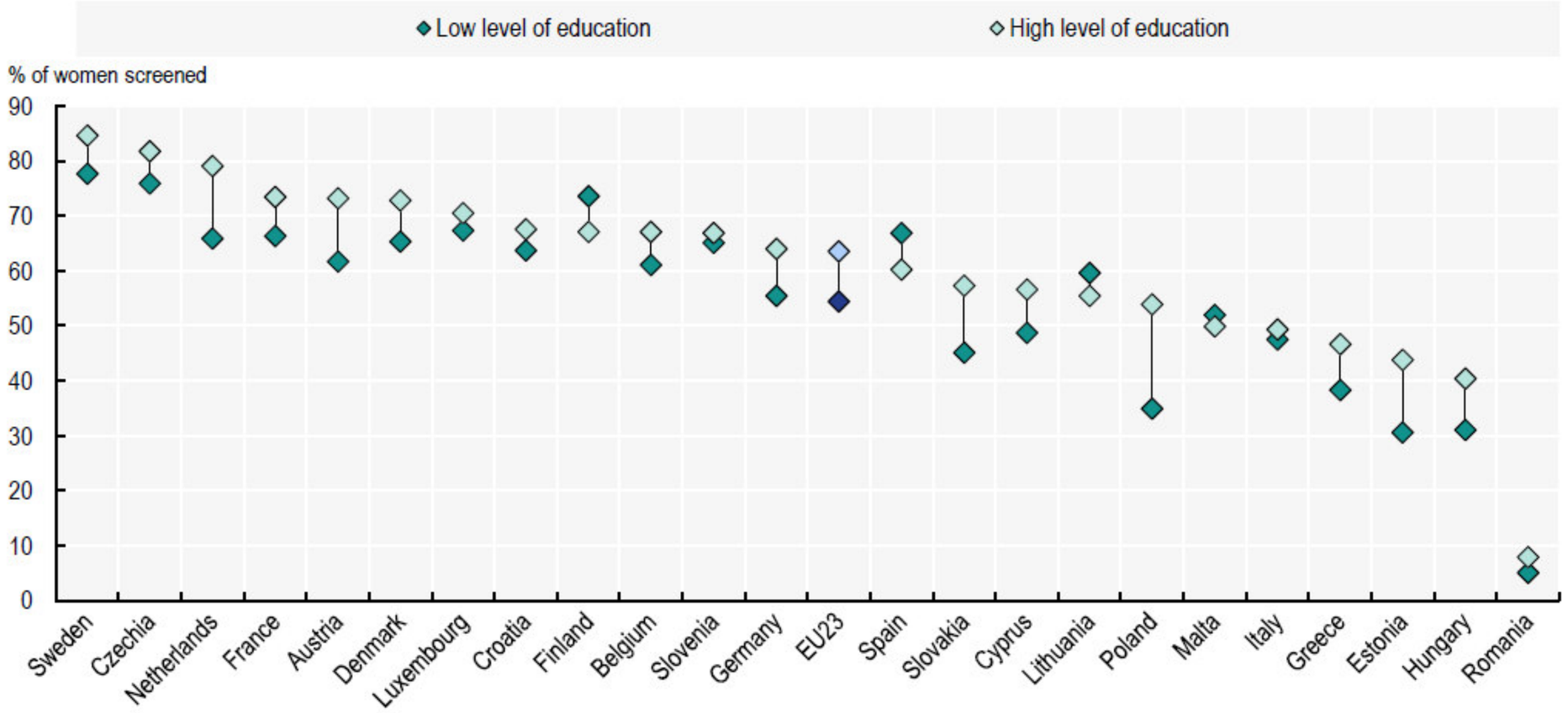
OECD Health Policy Studies

Tackling the Impact of Cancer on Health, the Economy and Society

Paris, OECD, 2024

Figure 1.9. Women with low education levels have a lower likelihood of receiving a mammogram in 19 EU+2 countries

Indirectly age-standardised probability of having had a mammogram, by country and education level

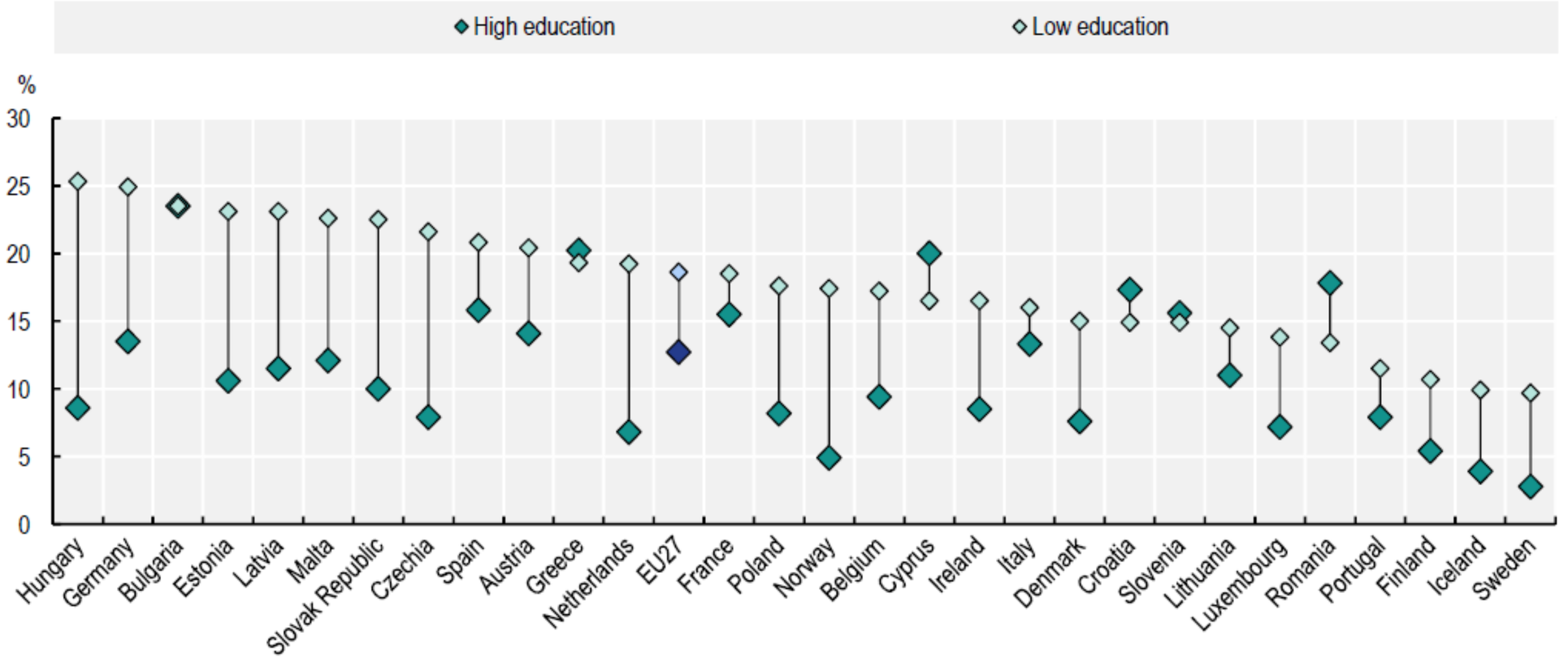


Note: Analysis based on 16 035 observations of women aged 50-74 living in a private household in 25 countries. Probabilities are based on indirect age standardisation. Education level is built according to the International Standard Classification of Education (ISCED), with ISCED 0-2 for low level of education and ISCED 4-6 for high level of education.

Source: Survey of Health, Ageing and Retirement in Europe (wave 8).

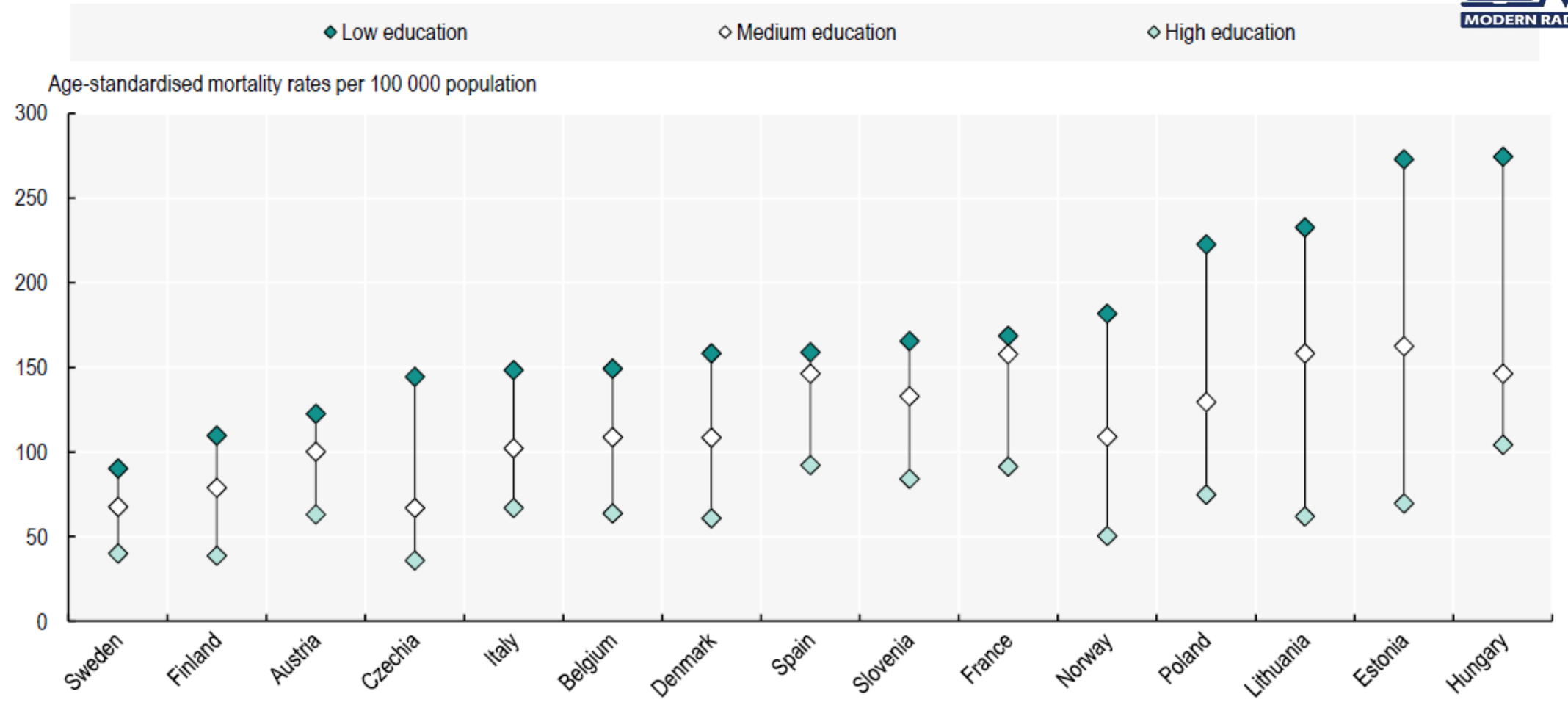
Figure 3.2. The proportion of daily cigarette smokers is 46% higher among people with low levels of education compared to those with high education levels

Percentage of people aged 15+ who smoke cigarettes on a daily basis, 2019

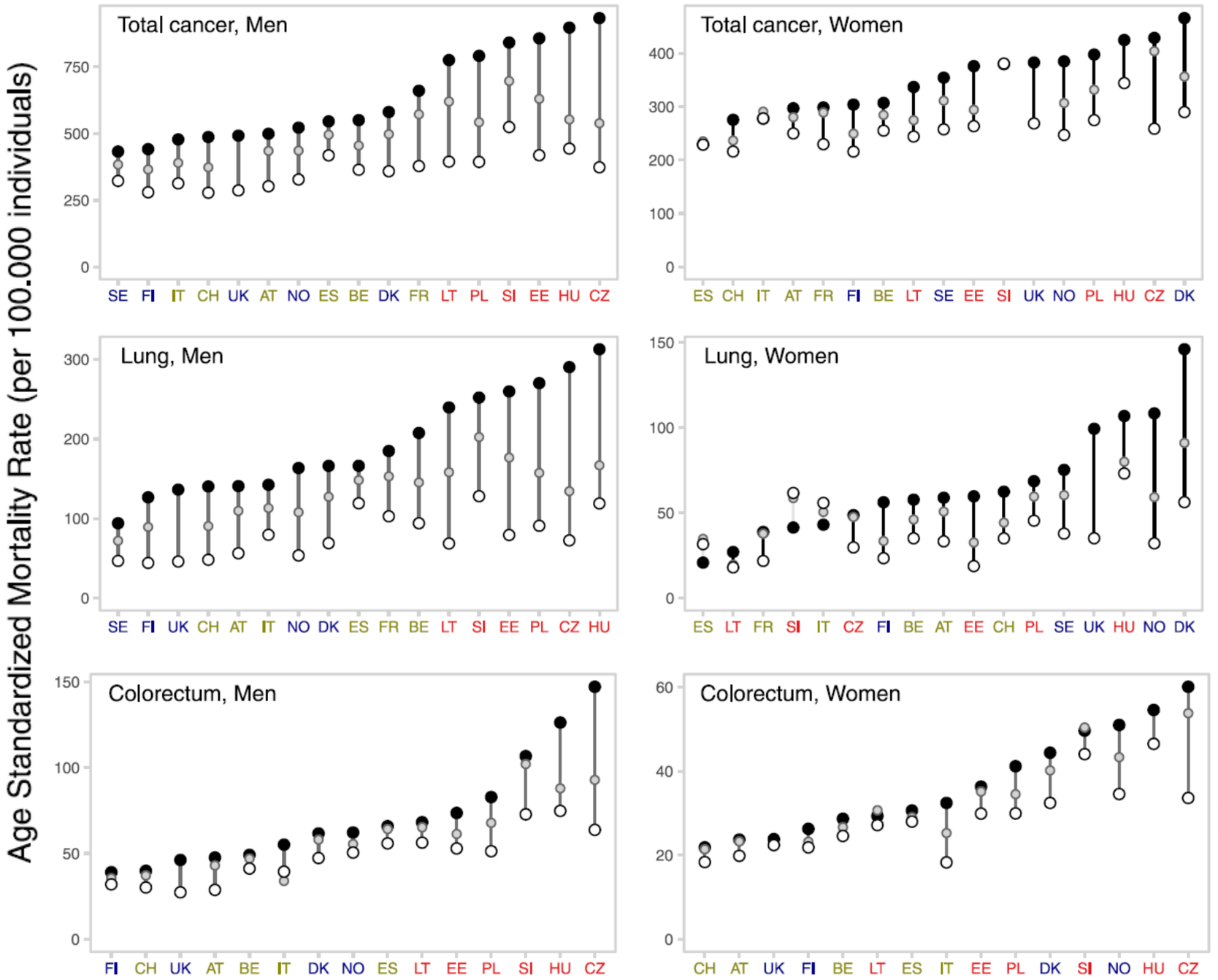


Note: EU27 is a weighted average. Low education is defined as people who have not completed secondary education (International Standard Classification of Education (ISCED) 0-2), whereas high education is defined as people who have completed tertiary education (ISCED 5-8).
Source: Eurostat (2023), "Daily smokers of cigarettes", European Health Interview Survey.

Figure 2.12. Lung cancer mortality rates among men vary with education level in all countries



Note: Caution is recommended when interpreting results, as the data are based on predictions for 2015-19, with different methodology across countries and varying level of population coverage.
Source: Preliminary findings from the EUCanIneq study.



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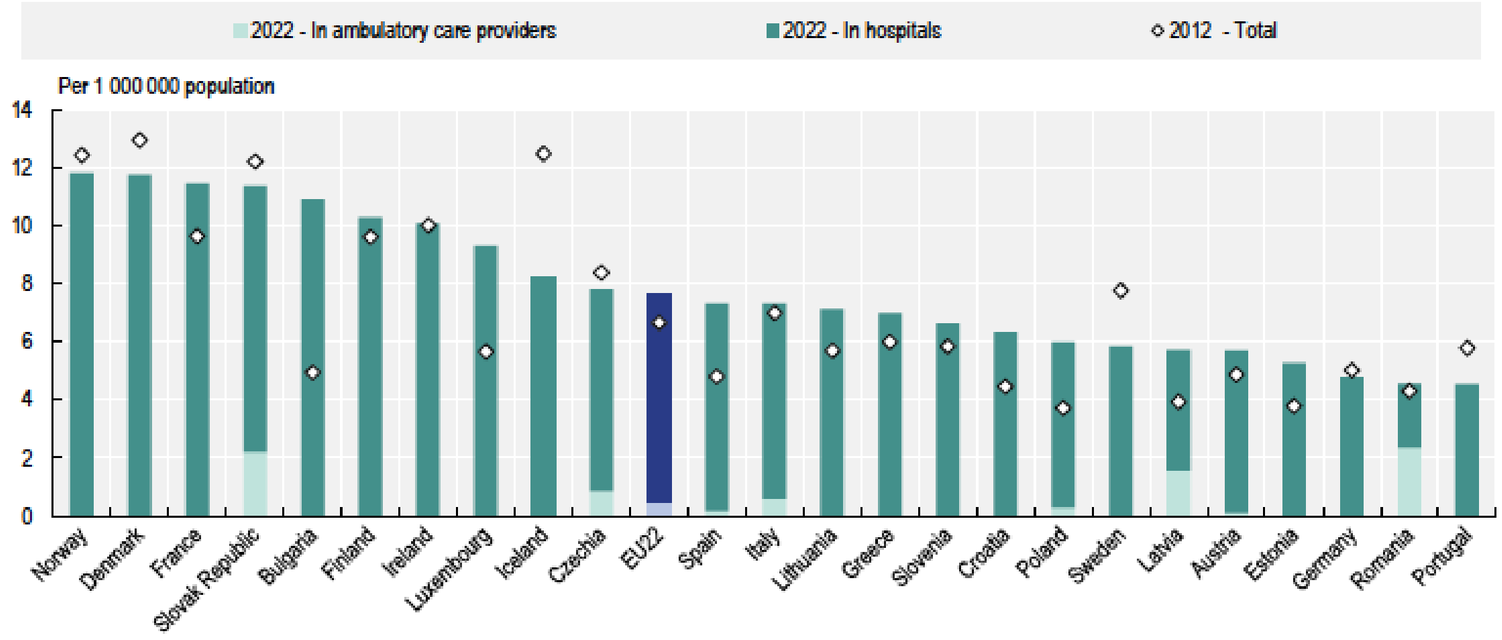
Socioeconomic inequalities in cancer mortality between and within countries in Europe: a population-based study

Salvatore Vaccarella,[a,*] Damien Georges,[b] Freddie Bray,[a] Ophira Ginsburg,[a,c] Hadrien Charvat,[a] Pekka Martikainen,[d,e] Henrik Brønnum-Hansen,[f] Patrick Deboosere,[b] Matthias Bopp,[f] Mall Leinsalu,[g,h] Barbara Artnik,[i] Valentina Lorenzoni,[m] Esther De Vries,[n] Michael Marmot,[o] Paolo Vineis,[p] Johan Mackenbach,[q] and Wilma Nusselder[q]

Fig. 1: Educational inequalities between and within countries in total cancer mortality, and for type-specific cancers, in Europe, by sex, for the last period of observation. Footnote: in each panel, countries are ordered (from left-to-right) according to an increasing level of ASMR for lower-educated.
The period of observation varies between 1998 and 2015, depending on the country. North; West/South; Baltic/Central/Eastern.

Figure 5.9. Volumes of radiation therapy equipment per population vary three-fold across EU+2 countries



Notes: Data refer to the nearest available year. Radiation therapy equipment includes linear accelerators, Cobalt-60 units, Caesium-137 therapy units, low to orthovoltage X-ray units, high-dose and low-dose rate brachytherapy units and conventional brachytherapy units.
Source: OECD Health Statistics 2023, https://doi.org/10.1787/health-data-en.

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ADVANCED CANCER TREATMENTS :

HOW TO FIND THE BALANCE BETWEEN INNOVATION AND EQUITY?

ROLE OF RECENTLY INTRODUCED TECHNOLOGY ON THE ORGANIZATION OF HEALTH SERVICES

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Effect of patient choice and hospital competition on service configuration and technology adoption within cancer surgery: a national, population-based study

Ajay Aggarwal, Daniel Lewis, Malcolm Mason, Arnie Purushotham, Richard Sullivan, Jan van der Meulen

Summary

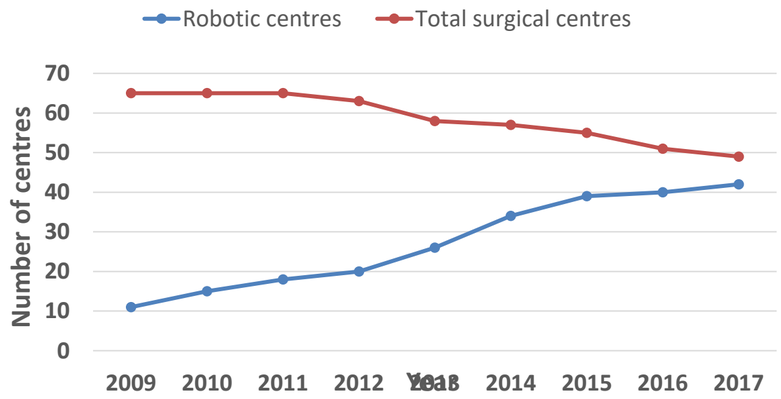
Background There is a scarcity of evidence about the role of patient choice and hospital competition policies on surgical cancer services. Previous evidence has shown that patients are prepared to bypass their nearest cancer centre to receive surgery at more distant centres that better meet their needs. In this national, population-based study we investigated the effect of patient mobility and hospital competition on service configuration and technology adoption in the National Health Service (NHS) in England, using prostate cancer surgery as a model.

Methods We mapped all patients in England who underwent radical prostatectomy between Jan 1, 2010, and Dec 31, 2014, according to place of residence and treatment location. For each radical prostatectomy centre we analysed the effect of hospital competition (measured by use of a spatial competition index [SCI], with a score of 0 indicating weakest competition and 1 indicating strongest competition) and the effect of being an established robotic radical prostatectomy centre at the start of 2010 on net gains or losses of patients (difference between number of patients treated in a centre and number expected based on their residence), and the likelihood of closing their radical prostatectomy service.

Lancet Oncol 2017; 18: 1445–53
Published Online
October 3, 2017
http://dx.doi.org/10.1016/S1470-2045(17)30572-7
See Comment page 1424

Department of Health Services Research & Policy (A Aggarwal MD, Prof J van der Meulen PhD) **and Department of Social and Environment Health Research** (D Lewis PhD), **London School of Hygiene & Tropical Medicine, London, UK; Clinical Effectiveness Unit, Royal**

- Several countries have introduced patient choice policies
- Limited empirical evidence that choice has influenced where patients receive treatment
- No evidence that competition has improved quality of patient care
- Era of centralisation of cancer services
- Health care market considered a driver of technology adoption but no evidence how this manifests



ADOPTION OF ROBOTICS: **LESSONS FOR HEALTH SERVICES ORGANIZATION**

- Competition **driver** for health system change
- **Market** operating in the **absence of performance metrics**
- Advanced technology and reputation potential drivers of choice
- Providers integrate technology to attract new patients and preserve market share (often at a financial loss)

- Aggarwal et al, Lancet Oncol, 2017

ADOPTION OF INNOVATIONS:
USER PERSPECTIVE

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People are not passive recipients of innovations. Rather (and to a greater or lesser extent in different persons), they seek innovations, experiment with them, evaluate them, find (or fail to find) meaning in them, develop feelings (positive or negative) about them, challenge them, worry about them, complain about them, "work around" them, gain experience with them, modify them to fit particular tasks, and try to improve or redesign them—often through dialogue with other users. This diverse list

THE DISSEMINATION OF HYPOFRACCTIONATED TREATMENT FOR BREAST CANCER MAY BE AN EXAMPLE

Users of evidence selectively interpret and use knowledge as it serves its own purposes, fits their unique situation and reflects their relations with their practicing community (1)

Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations

TRISHA GREENHALGH, GLENN ROBERT, FRASER MACFARLANE*, PAUL BATE, and OLIVIA KYRIAKIDOU*

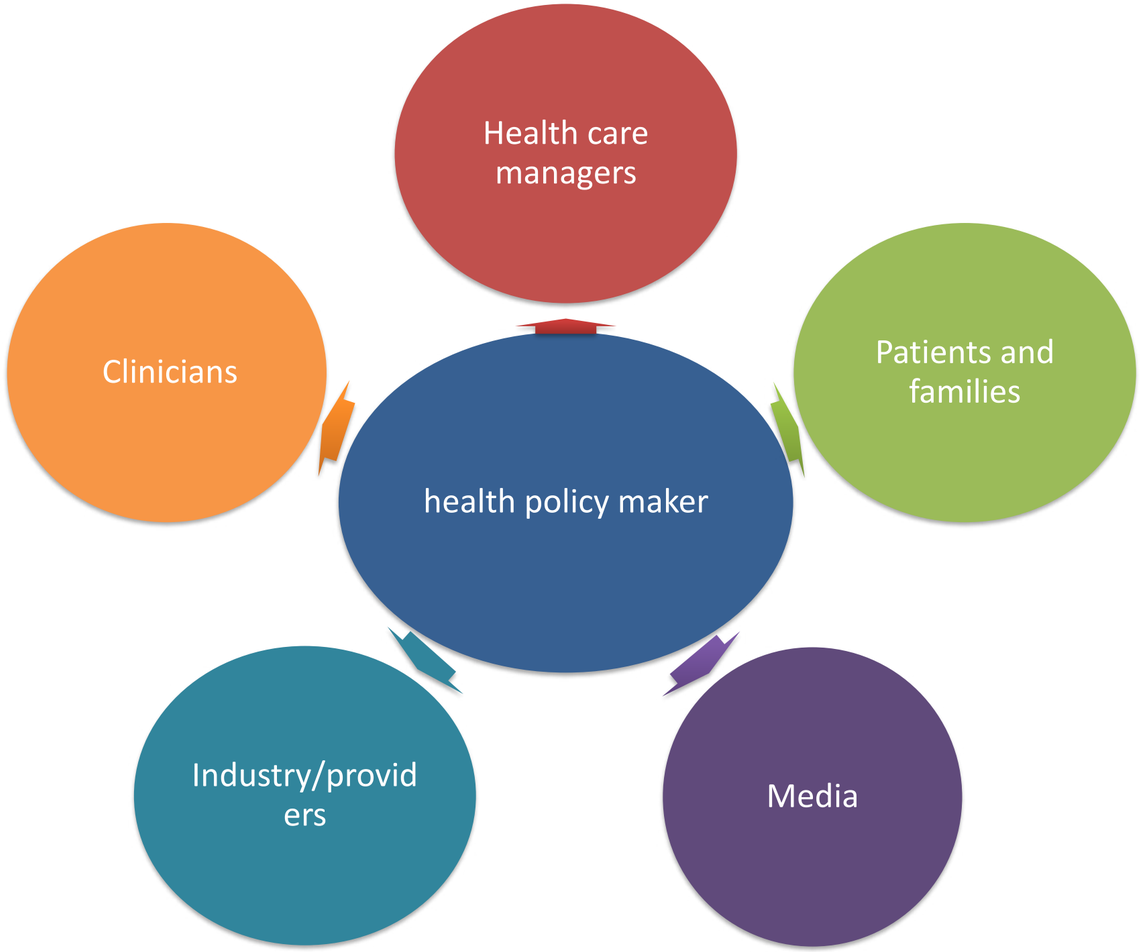
(1) Van der Ven & Jonhson. Acad Manage Rev 2006

ADOPTION OF INNOVATIONS: **ORGANIZATIONAL PERSPECTIVE**

- Large: size could be a proxy for other factors
- Mature
- Specialization: with functional differentiation among units and highly specialized knowledge (associated to readiness to value and accept innovations)
- Decentralized decision-making: autonomous decision making
- Resources available to be channelled to new projects
- Leadership

(1) Greenhalgh. How to implement evidence based medicine. Wiley, 2018.

AND THE HEALTH DECISION MAKER….



Decision makers' choices must fit in the narrow gap between a rock (Regional CEO of Health Care system or the Department of Economy) and a hard place (clinicians' needs and demands).

HEALTH CARE SYSTEMS FACING INNOVATIONS: **MORE INNOVATIONS THAN CAPACITY TO PAY FOR THEM**

- The supply of innovation and good ideas (proven) exceeds the capacity of the system to use (finance) them

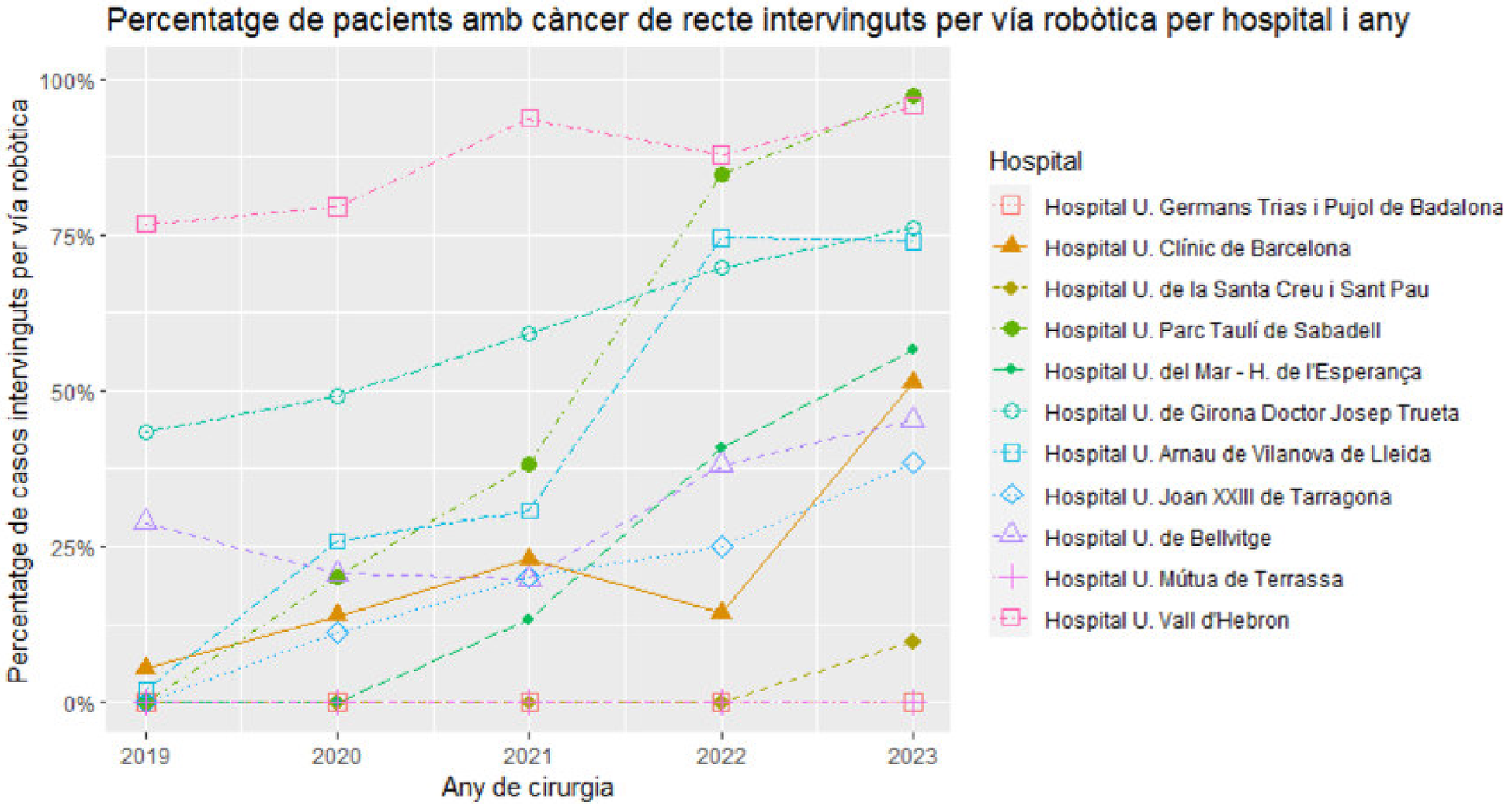
- Implementation of an innovation is therefore ‘rationed’ (prioritised) by policy makers according to factors like:
  - Cost
  - Potential resource use
  - Credibility of the clinician or manager who proposes it
  - Perceived opportunities by decision maker

RESEARCH USE IN HEALTH CARE AND POLICY MAKERS: HELPFUL BUT NOT NECESSARILY PROVIDES THE ANSWER WITHOUT CONTROVERSY

- Research is mostly used as a support a course of action that the decision maker was intended to take or to delay a decision
- Policy making is much about values as it is about evidence
- The consequence of all these factors is the lack of equity of access when considering innovations

Weis C. The many meaning of research utilization. Public Admin Rev 1979; 39:426
Greenhalgh T. How to implement evidence based medicine. Oxford: Wiley, 2018

WHAT ABOUT EQUITY? DISSEMNIATION OF NEW TECHNOLOGY, SPECIALLY IN EARLY STAGES IS UNEVENLY DISTRIBUTED



S'han exclós els pacients amb tipus d'operació escisió local, exenteració pèlvica,altres tipus i no consta, els pacients amb tipus de vía d'accés desconegut i els pacients amb la localització del tumor recte-sigma o no consta.

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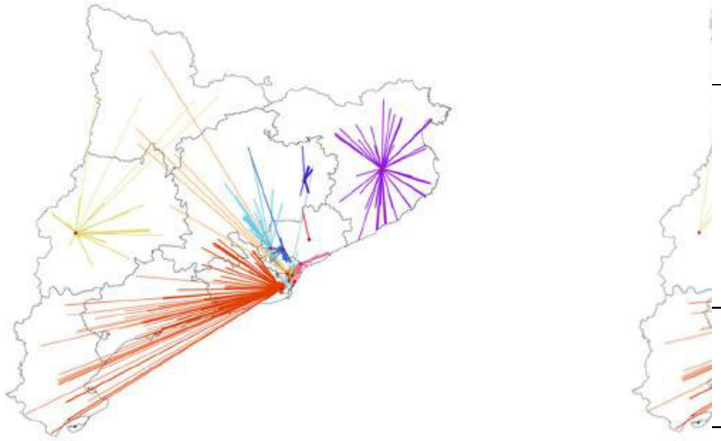
SOCIO-ECONOMIC DIFFERENCES ARE A PROBLEM IN EU, BUT COULD HEALTH SERVICES HELP?

EVALUATING DISTANCE TO THE REFERENCE HOSPITAL AND OUTCOMES PANCREATIC CANCER WITH RADICAL SURGERY



(a)

Figure 2. Distribution of pancreatic cancer cases acco
centers in Catalonia. (a) All cases of pancreatic ca
longest distances (>90th%) between the patients' hon
represents a different reference center.

		Univariate Analysis			Multivariate Analysis		
Variables	n	HR	95% CI	*p*-Value	HR	95% CI	*p*-Value
TNM staging							
0/I	201	1		<0.001	1		<0.001
II	334	1.01	0.71, 1.43	0.97	1.04	0.73, 1.48	0.81
III	761	1.36	1.00, 1.85	0.047	1.72	1.26, 2.34	0.001
IV	136	3.61	2.55, 5.10	<0.001	4.77	3.34, 6.81	<0.001
Non-stageable	23	1.05	0.45, 2.45	0.91	0.85	0.36, 1.99	0.70
Textbook outcome							
Yes	529	1			1		
No	926	1.58	1.30, 1.93	<0.001	1.46	1.20, 1.79	<0.001
Distance from patient home to reference center							
0–10 km	1040	1		0.70	1		0.044
11 km to <90th%	273	1.09	0.87, 1.37	0.47	1.08	0.84, 1.38	0.55
≥90th%	142	0.95	0.70, 1.30	0.75	0.67	0.46, 0.97	0.034
Income							
High–medium	379	1		<0.001	1		<0.001
Low	1006	1.55	1.23, 1.96	<0.001	1.28	1.00, 1.63	0.047
Very low	70	4.69	3.23, 6.81	<0.001	5.24	3.58, 7.67	<0.001

Socioeconomic Status and Distance to Reference Centers for Complex Cancer Diseases: A Source of Health Inequalities? A Population Cohort Study Based on Catalonia (Spain)

Paula Manchon-Walsh [1,2,*], Luisa Aliste [1,2], Josep M. Borràs [1,2], Cristina Coll-Ortega [1], Joan Casacuberta [3],

Int J Environmental Res Publ Health, 2022

EVALUATING DISTANCE TO THE REFERENCE HOSPITAL AND OUTCOMES
BY age, stage, distance and SES. RECTAL CANCER

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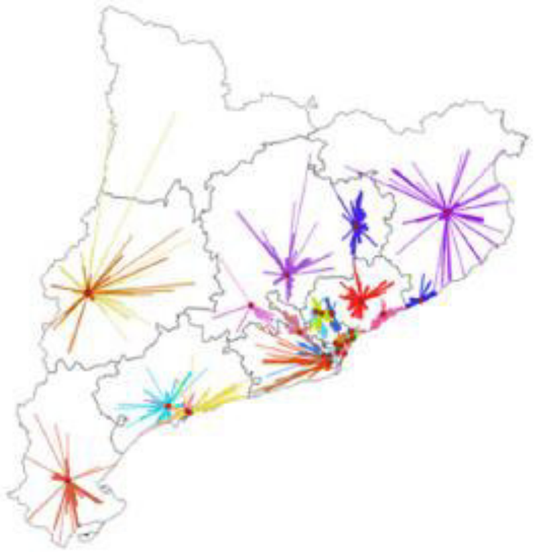

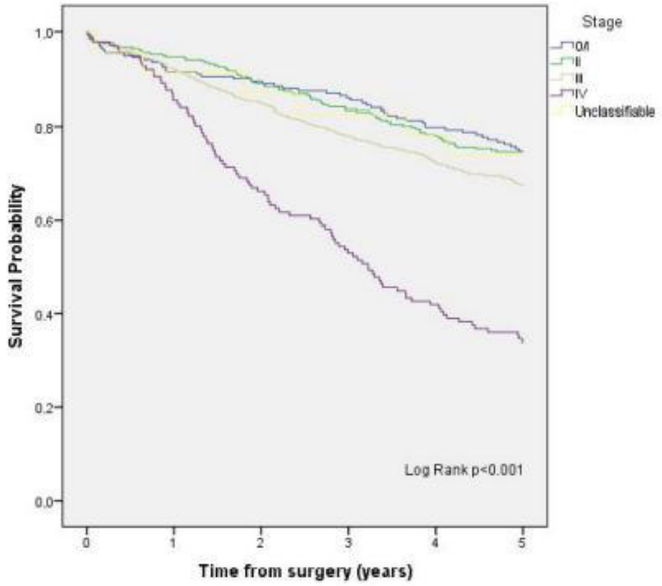

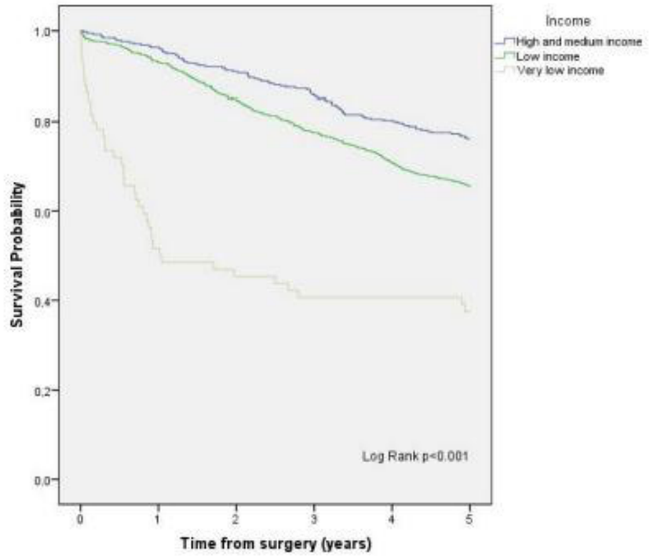

(a)

Figure 3. Distribution of rectal cancer cases according to locations of patients' homes and surgical centers in Catalonia. (**a**) All cases of rectal cancer (N = 1455). (**b**) Selection of cases with the longest distances (>90th%) between the patients' homes and the reference centers (N = 142). Each color represents a different reference center.

Socioeconomic Status and Distance to Reference Centers for Complex Cancer Diseases: A Source of Health Inequalities? A Population Cohort Study Based on Catalonia (Spain)

Paula Manchon-Walsh [1,2,*], Luisa Aliste [1,2], Josep M. Borràs [1,2], Cristina Coll-Ortega [1], Joan Casacuberta [3],

Int J Environmental Res Publ Health, 2022

SOCIO-ECONOMIC DIFFERENCES ARE A PROBLEM IN EU, BUT COULD HEALTH SERVICES HELP?

- Access to public health services should be equal according to need medically defined
- Quality of care should be delivered independent of social background of the patients

- But… we cannot arrange the existing social problems beyond the health care system, only mitigate.

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THE ONLY WAY TO COPE WITH THE CHALLENGE OF MAKING ACCESSIBLE ADVANCED CANCER CARE TO ALL IS ORGANIZING BETTER CANCER CARE IN EUROPE

WHAT COULD IT BE DONE?

- ELECTRONIC CLINICAL DECISION TOOLS
- IMPROVED REFERRAL FROM PRIMARY HEALTH CARE: IMPROVING EARLY ACCESS TO CANCER DIAGNOSIS
- ENCOURAGING THE ENTRY OF BIOSIMILARS AND GENERICS
- INCREASING ACCESS TO TARGETED TEHRAPIES AND COMPANION DIAGNOSTICS
- ESTABLISHING COMEPREHENSIVE CANCE CENTRES (CCC)

Box 1.3. Selected innovative or effective policy actions to improve cancer care

Early diagnosis and access to effective treatment are crucial elements to give patients the best chance for survival from a cancer. Some of the policies implemented by OECD countries to improve quality of care include:

Electronic clinical decision support tools (eCDSTs) in cancer: The diagnosis of cancer in primary care can be complex and challenging as patients can present with non-specific symptoms (Astin et al., 2011[15]; Chima et al., 2019[16]). eCDSTs use epidemiological data, symptoms and test results to improve cancer diagnosis (Chima et al., 2019[16]; OECD, 2024[4]). Information on the patient is entered into the eCDST by the GP, or automatically populated from the patient's electronic health record. Based on an algorithm, the eCDST then produces recommendations, prompts, or alerts for the GP to consider (Chima et al., 2019[16]).

Improved referral from primary care through to specialist oncology: Several countries such as Denmark, Ireland, Latvia, Lithuania, Poland, Slovenia and Sweden have developed fast track referral mechanisms (OECD, 2024[4]). Latvia introduced fast-track access for people with cancer (called the green corridor) in 2016. It is paid in full by the state budget and aims to streamline diagnosis and treatment decisions for suspected cancer cases by requiring specialist consultation and diagnostic examination within ten working days of the date of referral (OECD, 2024[4]). Access to cancer care improved, and the proportion of people diagnosed at early stages increased from 50% in 2015 to 55% in 2017 (OECD, 2023[17]; OECD, 2024[4]).

Encouraging the entry and use of generics and biosimilars: When the originator product has gone off patent or lost market exclusivity, the use of generics and biosimilars is becoming increasingly important in lowering prices for oncology treatments (OECD, 2024[4]). Nevertheless, there are still important country differences in the proportion of biosimilars being reimbursed. The mean time from EMA approval to public reimbursement/coverage of biosimilars also exhibited great variation between countries.

Increasing access to targeted therapies: To be able to effectively use new, targeted treatments, governments need to ensure access to their companion diagnostic. A companion diagnostic identifies whether a patient has a certain genetic feature, and would benefit from a specific targeted treatment. Fewer than half of EU countries currently have an automatic link between the coverage/reimbursement decision for a medicine and its companion diagnostic, meaning that it is possible that a treatment is covered by insurance while its companion diagnostic is not (Hofmarcher, Berchet and Dedet, 2024[18]).

Establishing Comprehensive Cancer Centres (CCCs): CCCs, which combine comprehensive, multidisciplinary care with research and education, can provide high-quality cancer care. In Europe, the Organization of European Cancer Institutes (OECI) and the European Academy of Cancer Sciences have established complementary quality accreditation systems to test the clinical and research excellence of CCCs (Oberst, 2019[19]). A benefit of these centres is increased collaboration in innovative clinical trials. For example, in Finland, four CCCs are working together on a clinical trial to determine the efficacy and toxicity of targeted anticancer drugs (OECD, 2023[20]; ClinicalTrials.gov, 2023[21]).

5. ENSURING HIGH STANDARDS IN CANCER CARE

Europe's Beating Cancer Plan will seek to ensure that people in the EU have the right to access affordable, preventive and curative healthcare of good quality, as called for under the European Pillar of Social Rights[54]. High-quality cancer care depends on a number of factors such as a high- quality workforce working in multidisciplinary teams, on timely access to specialised cancer services providing optimal and quality assured treatment, as well as the availability of essential medicines and innovation.

5.1. Delivering higher-quality care

When it comes to accessing high-quality cancer care, and particularly for timely diagnosis and treatment, patients are still faced with substantial differences in the standards of care, leading to unacceptable disparities across the EU. For instance, survival rates following treatment for breast cancer vary by 20% between countries and the five- year survival for colon cancer ranges from 49% to 68%[55].

Flagship 5: The Commission will establish, by 2025, an **EU Network** linking recognised National **Comprehensive Cancer Centres** in every Member State[56]. It will facilitate the uptake of quality-assured diagnosis and treatment, including training, research and clinical trials across the EU. This cross-border collaboration will improve patients' access to high-quality diagnostics and care and the latest innovative treatments. It can also help with patient mobility to ensure adequate treatment for patients with complex conditions. A new 'EU Cancer Treatment Capacity and Capability Mapping' project will help to map and share the different capabilities and expertise available across the EU.

This action will help deliver higher-quality care and reduce inequalities across the EU, while enabling patients to benefit from diagnosis and treatment close to home. The Cancer Plan aims to ensure that **90% of eligible patients** have access to such **centres by 2030**.

With this flagship initiative

→

This means we have to focus on:

- Multidisciplinary tumor-specific teams
- Patient pathways
- Quality indicators
- Continuous improvement process

Rationale for these objectives:

The organization of the delivery of cancer care matters¡¡

(survival and quality of life)

Comprehensive Cancer Centre (CCC)

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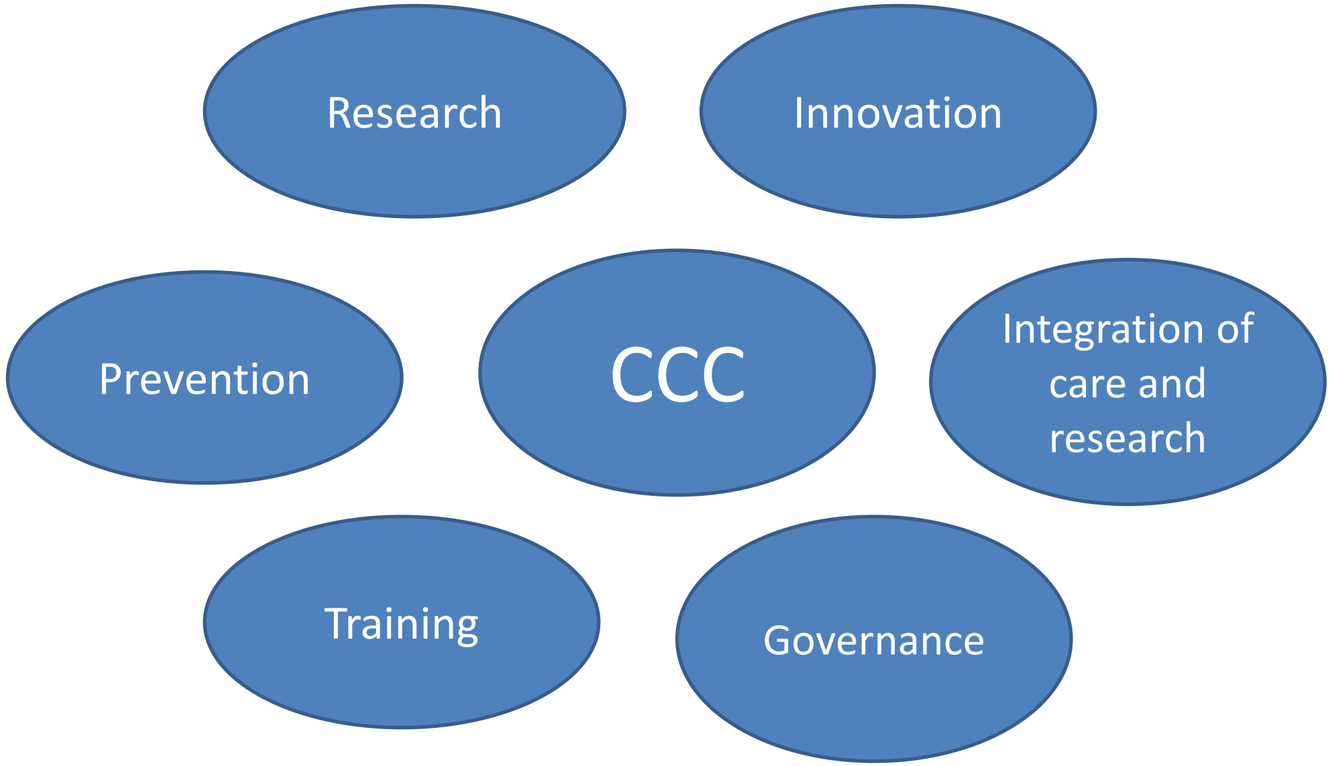
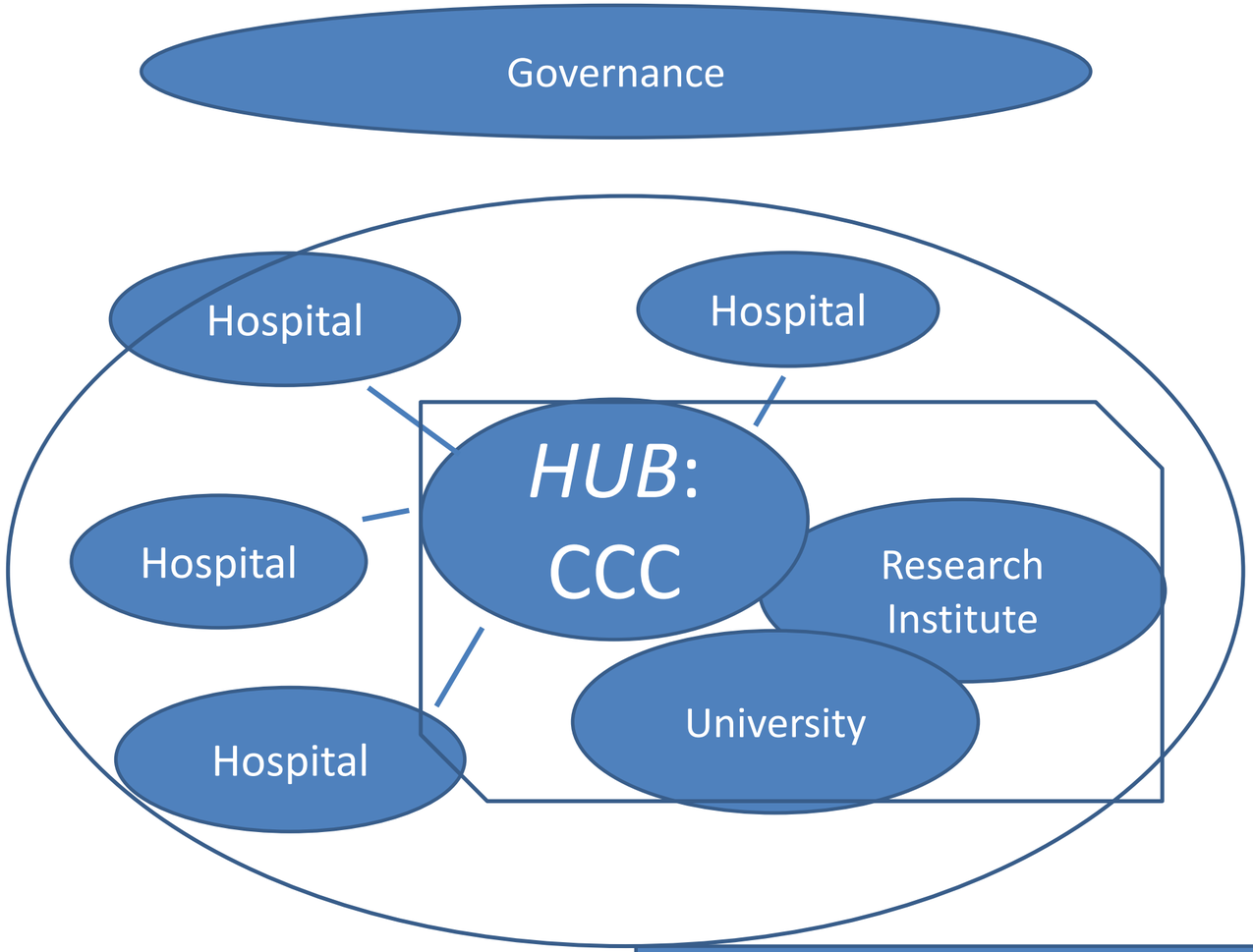


- Transdisciplinary
- Partners
- Institutional agreements
- Organizational capacity
- Involvement of patients in research and care

Impact on the catchmet area:
Networks y Clinical Pathways (CCCN)

Networks: *Hub and Spoke*



Greements between hospitals: formal agreement

Integration with Research Institutes

University Hospital

Clinical pathways for the most frequent tumors

Clinical Pathways

POLICY PROPOSAL: REIMBURSEMENT IN COMPLEX CANCER SURGERY AND RADIOTHERAPY ALSO MATTERS

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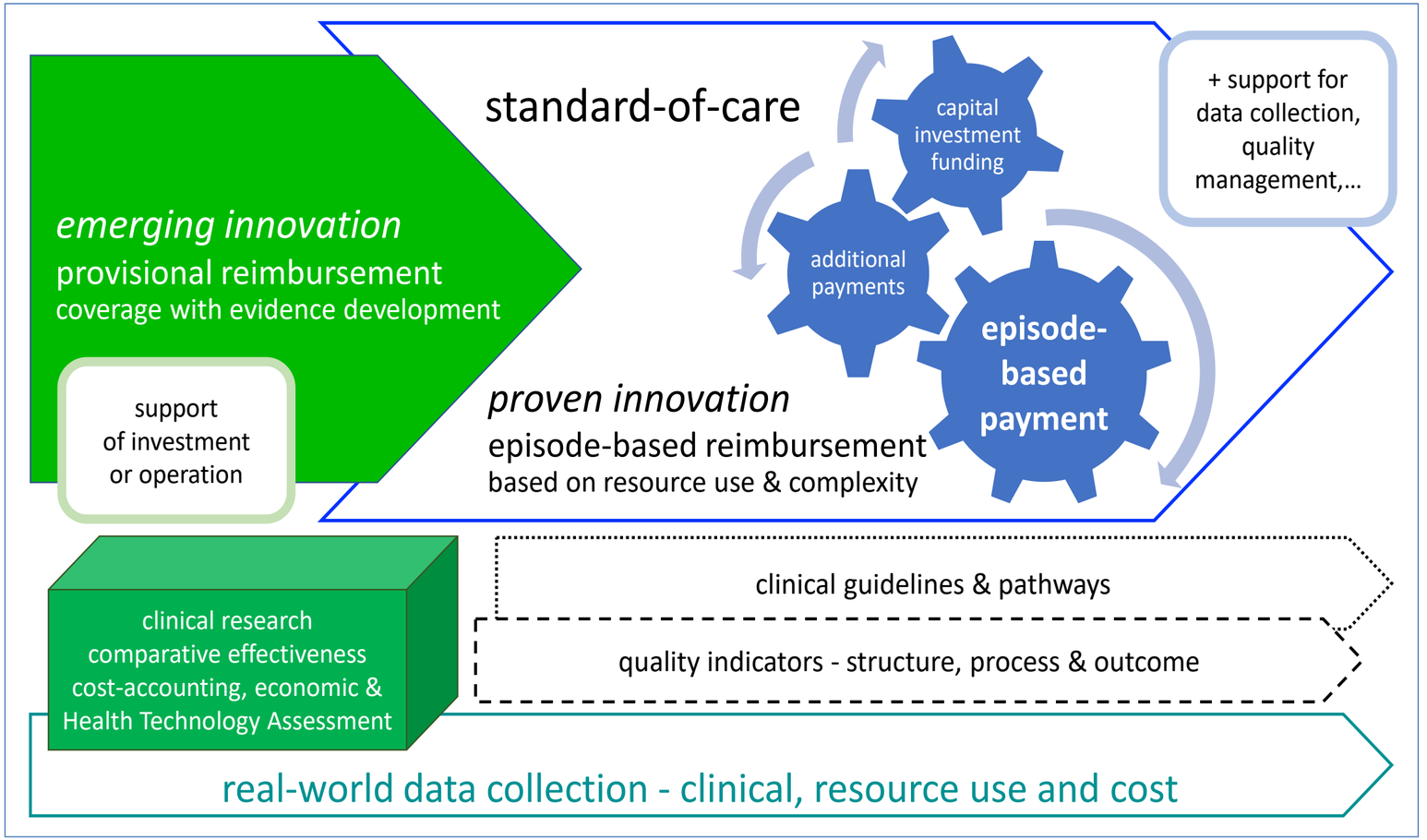

- **Time-bound episodes of care as unit for reimbursement**
- **Emerging innovation: Coverage with evidence development**

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Review Article

Innovation, value and reimbursement in radiation and complex surgical oncology: Time to rethink

Josep M. Borras [a,b,c,*], Julieta Corral [b,c], Ajay Aggarwal [d], Riccardo Audisio [e], Josep Alfons Espinas [b,c], Josep Figueras [f], Peter Naredi [g], Dimitra Panteli [h], Nicolas Pourel [i], Joan Prades [b,c], Yolande Lievens [j]

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CONCLUDING COMMENTS

- EQUITY AND ACCESS ARE TWO VARIABLES THAT SHOULD COMBINE TO OFFER A HIGH-QUALITY PUBLIC HEALTH DELIVERY OF CANCER CARE
- INNOVATION IS ALWAYS, SPECIALLY IN ITS EARLY STAGES, UNEVENLY DISTRIBUTED AND THE CONSEQUENCE IS DIFFERENCES IN ACCESS
- ORGANIZATION OF THE DELIVERY OF CANCER CARE (AND DIAGNOSIS) IS CRITICALLY ASSOCIATED TO THE OUTCOMES OF HEALTH CARE
- EVIDENCE IS NECESSARY BUT ONLY IS ONE ELEMENT OF THE DECISION:
    - CONTROVERSY IS ALWAYS PRESENT

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CONCLUDING COMMENTS

- CLINICIANS AND POLICY MAKERS INTERPRETED THE EVIDENCE ACCORDING TO THEIR PRE-EXISTING VALUES

- POLICY MAKING ABOUT INNOVATIONS IS ALWAYS A MATTER OF COMPETING PRIORITIES: WHO IS GOING TO SET THE PRIORITY AND RESOURCES AVAILABLE.

  - CONTEXT MATTERS¡

- BETTER INTERACTION AMONG CLINICIANS, MANAGERS AND POLICY MAKERS REQUIRE SHARED UNDERSTANDING ABOUT DIFFERENT PERSPECTIVES AND ABOUT CRITERIA FOR PRIORITIES

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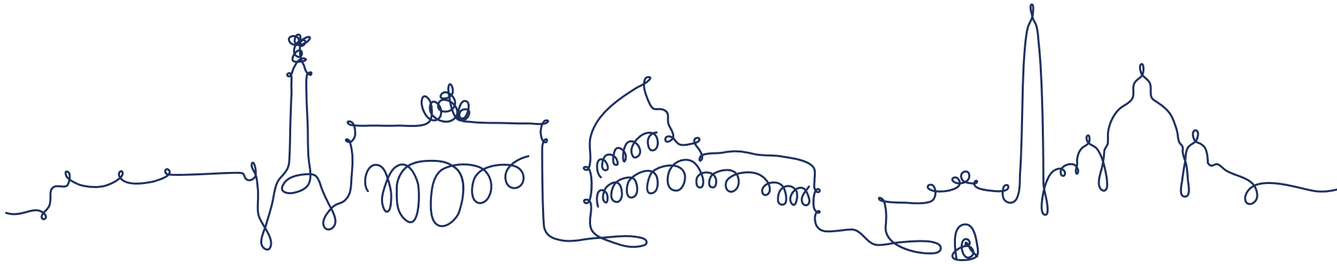

THANK YOU

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MRO.35: Equity and research in oncology. The subtle balance between personalized medicine and accessibility to care

26-27-28 OCTOBER 2025 - Fondazione Policlinico Universitario A. Gemelli IRCCS

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