Why is appropriate healthcare inaccessible for many European breast cancer patients?

Abstract

Inappropriate reimbursement and funding rules and regulations act as disincentives to best breast cancer care or, at worst, hinder best care in Europe. This problem was the focus of the 12th European Breast Cancer Conference manifesto, discussed during the conference, which was held virtually due to the COVID-19 pandemic. In general, reimbursement rules, established years ago, fail to evolve with advances in medicine and treatments such as outpatient (ambulatory) care rather than inpatient hospital admission, higher use of oral anti-cancer drugs rather than day-hospital intravenous administration, risk reducing surgery for BRCA mutation carriers, or moderately hypofractionated post-operative radiation therapy. It is recognized, that no one solution can solve healthcare reimbursement problems in all EU countries, and unfortunately, these problems cannot all be tackled at the European level. Each country will have to find its own solution. However, all European cancer patients deserve evidence-based treatment today, according to high-quality guidelines. Clinicians and patients are not asking for something that would be more expensive, rather they want to achieve fairer and more appropriate use of healthcare funding. Indeed, in many situations, these changes would result in more cost-effective healthcare that can better be aligned with optimal clinical practice guidelines.

Highlights

- Reimbursement rules for breast cancer care are not in line with evidence-based medicine and clinical practice guidelines.
- Reimbursement rules hamper access to treatments such as outpatient (ambulatory) care rather than inpatient or day-hospital admission, risk reducing surgery for BRCA mutation carriers, or moderately hypofractionated post-operative radiation therapy.
- Direct involvement of patients, educating patients on what they really should need to demand, and seeking their assistance in effecting these changes is necessary in order to adapt reimbursement rules.
- Clinicians and patients are not asking for something that would be more expensive, rather they want to achieve fairer and more appropriate use of healthcare funding.
- In many situations, changes to reimbursement policies would result in more cost-effective healthcare that is also better aligned with optimal clinical practice guidelines.

Table 1. Examples of tension between clinical practice and reimbursement rules along the path of oncological care for patients with breast cancer

Integration of breast imaging services into breast units and variable access to breast imaging modalities
Integration of breast imaging services into breast units is a slow process, and the multidisciplinary approach incorporating the clinical value of imaging findings is not largely practiced. In some countries, patients need to be hospitalized to receive certain types of imaging, thus increasing the inconvenience, disutility, and overall costs In others, population-based screening with full digital mammography is still not implemented, access to screening and diagnostic breast MRI and to MRI-guided or other image-guided needle biopsy procedures is difficult if not impossible, and reimbursement, if any, is not homogeneously regulated.
Molecular pathology
Molecular biology tests in most countries are not reimbursed, even when they are indispensable to select patients for the right targeted therapy.
Risk reducing surgery: *BRCA* mutation carriers
Bilateral risk-reducing mastectomy is the most effective method for reducing breast cancer risk among BRCA1/2 mutation carriers and reduces the risk of breast cancer by approximately 90%. Many healthcare funders, private and public, do not cover risk reducing surgery, even when such surgery is recommended as part of a risk reduction management plan for individual deleterious BRCA gene mutation carriers.
Moderate hypofractionated post-operative radiation therapy
Moderate hypofractionation schedules (15–16 fractions of <3 Gy/fraction) are recommended for routine postoperative RT of breast cancer. However, reimbursement rules are per-fraction-based and therefore favor conventional fractionation, leading hospital management to stress that hypofractionation should be used to a limited extent.
Administration of medication
Many treatments can be delivered orally, but since in many countries reimbursement is linked to day-hospital or inpatient hospital admission rather than of outpatient (ambulatory) care, there is an incentive to prescribe intravenous medication rather than oral, and thus favoring i.v. chemotherapy over oral hormone therapy or oral chemotherapy.
Optimal delivery of palliative care
There is consensus in contemporary cancer care on integration of oncology and palliative care, but implementation has not yet taken hold, among others because of lack of financing.