The uptake of cancer drugs funding by SHAs for rarer cancers in England: key success factors

PCN163

Prostate cancer screening practices in the Republic of Ireland—The determinants of uptake

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OBJECTIVES: To determine the extent of social inequality in uptake of prostate cancer screening in Ireland and compare inequalities across groups for whom the cost effectiveness of screening is thought to vary. METHODS: A series of decomposition analyses of inequalities in uptake of prostate cancer screening were undertaken using data collected as part of a large population based survey in the Republic of Ireland (SLAN 2007). Separate analyses were conducted for individuals differentiated by age on the basis of reported differences in the cost effectiveness of screening. A range of explanatory variables were used to explore the role of non-demand factors. RESULTS: Greatest need is for improvement in lifestyle risk factors (Z = -7.67), while the least need is for availability of hospital care with Pearson's correlation r = -0.05 in males and r = -0.01 and r = -0.05 in females. CONCLUSIONS: There are some substantial differences in availability of oncology care among the provinces since to some extent each of 16 regional departments of the National Health Fund (NHF) pursues its own health policy. The aim of this study was to estimate whether the differences in availability of oncology care are responsible for differences in cancer-related mortality rates among the provinces of Poland. METHODS: We used NHF data on contracts for oncology hospital and ambulatory care in 2008 and the National Cancer Registry (NCR) data on age-standardized mortality rates due to cancer in 2008. Data on hospital and ambulatory care and incidence data for each provincial community were used to estimate availability of oncology care per cancer patient. Incidence data were used due to lack of cancer precise prevalence data. RESULTS: We have found no strict correlation between mortality rates and availability of hospital care with Pearson’s correlation r = -0.01 and r = -0.05 in males and females. Surprisingly, no significant correlations between mortality rates and availability of ambulatory care were found with Pearson’s correlation r = 0.03 and r = 0.045 in male and female population, respectively. CONCLUSIONS: Further research, extended beyond simple relation between clinical outcomes and health care service financing is needed to explore inter-provincial variability. International Research Project on Financing Quality in Healthcare InterQuality, is aimed to address those discrepancies in health care.

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Does different availability of oncology care is responsible for differences in cancer-related mortality rates among the provinces of Poland?

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OBJECTIVES: Substantial differences in cancer-related mortality rates among the 16 provinces of Poland exist. Over the last 10 years the differences between the highest and the lowest observed standardized mortality rates varied at 33.9% to 54.2% in female population and at 24.1% to 40.9% in male population. The differences in mortality rates cannot be explained only by differences in cancer incidence rates among the provinces since weak correlation between both values exists (Pearson’s correlation r = -0.01). Previous studies have found that the variations between mortality rates and availability of ambulatory care were found with Pearson’s correlation r = 0.03 and r = 0.045 in male and female population, respectively. There are also substantial differences in availability of oncology care among the provinces since to some extent each of 16 regional departments of the National Health Fund (NHF) pursues its own health policy. The aim of this study was to estimate whether the different in availability of oncology care are responsible for differences in cancer-related mortality rates among the provinces of Poland. METHODS: We used NHF data on contracts for oncology hospital and ambulatory care in 2008 and the National Cancer Registry (NCR) data on age-standardized mortality rates due to cancer in 2008. Data on hospital and ambulatory care and incidence data for each provincial community were used to estimate availability of oncology care per cancer patient. Incidence data were used due to lack of cancer precise prevalence data. RESULTS: We have found no strict correlation between mortality rates and availability of hospital care with Pearson’s correlation r = -0.01 and r = -0.05 in males and females. Surprisingly, no significant correlations between mortality rates and availability of ambulatory care were found with Pearson’s correlation r = 0.03 and r = 0.045 in male and female population, respectively. CONCLUSIONS: Further research, extended beyond simple relation between clinical outcomes and health care service financing is needed to explore inter-provincial variability. International Research Project on Financing Quality in Healthcare InterQuality, is aimed to address those discrepancies in health care.

Funding by SHAs for rare cancers in England: key success factors in the uptake of Cancer Drugs Fund

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OBJECTIVES: Overall 2506 patients gained access (from a total of 2880 applications) for oncology treatment from the Cancer Drugs Fund within the first 6 months of its launch. However, there are significant variations in the number of applications that different Strategic Health Authorities (SHAs) are able to process and approve. This study aimed to assess the reasons for the observed inter-region variation in the application rates, processing and outcomes within the Cancer Drugs Fund from October 2010 to March 2011. METHODS: The results on the application rates from an audit undertaken by Rarer Cancers Foundation using the Freedom of Information Act were analysed, especially, the change in application rates over time and the outcomes of these requests. The analysis led to the development of a framework to understand the key factors influencing the application rates and its outcomes, which was then validated through a telephone survey of key SHAs in 2011. RESULTS: Along with significant variations in the application rates over time, there appears to be a north-south divide, with SHAs in the south of England approving a lower proportion of applications. Some of the underlying reasons were identified to be linked with administration costs, levels of routine access to cancer treatments (which itself vary according to the area of the country) and ‘timely’ decision-making. CONCLUSIONS: Some of the notions identified from this study are worth exploring further with a larger study, and they include the need for ongoing and systematic an analysis of the changes in the application rates of the Cancer Drugs Fund. Further work is required to understand the causes of this.

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