Centralisation of highly complex cancer diseases in Catalonia

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TYPE STATUS	Fully implemented policy	LAST UPDATE	September 2021	SPAIN REGION-WIDE Cancer care • Organisation

PROBLEM & OBJECTIVE

PROBLEM Outcomes of complex clinical cancer surgical procedures could be suboptimal if expertise of surgeons and the multidisciplinary team is not considered in the planning of cancer care.

OBJECTIVE Improve clinical outcomes through centralization of highly complex cancer diseases in expert centers.

KEY COMPONENTS / STEPS

- Designation of reference hospitals by the Catalan Health Service after a clinical audit (Instrucció Catsalut 1/2012 and 3/2018, see web catsalut.cat) .
- External clinical audits by the Catalonian Cancer Plan and the Heath Technology Agency of the Catalonian Health Care System. The variables of the process and outcomes were decided by a group of experts according to evidence and international standards.
- Patient flow map guiding referrals according to population access and quality outcomes of the hospital assessed in the clinical audit.
- Conditional cash transfers to foster adoption of the criteria of referral of patients.

KEY CONTEXTUAL FACTORS

This centralisation approach targeted the organisation of the public hospital system.

- Catalonia has a single-payer health system with a purchaser-provider split; the Catalan Health Service (CHS) is the public agency whose principal role is to contract health services from hospitals.
- Before the 2012 reform, complex cancer diseases could be treated in any of the 64 publicly funded hospitals; since then, 20 highly complex cancers or surgical procedures have been centralised in the region.

MAIN IMPACTS / ADDED VALUE

- A quality framework for complex cancer diseases, involving centralisation of care in reference centres and external clinical auditing, led to improved clinical outcomes while ensuring equitable access for all patients.
- The main benefit for patients was increased quality and improved clinical outcomes, including survival (e.g. 34% of increased survival at 2 years in rectal cancer, $p < 0.005$).
- Equitable access to quality cancer care is ensured through guidance for patient referral, based on geographical flows between authorised and non-authorised hospitals.
- Reference hospitals are designated according to population density of the territory. The main barriers to centralising care have been implementation delays due to professional and institutional resistance.

LESSONS LEARNED

- Centralisation policies should be comprehensive. Quality criteria should be established to improve patient transitions between hospitals (e.g. agreements on the imaging tests) and to establish channels for clinical communication with authorised centres.
- Disincentives for non-authorised hospitals is essential in order to accelerate the adoption of the regulation.
- It is advisable to create clinical pathology networks among experts in the authorised centres in order to promote knowledge transfer as well as patient access to clinical trials or innovative treatments.
- The centralisation policy should be combined with external quality assessment systems for the centres that contribute to legitimising the policy.

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