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Access to cancer care in Colombia, a middle-income country with universal health coverage

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ABSTRACT

In this paper, we present the most currently available data on real access to high quality diagnostic and curative and palliative care in Colombia, a middle income country with relatively recent large healthcare reforms. We will focus on cancer types with a good average prognosis when detected and treated adequately and which are prioritized in national policies and cancer plans: cancers of the breast, cervix, prostate, colorectum and childhood cancers. These cancers have a quite poor prognosis compared to high-income countries. We find that, despite having achieved an almost “universal health coverage”, Colombia suffers serious problems in accessibility to preventative, diagnostic and treatment services for patients with cancer. People living in poverty have lower real access to all types of care, but other problems are due to lack of health literacy, beliefs and knowledge. Much can be gained by early detection, the advanced stages at diagnosis of many cancers can be avoided by increasing awareness amongst both the general public and health care professionals. Delays in diagnosis and treatment can be reduced, changes in legislation and bureaucratic processes, and increases in trained human resources and equipment is needed. The economic impact of getting a cancer diagnosis to patients and their families is understudied but seems to be substantial, as well as studies on quality of life of cancer patients and survivors - providing ample room for improvement.

1. Introduction—cancer in Colombia

Colombia is a large country (~47 million inhabitants) that has experienced large demographical and societal changes over the past decades [1]. The population is growing and ageing, a long-term internal conflict seems to be coming to an end, economy has grown and the healthcare system has been transformed into a system with “universal coverage”. Lifestyle habits are changing with decreasing physical activity and fertility rates and increasing obesity rates [1,2]. As a consequence, cancer is a disease of growing importance in Colombia, the incidence patterns are changing, with decreases in important cancers like stomach and cervical neoplasms, and increases in breast, colorectal and prostate cancer [3].

Overall cancer age-standardized incidence in Colombia is estimated to be between 151 and 175 per 100,000 males and 145–151 per 100,000 females [5,6]—translating in around 72,000 new cancer patients being diagnosed annually. Mortality rates are between 70 and 80 per 100,000 inhabitants for both sexes and the ratio of incidence to

mortality rates is relatively high, —indicating suboptimal survival. Very few population-based survival data are available; being the most comprehensive ones the Concord estimates for patients diagnosed between 2005 and 2009, even though based on quite small and sometimes unstable population numbers [7]. Childhood cancer survival, often considered as a general indicator for quality of cancer care in a country, is lagging behind: 5-year net survival rates for Childhood Acute Lymphoblastic Leukemia were 55% for Colombian children, versus above 85% in Western European countries, Canada and the United States. Similarly, estimated net survival was far below those for developed countries for stomach (16.6%), colon (43.3%) liver (5.3%), lung (9.0%), breast (76.1%), ovarian (31.1%) and prostate (78.6%) cancer and adult leukemia (20.1%). Only for cervical cancer are net survival estimates similar to those of the US (59.3% in Colombia versus 62.3% in the US) [7]. Factors contributing to this poor prognosis include more advanced stages at diagnosis and limited access to and uptake of effective early detection and treatment services [4].

In this paper, we present the most currently available data on the

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situation in the country in terms of real rather than theoretical access to high quality diagnostic and curative and palliative care, trying to identify factors of success and failure of the current system and formulate recommendations for improvement. We also present the very few data available on quality of life of cancer patients. We will focus on 5 groups of cancers—all of which with a good average prognosis when detected and treated adequately and all five prioritized in national policies and cancer plans [8,9]: cancers of the breast, cervix, prostate, colorectum and childhood cancers.

2. The Colombian healthcare system and cancer policies

Colombia introduced mandatory social health insurance with a large healthcare reform in 1993, aiming to improve equity in access to health care services through mandatory universal health insurance and a compulsory health plan. To ensure access to healthcare services, the reform introduced competition into both insurance and the provision of care segments through a managed-care competition model, with public and private participation. This mandatory national social insurance scheme included two different insurance schemes, a contributory one financed by payroll contributions and a subsidized scheme for poorest population payed general taxation [10]. Historically, beneficiaries of the contributory scheme had access to a wider explicit benefits plan than beneficiaries of the subsidized regime, until 2015, when this gap converged in the context of a sector reform which promotes health as a fundamental right. Financial protection against health risk has improved due to a considerable public health expending, reflected in a population insurance health coverage of 96,6% and a moderate out-of-pocket expense, near to 14% [11].

Colombia has a limited offer of oncology services; only about 250 medical oncology specialists are registered at the local oncologists society (out of > 77.000 physicians [10,12]). Most of the important cancer treatments are available, but not always covered by the system. The problems lie largely in obtaining a timely access and receiving continuity of care. Once a (sometimes multidisciplinary) medical team decides with the patient on the treatment of choice [13], the patient has to process a permission from the health insurance institution (EPS) for that treatment. Once the treatment is approved upon, there are usually some waiting times within the treatment centres, and it is not uncommon for patients to have to re-apply to be able to continue their treatment with their EPS on a monthly basis, or filing legal claims (so-called “tutelas”) to obtain access to the treatment [13]. Seriously ill persons do not have the time and energy for such processes, and may be left without treatment, unless they have relatives helping with the paperwork.

Although in theory the beneficiaries of both regimes have access to a wide package of treatments and medical services, in practice, health insurers may limit access to healthcare [14]. This, combined with the sometimes moderate quality and long waiting times offered by providers that belong to health insurers’ networks in the mandatory regime, has opened a window for private health insurance. Supplemental health insurances usually do not cover out-of-pockets for social insurance coverage items, but provide access to health services of better quality—mainly reduced waiting times and access to better hospitals and physicians.

3. Access to cancer care

Access to care is a multidimensional and complex concept, and therefore must be assessed on its’ multiple dimensions [15]. We discuss access to cancer care trying to integrate the process of care across the cancer continuum [16], and some access dimensions proposed by Gulliford et al. [17].

3.1. Service availability and utilization in the continuum of care

Although all services for cancer care (primary prevention, screening and early detection, diagnostic services, oncological treatments and palliative care) are available in the Colombian health care system, getting effective access to them may be problematic because of organizational or logistic causes. Diagnostic and palliative care services should be available in a decentralized manner, whereas centralization of highly specialized care such as radiotherapy, surgical oncology and chemotherapy are needed to provide high quality care [13]. One problem in many Colombian institutions providing specialized care is that they provide only some specialized services (e.g. only chemotherapy), causing delays and fragmentation in treatment of cancer patients who need combinations of treatment.

3.1.1. Primary prevention: vaccination against Human Papilloma Virus and Hepatitis B

Important cancer types in the region can be prevented by vaccinating the population against their important causes: the vaccines against Human Papilloma Virus (HPV) and Hepatitis B (HepB).

Similar to many countries in Central and South America [18], the current national vaccination program includes the HPV vaccine, free of charge, for girls aged 9–17 years. In 2012, Colombia was one of the countries with the highest HPV vaccine coverage rate—with coverage of school-attending girls aged 9–17 years of 98% (first dose), 97% (second dose) and 89% (third dose) [19,20]. Upon including non-school attending girls in 2013, coverage decreased slightly. In March 2014, upon administration of the 2nd dose of the vaccine in local schools in Carmen de Bolívar, hundreds of young girls were admitted to the hospital with mysterious new medical conditions. This caused the vaccination coverage to drop to rates below 10% in some departments and 56,8% nationwide [19] (Fig. 1).

The hepatitis B vaccination program recommends a first dose for newborns, a second dose as part of the pentavalent vaccination at two months of age, a third at four months and a fourth at 6 months of age. Fig. 1 shows the coverage of the full recommended schedule between 2012 and 2015 as provided by the Ministry of Health—which is stable around 90%.

Other efforts within the field of primary detection such as reduction of tobacco smoking, increasing consumption of fruits and vegetables and increasing physical activity are lines of action in the national cancer plan [8], and fortunately the first declines in lung cancer mortality are observed [4].

3.1.2. Early detection and screening

Colombia, like most countries in the region, provides opportunistic screening for cervical cancer (Cytology and HPV-testing as well as visual inspection – see and treat- for specific rural areas), breast cancer (mammography) and colorectal cancer (faecal occult blood test FOBT).¹ For prostate cancer, opportunistic screening by PSA tests combined with rectal examination among asymptomatic males aged 50 and above, attending for medical care for other causes, is recommended [21].

In recent years, cervical cancer incidence and mortality rates have declined, but incidence of colorectal and breast cancer has been on the rise, with recent apparent stabilizations in breast cancer mortality [22].

The process of early detection of cervical cancer and precancerous lesions, has probably improved substantially over the past 10 years, but still major improvements can and should be obtained. Part of the solution lies in the suboptimal quality of the vaginal smears [23], and in

¹ In 2015, Guyana, Haiti, Suriname, Trinidad and Tobago and Venezuela didn’t have a national screening program for breast cancer; and, Haiti, Suriname and Venezuela didn’t have a national screening program for cervical cancer. Source: Global Health Observatory data repository, available in: <http://apps.who.int/gho/data/view.main.24766>.

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