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“Shopping around” for treatment is not a solution to cancer backlog

Ajay Aggarwal and colleagues argue that relying on patient choice to cut waiting times is oversimplistic and likely to widen inequalities

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The covid-19 pandemic has exacerbated extensive backlogs in the diagnostic and treatment pathways for patients with cancer in the UK. Nationally, only 65% of patients receive treatment within two months of a primary care referral for a suspected cancer (the target is that at least 85% of patients are treated within this timeframe), with substantial regional variation.¹ In its report on NHS cancer services, the House of Commons Health and Social Care Committee acknowledged that the ongoing disruption of cancer treatment resulting from the covid-19 pandemic is likely to result in substantial loss of life years.^{2,3} Although the target to clear the cancer backlog has been moved back by a year to March 2023,⁴ even this time frame seems optimistic⁵ given that 57% of hospital trusts failed to meet the two month wait time target in 2016.⁶

Providing timely cancer diagnosis and treatment is challenging. The diagnostic pathway is complex, requiring specialist procedures for diagnosis and often multiple staging investigations to define the extent of disease and determine an appropriate management strategy. Most patients also need an array of specialised treatments such as surgery, radiotherapy, and systemic anti-cancer therapy, sequentially or in combination (multimodal therapy), and provided by one or more hospitals, requiring coordination over extended periods. For patients and their families, the concern is that delays in diagnosis and treatment will result in disease progression and an overall worse prognosis.² Although long term commitments have been made to expand the NHS workforce as well as diagnostic and treatment capacity,⁷ short term solutions are urgently needed that use existing NHS capacity more efficiently.

One of the government's responses to managing the NHS treatment backlog, announced by the health secretary in March 2022, includes giving patients the opportunity to “shop around” for their care, so that they are able to choose to have treatment at hospitals with the shortest waiting lists.⁸ This My Planned Care service will formally start in December 2022 and initially be available to patients with very long waits

for elective treatment before being extended to all patients. For patients needing to travel, free transport and accommodation are expected to be provided.

We argue that the use of patient choice as a vehicle for managing the NHS cancer backlogs is naive because it does not consider the complexity of patient choice or disparities in quality of cancer care across England, let alone the challenges in coordinating diagnosis and treatment. Instead, evidence suggests that unless there is universal improvement in the quality of cancer care, patient choice could worsen waiting times, widen inequalities, and burden cancer patients with extra decisions regarding their treatment without improving outcomes.

Patient choice has not driven improvement

Patients in the English NHS, a publicly funded health system, have been able to choose where they go to hospital since 2006.⁹ Reimbursement for services was fixed according to a nationally agreed tariff, and information about the quality of care delivered at individual hospitals was made publicly available. Patients were expected to act as healthcare consumers, choosing not to be treated at their nearest hospital if other hospitals seemed to provide better quality care. In theory at least, competition between hospitals should stimulate improvements in quality.^{10,11}

Three analyses suggest that patients with cancer are highly responsive to choice policies.¹²⁻¹⁴ The proportion of patients selecting alternative hospitals is well above the 5-10% considered necessary to stimulate improvements in outcomes through market competition.¹¹ For example, one in three patients, mainly from higher socioeconomic groups, having radical prostatectomy for prostate cancer moved beyond their nearest centre during 2010-14 (fig 1).^{12,15} Similarly, nearly 30% of patients with bowel cancer were not treated at their local surgical centre between 2016 and 2018.¹³ There is no clear evidence, however, that policies enabling patients to select a cancer treatment provider of their choice has led to better health outcomes or driven quality improvements.¹⁵⁻¹⁷

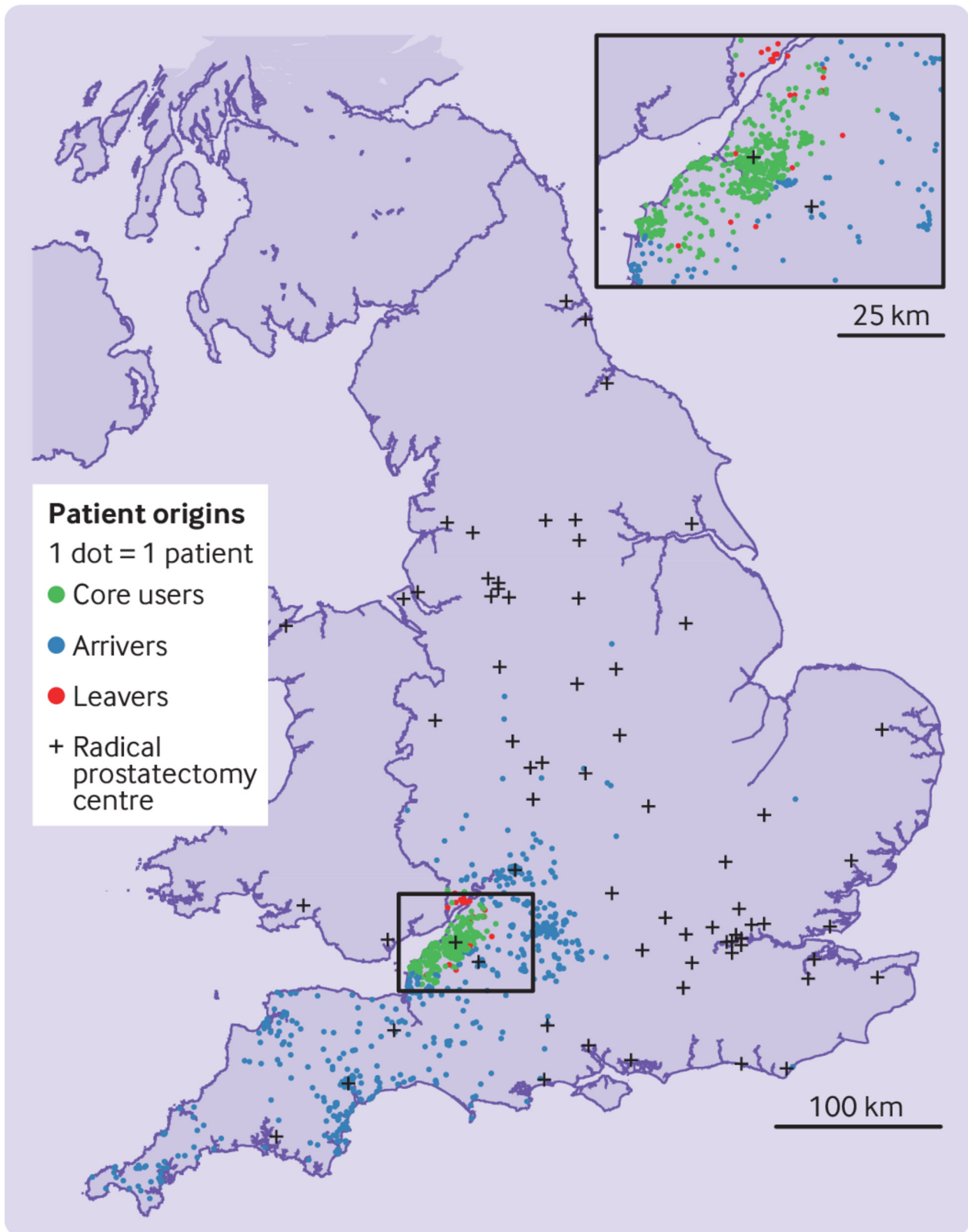


Fig 1 | Place of residence of patients who received radical prostate cancer surgery at an NHS cancer centre (indicated with + in the area of core users (green dots)) that had a net gain of patients from outside its local area (patients represented as blue dots)¹⁵

In European and North American countries with active patient choice policies, 25-75% of patients do not use their nearest treatment provider for secondary care services.^{18 19} However, evidence from

five European countries and the US, each of which has different incentive structures to support patient choice and provider competition, has not consistently shown improvements in patient

outcomes from these policies.^{19,20} In 2019 the NHS moved away from competition (turning instead to collaboration and integration of care²¹) given the lack of evidence that it improved quality as well as concerns that it could also exacerbate inequalities. However, patients' ability to choose where they have treatment within the NHS remained enshrined in the NHS constitution.²² The launch of My Planned Care in the English NHS,²³ effectively rebrands patient choice but this time as a mechanism for managing current diagnostic and treatment backlogs by enabling patients to choose hospitals with shorter waiting times using information available on the My Planned Care website.

Factors influencing patient choice are complex

Patient choice in hospitals and cancer treatment providers is driven by many interlinked context, culture, and person specific factors.²³ Population based observational studies and patient surveys show that patients are attracted to hospitals that deliver better outcomes according to official ratings, perform a higher volume of procedures, offer more advanced technologies (eg, robotic surgery), or have a better reputation according to local and national media.^{12 13 18 24 25} In an analysis of the characteristics of NHS prostate cancer centres that treated high numbers of patients from outside their catchment area, patients seemed to respond to the availability of more advanced surgical technology and the perceived reputation of the hospitals or surgeons.^{12 15}

For choice policies to be effective, patients are expected to review online information or report cards about hospital quality and waiting times to inform their decisions. However, a 2010 study found that only 4% of 1033 patients offered a choice used an NHS website that provided information on quality of care when deciding where they wanted to be treated.²⁶ Similarly, in the US, which has a longer history of patient choice policies, a review found that only 6-17% of patients across the studies consulted online hospital rankings or report cards when making decisions regarding their healthcare provider.²⁷ In addition, indicators of quality for many treatments are not publicly available to inform patient choices as they take considerable time and resource to develop. Instead, qualitative data suggest that most men with prostate cancer rely on advice from their family and friends, previous experience, and their primary care physician to choose a cancer provider.²⁸

Paradoxically, this could mean that patients prefer care at hospitals that have longer waiting lists since those that are perceived to perform better are likely to attract more patients from outside their local area.²⁹ An unpublished national observational study in the UK of 69 153 patients with breast cancer diagnosed between 2016 and 2018 found that patients were more likely to travel for their breast cancer surgery to centres with the longest waiting times.

Yet, underpinning the UK's new cancer care initiative is the belief that patients will decide where they want to receive their care based on waiting times. While patients in some studies chose a hospital or cancer treatment provider because it had shorter waiting times,³⁰ the evidence is inconsistent^{31 32} and has almost exclusively been from patients seeking care for less complex conditions (eg, hip and knee surgery) or regional NHS pilots.

Another reason patient choice is unlikely to reduce waiting times for cancer treatment is that the quality of cancer care is not the same across the NHS. National audits of multiple cancer services in England and Wales have shown significant variation in the structure, processes, and outcomes of care.^{33 34} For diseases where quality of treatment has implications for mortality and long term morbidity, patients are likely to give waiting time priority only if they are confident that their care will not be compromised and that

they will also receive the appropriate aftercare at their local centres. Patients may prefer to wait longer for treatment at centres that may provide better quality care while accepting a potentially increased risk of cancer progression. A more nuanced approach is therefore required to reduce waiting times.³⁵

Implications for health inequalities

Unfortunately, policies based on patient choice, both in the English NHS and elsewhere, have been found to widen inequalities in access. As Sajid Javid said when health secretary in 2022: "Disparities in health are exacerbated by the fact that it's middle-class people in leafy suburbs that are better able to push the system to work for them."⁸ Patients choosing to travel to hospitals further away are typically younger, fitter, and more affluent,^{12 14 18 36} even more so if the choice of provider includes private sector provision.^{37 39} To put it simply, marginalised patient groups are less likely to travel beyond their nearest hospital for care and therefore less likely to access or benefit from hospitals reporting shorter waiting times or better quality care.

Other structural factors can further widen inequities, including unequal access to accurate information and user friendly tools to shop around⁴⁰ as well as geographical variation in the availability of services, necessitating longer—or impossible—travel times for some patients.⁴¹ Even if travel costs are covered, it is difficult to see how patients who need to continue to work or have caretaking responsibilities would be able to access quicker treatment if it required travelling for 2-3 hours a day for six weeks for radiotherapy without paid time off.

Alternative approach to reducing backlogs

A policy based on allowing patients to shop around for their cancer treatment is thus not a sustainable solution for the backlogs in cancer diagnosis and treatment. Instead, we propose that the NHS builds on the opportunities provided by existing models of cancer care delivery to manage the cancer backlog and support meaningful patient choice.^{21 42}

We need to identify spare capacity, assure its quality, and coordinate its best possible use based on the complexity of the needs of individual patients. This requires an understanding of the configuration of healthcare provision in each region as well as data about the current patient flows between hospitals for each tumour specific treatment. To achieve this, the 21 cancer alliances (NHS structures in England that are responsible for managing and coordinating cancer care pathways regionally), should consider using routinely collected administrative and clinical datasets such as Hospital Episode Statistics and the national cancer registry, also including waiting times for cancer care to establish how existing capacity is being used.⁴³

Capacity of available services then needs to be managed and allocated equitably based on the need of individual patients. In the English NHS, as in many other countries, specialist multidisciplinary teams are already responsible for defining pathways of care and delivery of cancer treatments within a defined region for each newly diagnosed patient.⁴⁴ The typical hub and spoke structure consists of one or more specialist treatment centres coordinating services for the referring local cancer units. Currently specialist multidisciplinary teams do not allocate patients to specific hospitals as there may only be a single surgical or radiotherapy treatment provider within the specialist multidisciplinary team region. However, with better access to information about waiting times and available capacity at other hospitals within or outside their region, the specialist multidisciplinary teams are well placed to recommend

where patients should be treated according to severity of the cancer and the technical complexity of any indicated procedures. This would offer a ready made and low cost solution that would also be sensitive to the patients' individual needs. It does require coordination across the existing cancer alliances and would benefit from designated pathway coordinators to liaise between specialist multidisciplinary teams.

Pathways of referral and care may need to be restructured to facilitate the coordination of care for patients based on complexity of their cancer. This could mean that more technically complex surgical procedures such as rectal cancer surgery are centralised to fewer, high volume hospitals to assure quality.⁴⁵ The resulting spare capacity in hospitals no longer performing rectal cancer surgery could then be used for less complex but high volume procedures (eg, colon cancer surgery). This type of restructuring has been occurring during the pandemic.

Greater partnership between primary and secondary care could also deliver a more patient centred approach to managing diagnostic and treatment backlogs. In the English NHS, for example, the decision about where a patient with suspected cancer is referred is critical.⁴⁶ A redesign of referral pathways from primary to secondary care provides an opportunity to develop a much more nuanced system of referral, encouraging shared referral decisions that explicitly consider waiting times, care quality, proximity, and other morbidities.⁴⁷ This approach could be further strengthened with the planned opening of more than 100 new community diagnostic centres across England, although this remains an untested organisational change.⁴⁸

Simply giving patients information on waiting times through the NHS website My Planned Care is unlikely to solve the problem of treatment backlogs and risks making care more inequitable. A more effective, low cost solution is likely to come from enhanced use of routinely collected data about cancer care to enable existing regional multidisciplinary cancer teams to advise not only on what treatments newly diagnosed patients should receive but also where they should receive it, and a restructure of cancer referral pathways across the health system.

Key messages

- Encouraging patients to “shop around” for cancer care is unlikely to reduce waiting times and risks widening inequalities in access
- Informed choice requires better access to information about waiting times, care experience, and cancer outcomes in NHS hospitals
- Care teams are better placed to advise where patients are treated based on individual needs and capacity
- Restructuring of care pathways could help free up space and improve quality

Contributors and sources: AA is associate professor in health services research and policy. His research focuses on the role of choice and competition policies in cancer care and the design of NHS cancer services. FW is involved in national level policy making with respect to cancer pathways and supporting early cancer diagnosis. RS has expertise in international policy development and health system strengthening as part of cancer control planning. JvdM leads two national cancer audits evaluating the quality of cancer treatment delivery in the NHS and is also a cancer service user. AA devised the idea for this article. All authors contributed to developing the first draft and writing of subsequent versions. AA is the guarantor.

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