EFFICIENCY IN CANCER: THE COLOMBIAN CASE

1. Executive Summary

Cancer continues to be one of the main causes of death worldwide, and Colombia is not the exception. However, amidst the search for solutions to this immense issue concerning human health, there is work underway in a new global strategy that seeks to generate greater efficiency with regards to the approach to cancer, meaning addressing resources towards what is important for patients, and thus achieving better results.

In a global exploration of the literature, we found that in Europe as well as in the United States and Colombia there are several examples of malpractice in cancer efficiency; therefore, studying these cases to identify the failures is paramount. Likewise, the increasing cases of new **diagnosis** and cancer related deaths in Colombia, with COVID-19 as one of its possible causes, put a spotlight on the need to study the measures that the regulator and legislator need to take to face this situation and improve life quality and life expectancy of patients with any type of cancer diagnosis in the country. This is a joint work of the National Government and the Colombian Congress, scientific experts and even the pharmaceutical industry.

2. Key Definitions

- *Cancer:* According to the National Cancer Observatory, this is the term to refer to an abnormal and uncontrolled cellular division that may invade surrounding tissues. These cells can migrate to other parts of the body through the circulatory or lymphatic system. In turn, there are several types of cancer that can start in different locations and tissues, including the connective, bone, muscular, blood, nervous and interstitial tissues. Cancer also receives other names such a malignant tumor or malignant neoplasia.

- *Efficiency in Cancer:* For All.Can International, Cancer Efficiency is directing resources to what is important for patients, thus achieving better results. Waste in cancer care is not just about money, but time, quality of life and lost opportunities for patients and their families. In this sense, the 7 categories regarding efficiency

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in cancer are clarified: (i) the focus is on the patient; (ii) information and data; (iii) technology; (iv) good practices; (v) Human Talent in Health; (vi) interoperability; and (vii) appropriate incentives.

- *Perverse Incentives*: In literature, this expression is known as those decisions or public policies that lead people in a society towards making wrong decisions, which represent an apparent improvement with respect to any problem and that may even have specific benefits in that area, but which nonetheless affect other behaviors and create deficiencies in addressing other problems.

- *General Health related Social Security System in Colombia (GHSSS):* Under the provisions of the preamble of Law 100 of 1993, GHSSS is the group of institutions, regulations and procedures available to the person and the community to enjoy living standards through progressive compliance with plans and programs developed by the State and the society to provide comprehensive coverage of contingencies, especially those lessening the population's health and economic capacity to achieve individual well-being and integrate the community.

- *Ten-Year Plan for Cancer Control*: It is a public policy tool that seeks to position cancer as a public health problem in the public agenda to mobilize State action, inter-sectorial action, corporate social responsibility and individual co-responsibility for the control of this disease in Colombia.

3. Introduction

3.1. How do we understand Efficiency in Cancer?

Efficiency in cancer is a growing issue that is acquiring relevance at a global level. This apparently ambiguous concept encompasses countless aspects that are paramount to fully developing oncologic patients in all stages of their disease and areas of their lives. All.Can International, a multi-stakeholder initiative that works to improve the efficiency of cancer care focusing on what is relevant to patients (All.Can International, s.f.), has set forth its own definition of efficiency in cancer care: *to focus on what matters to the patient and society.* It also considers some elements included in its concept, since they have a direct impact on the patient and society:

i. *The focus is on the patient*: Ensuring that the patient's perspective is the main factor when defining important health results, in line with the concept of values-based healthcare.

ii. *Evidence-based and data-driven information:* Defining key results and quality/performance indicators through multi-stake collaboration and assessing data generated in terms of health results achieved in relation to the resources spent.

iii. *Investing in technology:* Identifying, assessing and adopting diagnostic and digital tools to improve health results. Investing in digital innovations to support care provision and consistent use of health data.

iv. *Expanding good practices:* Advocating for efficient and innovative cancer practices and withdrawing ineffective, copied, harmful or wasteful cancer interventions.

v. *Support for Human Talent in Health (HTH):* Provide HTH with the opportunity to learn how to improve efficiency in cancer care.

vi. *Breaking barriers:* Fostering efficiency through a cross-barrier approach that includes the entire healthcare system. Synergy between health system units.

vii. *Implementing appropriate policies and incentives:* Public policy-makers at all levels of decision-making should implement appropriate legislative frameworks, policies and incentives to promote efficiency and include clear and practical goals to improve results of patients with cancer.

This broad concept of efficiency is supported by other contributions in literature at a global level. The "*Improving Efficiency and Resource Allocation in Future Cancer Care*" report published by the *Office of Health Economics,* defined efficiency as "the allocation of scarce resources that maximizes the achievement of aims." (Cole et al., 2016.). Likewise, the cases reported from European countries raise efficiency around questioning how much available resources are being used by spending the health care budget on service that has a greater positive impact. In this sense, it is important to ask ourselves if the resources inputs are being used effectively to achieve better results, and if the investment is made in services and treatments that offer the best value for money. Another question raised by this study is on the adequacy of the level of resources available for medical care, which is related to the suitability of funding for cancer care when considering the mechanism that could increase the spending level on cancer.

Similarly, this report also develops other concepts such as dynamic efficiency, which states that "to be dynamically efficient, the system will reduce costs through the execution of new production processes" (Cole et al., 2016). This is relevant for the health sector since introducing new technologies and knowledge will change the health service's capacity to provide better care to patients.

3.2. The European example

Europe is a great example of efficiency in cancer. The European Union has several measures implemented in its affiliated countries, which complement the above stated

definition from the various areas that comprise efficiency in cancer. The most important early action taken by the EU in the fight against cancer was the European Council's launching of the "Europe against cancer" program in 1985, which published its first action plan in 1997 (European Commission, 1995). One significant result of this collaboration has been the developing and publishing the "European Code against Cancer" for the first time in 1987 to focus on prevention (European Commission, 2014).

Additionally, it also published its Communication on action against cancer in 2009, which includes 5 main objectives (European Commission, 2009):

i. Reducing the cancer burden by achieving a 100% coverage for breast, cervical and colorectal cancer detection by 2013: 125 million tests per year.

ii. Developing a coordinated approach for cancer research; achieving coordination of one third of the research of all funding sources.

iii. Ensuring accurate and comparable data on cancer incidence, prevalence, morbidity, cure, survival and mortality in the EU for 2013.

iv. Achieving a 70% reduction of existing inequalities in cancer mortality among member states by 2020.

v. Ensuring that all member states implement integrated cancer plans by 2013.

In addition to the above, the EU created the European Partnership for Action Against Cancer (EAAAC) for the period 2009-2013, the main purpose of which was ensuring that all the member states implemented National Cancer Control Plans (NCCP), aiming at reducing the number of cancer cases and to improve the living standards through strategies based on evidences for cancer prevention, early detection, diagnosis, treatment and palliation. These plans enabled setting a new and ambitious, by important objective: to reduce the burden of cancer in the EU in 15% by 2020.

Country	Specific budget allocation for the implementation of different measures within the plan?		Specific activities to receive additional funding
	Yes/No	Sufficient?	
Belgium	Yes	Yes	Cancer detection and care programs: staff, innovation, pediatric oncology, drugs

			reimbursement, rehabilitation, research and innovation
Denmark	Yes	Yes	Almost all initiatives in the plan are followed by additional funding to cover the development and implementation of the initiative
England	Yes	Yes	Increased radiotherapy capacity, improvement in detection programs, better primary care access to diagnoses and publicity campaigns to improve public awareness of symptoms, data collection.
France	Yes	Yes	The 30 measures received specific additional financial resources for their implementation.
Germany	Yes	Uncertain	Additional financing for the organization/management and for research
Italy	No	No	Budgeting procedures do not allow allocation of budgets for specific diseases or actions.
Holland	No	No	All actions and activities must be financed from the strategy itself and the annual budgets of the relevant organizations.
Poland	Yes	Yes	Equipment replacement
Sweden	Yes	No	Construction of regional cancer centers, pilot projects to improve processes and reduce waiting times, anti-smoking activities, improvement of information collection and dissemination, promotion of concentration of cancer care

Source: Taken from Cole et al., 2016. Own translation. Adapted from Gorgojo et al., 2012.

In describing a health systems approach for NCCP, the EAAAC established four pillars for cancer control: primary prevention, secondary prevention (detection), integrated care (including psychosocial care and palliative care) and research (including surveillance and cancer registries). With respect to funding, 20% of the 28 member states stated that funds were insufficient to implement NCCPs as drafted. This evidences that the number of programs that stop being executed as a result of budget shortage is high and they represent a loss of efficiency in cancer in the medium and long term.

3.2.1. Other relevant cases

The research undertaken to draft this document showed that Europe is the territory with the most advanced work in terms of cancer efficiency, where good and bad practices have been applied. In this sense, some of the findings mentioned in the study (Cole et al., 2016) are listed below:

- Examples of good practices
  - Flexibilization and acceleration of access to treatment
    - Poland: the government has introduced a "cancer treatment package" addressed at shortening waiting times; reinforcing primary attention in early diagnosis by improving training and expanding diagnostic procedures; introducing a waiting time limit of nine weeks from diagnosis until treatment; and abolishing the health insurance quotas for cancer treatment in secondary (specialized) and tertiary (hospital) care.
    - England: Introduced national cancer waiting time standards, providing rigorous monitoring of a series of key goals and incentives for improvement (for example, 2-week urgent referral ways - 93% of urgent referred patients must be seen by a specialist within 14 days of referral from a GP).
  - Coordinating oncological patients through collaborative work and clinical guidelines
    - France: in order to improve coordination and exchange of information between providers, considered as a problem in France, the 2014-19 Plan against cancer will create a communication file on cancer and will formalize the transfer between the hospital and the teams or primary care.
    - The Netherlands: It established the Dutch Association for Medical Oncology in 1997. One of its committees, BOM, assessed the clinical value and its purpose is to improve national collaboration and coordination in

oncology practice. The National Oncology Foundation (SONCOS) defines and monitors the national quality of cancer care standards in collaboration with the surgical and radiation therapy associations.

- Italy: there are several initiatives in different regions to develop clinical ways to guide the course of cancer treatments, although coverage is still limited both by disease and geography. Currently, several groups are working on developing clinical guidelines, but the leading region seems to be Emilia Romagna. To the extent that this practice also reaches regions where quality care is usually lower (mainly in the South), it could contribute to reducing inequality between regions. Forming "oncology networks" in Italy is expected to include among other results, a better primary care integration in the general process, an earlier diagnosis, greater appropriateness of treatment and a reduction in geographic inequality even within regions.

- Centralization / Integrating oncological services

  - France and Belgium: The measures to ensure excellence in service provision in France include the need of an "authorization" to provide cancer services; among other things, it is based on minimum activity level thresholds. These minimum activity levels are intended to ensure that all patients have access to a safe and high-quality care. These are implemented in a similar way in Belgium.

  - Germany: as of January 2012, a change in legislation opened new opportunities to integrate specialized outpatient medical treatment, under the idea of addressing the barriers between hospital and outpatient care. German legislation addresses the fact that rare diseases and pathological cases with a relatively small number of cases, or severe progressive forms of diseases with specific pathological processes, as well as highly specialized services, are particularly demanding in terms of diagnosis and treatment. The change facilitates access to interdisciplinary care and treatment for cancer patients. The Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA) is currently involved in developing new guidelines based on this standard. These will cover new ways of contracting with resident specialists and innovative service complexes.

- Examples of malpractice

  - Waiting times and referral practices

- Poland: among the countries with the highest waiting times in Europe (OCDE, 2013). Addressing long waiting times is critical to improving the rate of early diagnosis of cancer.

- Denmark: has a regional inequality in waiting times. Efforts have been made to address the long waiting times in the last years, including a political movement to label cancer as an "acute" disease that must be treated immediately, and the creation of clinical pathways to set forth maximum waiting times.

- Scarce data / Transparency of the evidence of clinical malpractice

  - The Netherlands: Apparently, many performance indicators for quality of care are not transparent to the general public.

  - England: Information sharing by the Health and Social Care Information Center (HSCIC) has turned to be more problematic due to concerns on the patient confidentiality. It is necessary to collect better evidence on the results. An excessive focus on activity-based rather than health-based results, can lead to inefficient funds allocation within cancer care.

- Fragmentation

  - Italy: the effects of the fragmentation or decentralization, which characterizes the Italian health service, could be many. One advantage of organizing by region is that care plans are tailored to the local community; some regions tend to be leaders in organizational innovation, and other regions often follow the latter in adopting best practices. However, efficiency can be hampered by duplicating efforts for some activities. For example, several drugs are assessed at both regional and national levels. The large variation between regions also clearly raises equity concerns.

  - Belgium: low volumes of procedures and variability of care represent a problem in Belgium, particularly for highly complex interventions in rare cancers.

- Dichotomization between cancer care providers

  - Germany: Dichotomization between outpatient and hospital care is regularly mentioned as a major source of inefficiency.

- England: the barrier existing between primary and secondary care. Is a key subject of NHS England's five-year vision for the future. Primary care should be deemed as comprehensive part of the provision of cancer care services through an integrated way.

- Perverse incentives for doctors and health personnel[1]

  - Germany: payment incentives for physicians can perversely affect appropriate treatment decisions. This is because physicians are paid using the Medical Services and Associated Scores Catalog (MBE) which has sections for sub-disciplines. If not elaborated properly, these can discourage specialists from prescribing the most appropriate treatments.

  - France and Germany: the EuroDRG project explored inefficiencies in payment systems based on diagnosis-related sub-groups and found that intentional coding and overtreatment are substantial problems in France and Germany (Medeiros & Schwierz, 2015).

3.2.2. Cost-effectivity in Spain

The Spanish case deserves a separate section since it is a very particular case. Spain has several cancer treatment options available for its patients, but some are more expensive than others. For this reason, an economic evaluation was carried out (Oyagüez et al., 2013, 240), to identify the cost effectiveness of the different treatment options available in the country. To this end, it is important to know beforehand the incremental cost-efficiency /cost-effectiveness (RCEI), which is estimated as follows:

$$RCEI = \frac{\text{cost of assessed scheme} - \text{Purchaser cost}}{\text{Efficacy of assessed scheme} - \text{Purchaser efficacy}}$$

At that time, the WHO had classified the cost-effectiveness according to the result of this operation: highly cost-effective strategies (RCEI lower than per capita income), cost effective strategies (RCEI higher than per capita income, but lower than three times per capita income) and non-cost-effective strategies (RCEI above three times per capita income) (as mentioned in Oyagüez et al, 2013).

Out of 40 cancer schemes for 13 metastatic tumors that were considered by Oyagüez et al, in their study, effectiveness measured in months of global survival (GS) ranged between 5,3 to 33,3 months and progression-free survival (PFS) ranged between 1,5 and 12,4 months. These results shed light on the difference in criteria when determining price and financing of therapies in Spain. Likewise, the authors concluded that, “it is curious to see

[1] Definition available in the section of Key Definitions of this document

that, according to the clinical trial conditions, some of the therapeutic regimes are not associated with gains in terms of survival (GS and/or PFS) with respect to comparisons included in these trials". Consequently, they suggest that drugs have been approved under the hypothesis of non-inferiority, which implies increasing the physician's therapeutic arsenal to treat a pathology, but they invite us to reflect on the high cost of administering an authorized therapy without proving its superiority, and focusing only on its non-inferiority of results or superiority based on statistically meaningful differences, without this implying survival. In this sense, having an explicit efficiency threshold is necessary to facilitate decision-making on public financing of medications and including principles such as equity and justice.

Therefore, the Spanish case in this document can serve as an example of apparent cost-effectiveness efficiency that needs to be taken cautiously since its background may represent completely the opposite.

3.3. The Example of the United States

The United States has multidisciplinary cancer boards. It is a group of experts on the subject responsible for finding better ways to diagnose and treat the disease, for each type of cancer. These boards or work groups allow implementing clinical practice guidelines and can help to capture cases for clinical trials. Furthermore, they are also a form of second opinion provided by a group that includes case reviews, evidence-based recommendations and experts' opinions.

In 2011, a providers' survey of Los Angeles Women's Health Study, which examined breast cancer care, found that tumor boards provide a framework for improving quality care, and that agendas and tumor boards policies are necessary to promote patient care and improve health outcomes. The work carried out by El Saghir et al. (2014), found a positive relationship between the presence of carcinogen tumor boards or work groups and efficiency in care and results. The Cancer Care Results Research and Surveillance Consortium analyzed the association between the characteristics of the tumor board and quality care measures and found that the positive relationship depends on the presence of qualified and effective teaching staff, good preparation and case selection, format and structure of the meeting, experience, efficient leadership and interactions between present physicians that are present. Furthermore, in small community hospitals, rural areas, and areas with limited resources, the limitations in diagnosis and management showed that they could be overcome, or at least optimized, with student meetings, especially those with videoconferencing facilities. On the other hand, better team dynamics, communication and educational opportunities for health professionals, greater patient satisfaction and, hopefully, better clinical results reflected in better survival rates were reported. In conclusion, overall, the tumor boards allow the discussion, dissemination and implementation of general clinical practice guidelines (such as those of

the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology, among others), guidelines adapted (NCCN-Middle East and North Africa, NCCN-Asia, and others) and those sensitive to resources (Global Initiative for Breast Health), generating good results for those territories with low infrastructure and resources for cancer diagnosis and care. Nevertheless, being able to study the cases in a detail and having all attendees make a cautious review exercise is essential, since board members require having enough information, in addition to ensuring that teams are diverse and made up of multidisciplinary medical oncologists, surgeons, radiotherapists, pathologists, radiologists, and other specialists.

Finally, the review carried out evidenced risks associated with the boards, which would be triggered by the total non-compliance of the important aspects to take into account, meaning incomplete or inaccurate information, as well as the absence of any essential discipline in the board, which could generate less than optimal decisions or that generate care inefficiencies.

4. Approach and Results

After a contextualization process and a review of literature at the global level, which evidenced the definition on efficiency to be considered, and specified several examples of relevance of good practices and bad practices, it is necessary to carry out an internal review to identify what progress has been made in Colombia on this matter, what are the strengths and what opportunities the country has in this scenario.

4.1. Efficiency in Cancer in Colombia

In the process of joining efforts to improve the health situation of patients with cancer and other pathologies in the country, Colombia created the High-Cost Account (HCA) under Decree 2699 of 2007. Pursuant to this Decree, the HCA is a non-governmental technical entity of Colombia's General Health Social Security of System, to which the EPS of both regimes and other EOCs (Entities Obligated to Compensate) must associate to address the High Cost. Likewise, it operates as a self-managed Fund that contributes towards stabilizing the health system, guaranteeing that solidarity truly operates and discouraging selecting and discriminating the population through a risk adjustment of the basic premium centered on high-cost cases. (High Cost Account, s.f.). Likewise, today the HCA is one of the largest sources of information and reliable data of the health system, especially in regards to cancer.

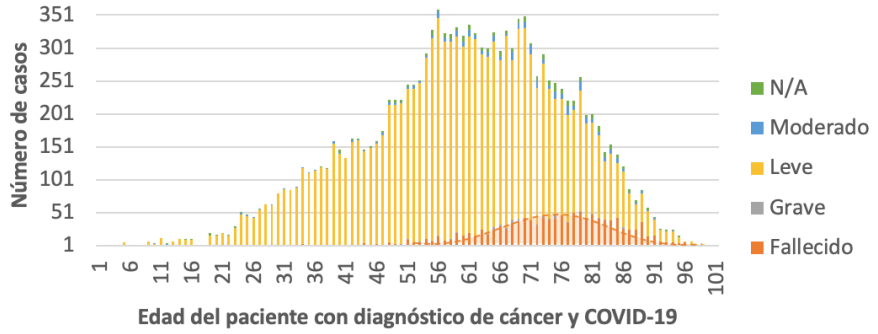
With respect to the current situation in the country, according to the figures published in 2020, available in the WHO Global Cancer Observatory and disseminated by the HCA, cancer in Colombia has an estimated incidence of 182 per 100,000 inhabitants and a mortality rate close to 84 per 100,000 inhabitants. Regarding the types of cancer, the last decades have shown that there was a political change that produced positive results and

allowed a drop in the rates of stomach and lung cancer, at a general level; meanwhile, breast cancer rates have has increased, and are placed next to prostate cancer as those with the highest rates. (Ministry of Health and Social Protection, 2021)

Cancer incidence, first five causes, estimations (3)
1. Prostate 47 per 100.000 inhabitants
2. Breast 34 per 100.000 inhabitants
3. Cervical 19 per 100.000 inhabitants
4. Lung in men 13 per 100.000 inhabitants
5. Colon and rectum men and women 12 per 100.000 inhabitants

Source: Taken from the Ministry of Health and Social Protection, 2021. Adapted by the World Health Organization, 2020.

Regarding the region, Colombia is in sixth place in cancer mortality after Uruguay, Argentina, Chile and Brazil. Specifically, in the last two decades the cancer mortality rate has dropped, with minor fluctuations and a discrete flattening of the tendency in the last 5 years. In this scenario, cancer was not immune to the impact of the pandemic; 13,662 cancer patients infected with COVID were recorded, 1,271 of which have died due to complications associated to this disease and 92% of these deaths correspond to patients over 57 years old.



Source: Taken from the Ministry of Health and Social Protection, 2021. Adapted by the World Health Organization, 2020.

Comentado [PZ1]: Age of patient with a cancer diagnosis and COVID 19

N/A
Moderate
Slight
Serious
Deceased

4.1.1. At the economic level

With this situation, the Government of Colombia has sought to strengthen the General Health Social Security System (GSHSS), which purpose is to regulate the essential public health service and create conditions to access the service for the entire population in all levels of care, to ensure coverage of the care services provided in the Health Benefits Plan (Ministry of Labor, n.d). In this sense, Colombia went from having 29.21% of the population insured in 1995, to having 93.63% in 2010 and 95.97% in 2019. This achievement has improved access to health services and transformed numerous public health indicators, including those directly related to cancer. Even though this resulted in a considerable decrease in out-of-pocket spending on health, this type of spending is now fully dedicated to cancer related issues. Consequently, the Government implemented a drug price control policy; by March 2020, 2,513 commercially available drugs and 279 active ingredients had been included in direct price control. This represented an average 48% drop in the price of the drugs with respect to their international reference price, which results in of 6,5 billion Colombian pesos in savings for the system, as measured in regards to the international reference price (Ministry of Health and Social Protection, 2021).

4.1.2. Ten-Year Cancer Control Plan

in 2012, Colombia issued first Ten-Year Plan for Cancer Control (PDCC) regarding cancer prevention, treatment and control, which became the most important public policy on the subject and served as a regulatory roadmap for the following governments. The purpose of this Plan is to “position in the political agenda and mobilize State action, inter-sectors action, corporate social responsibility and individual co-responsibility for disease control”

(Ministry of Health and Social Protection, 2012). However, results recently socialized by the Ministry of Health showed that the execution of the PDCC fell short and few achievements were made in the past 10 years. Consequently, the points that have not been fulfilled are expected to reactivate in the next decade and adapt to the country's current health situation; there is work underway in formulating a Ten-Year Public Health Plan, which will incorporate cancer as a foremost component, replacing the Ten-Year Plan for Cancer Control.

4.1.3. Sandra Ceballos Law

Another effort at the regulatory level that has been undertaken in Colombia is the passing of Law 1382 of 2010, better known as the Sandra Ceballos Law; it seeks to impact the burden of cancer disease and sets forth actions for its comprehensive management by establishing that the State and the actors involved in the GSHSS services will guarantee that treatment, rehabilitation and palliative care services will be provided. This law enabled people who in the past did not have the funds to have an early diagnosis, to have access during the different stages of the disease to comprehensive treatment, appropriate rehabilitation or decent palliative care. The passing of this Law opened a wide prospect in Colombia to improve the quality of life of patients with terminal illnesses, given that in the past they required numerous legal actions to demand palliative care services; it also paved the way for patients in an early stage of the disease to access the medical care they require. However, there are still several barriers to access care for people with breast cancer, which are determined by social characteristics and that the system is unable to face (Piñeros et al, 2011, cited in Salazar et al, 2018).

4.1.4. Conversation with Experts

In preparing this study, we talked to different cancer experts in Colombia in order to learn, from their experience what their perspective is on managing efficiency in cancer in the country. The trends observed show that in Colombia there is an enormous gap between what is stated on paper in the regulations and how these regulations apply to the daily life of people diagnosed with cancer. This is frequently due to intrinsic factors of how society conceives the health system. For example, the system is divided according to the type of affiliation scheme, subsidized and contributory, regardless of the fact that the system has spirit of health care for all. For the experts, this classification creates differences in care, as some IPSs are more effective in caring for patients who belong to the subsidized regime, while there are regions where the opposite occurs.

On the other hand, some experts believe that the campaigns that health and oncology authorities have been carrying out in the country are insufficient; like the regulations, they fall short in going from theory to practice. Thus experts believe that it is important to strengthen communication, education and information campaigns to improve self-care in

Colombians; extend screening campaigns to other cancers that are less common but affect the lives of patients; increase human talent in health available in places of initial care, primary care or where the first contact is provided, unify existing campaigns that may strengthen each other and turn the message much more powerful and be able to generate cultural changes in the population that allow people to adopt healthier habits.

With regards to the health information handled in Colombia, there is a clear effort to improve the interoperability of the system; however, this effort is still in its initial phases. The main challenges are in rural areas and remote areas of the country, where access to information and connectivity place patients at a great disadvantage and generate loss of opportunities. However, Colombia has a meaningful annual financial support for the country's health sector and especially for health technologies that improve access to treatments and provide greater hope of survival to patients with cancer and other pathologies.

Likewise, we acknowledge the important work carried out by the Institute for the Evaluation of Health Technologies (IETS) in Colombia; they make a big effort to review whether the molecule or new technologies are more cost-effective or not, compared to what is available in the market; to guide and be clear in terms of defining the cost-effectiveness of a technology and generating clinical practice procedures that guide physicians in their work.

Regarding the instances where there the system has are greater delays, experts agree on indicating access to services and products that are necessary for treatment. In other words, patients experience delays when seeking authorization for medications, medical appointments with specialists and transferring authorizations in cases in which there is a lack of competent professionals in the city or municipality of residence. In this sense, it is necessary to make improvements in managing Human Talent for healthcare providers; to improve their contractual conditions, provide them with quality professional training opportunities and organize social work groups with healthcare personnel that allow them to reach the areas far away from urban areas. Similarly, the current incentives are focused on insurers and not on health providers and professionals; additionally, they lack long term perspective.

Finally, the experts suggest that the cancer component of the new Ten-Year Public Health Plan should prioritize early detection, continuity in treatment, strengthening of HTH, and measuring results by insurers and providers.

5. 5. Conclusions

As previously stated herein, there are several examples at the global level of good and bad practices in efficiency in cancer. Several governments worldwide have been concerned about the issue and have sought to act with positive and negative results. However, in

spite of the efforts made in Colombia, there are several examples of malpractices that result in inefficiencies in the attention and care of cancer patients. There are numerous cases in the country that must endure several tedious processes in the middle of their disease in order to be treated. Similarly, corruption scandals in the system and lack of good management by the companies administering funds, make cancer patients undergo moments of great stress to request services from the health system in the country. Furthermore, HTH is not unfamiliar with these problems in the system, which in turn means it must be considered as a relevant actor during decision making moments.

6. Recommendations

As previously stated, Colombia needs a structural change in how it approaches cancer. Public policies and social programs require focusing at solving the main problems that a patient must face when diagnosed with cancer and during treatment. Likewise, the solutions proposed or decisions made in this regard should coordinate civil society, patients and medical experts that allow them to work together and from their specific experience to strengthen the effectiveness of the plans that are to be put in place. Additionally, it is necessary to strengthen the creation of scientific literature that allows accessing greater knowledge and generating proposals focused on improving efficiency in cancer.

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