Changes in European Cross-Border Cancer Research and Treatment

By Marie Gethins

Irish TV newscaster Tommie Gorman was working as a European correspondent based in Belgium when he became ill in 1994. He was diagnosed with carcinoid tumors, a rare cancer with an incidence of approximately 1 in 100,000. Initially treated in Belgium, Gorman began to investigate other European treatment programs. Kjell Öberg, M.D., Ph.D., of Uppsala University Hospital’s Endocrine Unit in Sweden impressed him, and in 1998 Gorman opted to seek additional treatment there. However, his tax payments, which had covered his Belgian care, were not applicable in Sweden. Then Gorman discovered the E112 form. “The E112 form says that if there is a treatment available in another European Union member state or Switzerland that is cost effective, useful, and significant,” Gorman said, “then you are entitled to medical benefits on the same basis as nationals in that member state—but it has to be sanctioned prior to travel.” In Gorman’s case, an Irish medical oncologist supported the referral and authorization was granted.

European Cross-Border Health Care Directive Passed

In the decade since Gorman’s first treatment at Uppsala, cross-border cancer treatment has remained relatively limited. Several European Court of Justice rulings since 1998 confirmed that EU citizens may seek health care in other member states, with the cost covered by their own countries’ national health systems. These rulings included not only treatment for rare diseases or specialized approaches but also highlighted patients in border regions, where the nearest appropriate hospital may be in another European country. Yet according to the EU Executive, cross-border treatment accounts for just 1% (€10 billion) of overall public health spending (€1,000 billion) in the 27 EU states.

That may change with the Cross-Border Health Care Directive, which passed in January 2011 and goes into effect in 2013. As with the E112 form, the patient’s home country health service will require prior authorization for treatment, but only if a hospital stay is involved or the treatment is very expensive. According to the parliament report on the directive, “the aim is absolutely not to encourage cross-border health care as such but to ensure its availability, safety, and quality.” Under the directive, a patient’s request can be refused only if the treatment could quickly be obtained in the patient’s home country or for doubts about the qualifications of the physician in the other member state. Each member state must establish at least one national patient contact point for information on health providers, reimbursement procedures, and when prior authorization is necessary. Patients may choose between public or private facilities.

However, the directive’s stipulation that patients bear any costs incurred beyond the level reimbursed by their home country might deter some patients. Long-term care and organ transplants are exempt. And the directive doesn’t cover travel and accommodation costs. The European Commission estimates that under the new rules, overall EU 27-state public health spending will go up by just €30 million a year.

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Cross-Border Cancer Research

On another front, an EU-wide initiative aims to improve cross-border cancer research and treatment by improving links between institutions. The EurocanPlatform project, involving 28 leading European cancer institutes and organizations across 11 countries, aims to streamline cross-border cancer research and treatment. At the end of March 2011, EurocanPlatform received a €12 million EU grant. Project coordinator Ulrik Ringborg, M.D., Ph.D., of the Karolinska Institute in Sweden, said at the launch, “The project will last 5 years, leaving a legacy of a collaborative structure within the EU for cancer research.” Ringborg also highlighted that EurocanPlatform should facilitate cancer research in the current cost-sensitive climate. “No one research center can have the resources needed. We must make sure that we coordinate and exploit the resources we have to the full,” he said.

Through cross-border information exchange and coordination across institutes, EurocanPlatform may improve patient access to patients in their home countries, reducing the need to travel. Most institutes involved in EurocanPlatform are clinical. “An important part of the project concerns getting the right therapy to the right patient at the right time,” said Ringborg. The project also strives to promote the mobility of cancer researchers through knowledge enhancement and harmonized treatment approaches.

Medical Oncologist Mobility

New moves to increase medical oncologist mobility across Europe are taking place as well. In March 2011, the European Society for Medical Oncology (ESMO) announced that authorities have included medical oncology in the medical specialties covered by EU Directive 2005/36/EC, which supports the recognition of professional qualifications across member states.
David Kerr, M.D., who is ESMO president and a professor at the department of clinical pharmacology at the University of Oxford, UK, said, “It’s different than in the States, where medical oncology has been recognized as a subspecialty for many years. Having this rule enacted means there’s going to be a much better, more uniform degree of training for medical oncology.”

However, Kerr cautions that the recognition, though important, is a first step. “We are standing on the threshold of a new age,” he said. “We in ESMO have developed an exit exam that is done to a very high standard. For example, in Germany, the exit exam for trainees is the ESMO exam.” Although European employment law governs doctor movement across Europe, a framework to regulate medical qualifications across Europe has yet to be put in place. “There’s still work to be done,” Kerr said. “I think in the future we will see a greater harmonization of training and standards.”

Considering cancer patient mobility, Kerr favors a national “network of excellence” model, with locally based cancer services treating patients to a high standard and referring to larger centers only as continued on page 853
necessary. “With networks, you get the best of both worlds: high-quality, guideline-associated care locally—and for rare or very rare cancers, offer treatment at the bigger center,” he said. “Eighty-five percent of cancer care should be delivered as close to the patient’s home as possible.” Kerr also favors making treatment option information available to patients and referring physicians in an easy-to-follow map format, already available in the UK. “Treatment shouldn’t depend on the patient being superinformed,” he said. “In the world of the Web and egalitarianism, this is information we should share.” Kerr said that the maps will eventually include outcome statistics, allowing patients and referring physicians to make treatment center choices on the basis of 5-year survival rates and other metrics.

**Cross-Border Care**

In cross-border patient consultation and treatment, Kerr already gives second and third referrals for Denmark’s complex colorectal and liver cancer patients. “We have a contract with the Danish government, so all the hospitals there can get a second opinion,” Kerr said. “Sometimes we treat them here at Oxford, but much more often we come up with a joint treatment protocol delivered in Denmark rather than bringing the patients back and forth all the time.”

For Tommie Gorman, travel continues to be an essential part of his carcinoid cancer treatment, with trips to Uppsala every 6 months. He now receives an infusion of the radioactive isotope lutetium, manufactured in a Dutch nuclear plant. This protocol is available in just a few European countries and is in U.S. trials.

Gorman has noticed an increase in foreign patients at Uppsala. Most are from other member states on the E112 form, but increasingly patients come from the U.S., Canada, Israel, and Australia. Although Canadian patients are covered through their national health service, other foreign patients use private insurance or pay their own costs. The Uppsala endocrine unit alone treats almost 200 overseas patients each year, between 20% and 30% of total unit patient volume. Like Kerr, Gorman hopes that treatment information will become more widely available to cancer patients. “Disease doesn’t recognize borders,” Gorman said. “Knowledge shouldn’t be limited to those who know where to look.”