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Game changer in cancer treatment in Switzerland

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ABSTRACT

Background: It is time for a game-changer in the cancer pathway in Switzerland and around the world. COVID-19 has made this more evident than ever. The prevalence, complexity, and cost of cancer care are increasing in Switzerland. Losses in efficiency, resources, and inappropriate attribution hinder health outcomes. This study examined opportunities for improvement across the cancer path, with a focus on patient-provider communication, effective policies and approaches to strengthen interprofessional collaboration.

Methods: A qualitative study was undertaken. Key stakeholders, selected on the basis of their expertise in different areas of the cancer pathway, were assessed through interviews. The need to develop and implement innovative strategies to prevent and treat cancer was investigated, and key recommendations were identified for discussion with politicians and policy makers. Inductive content analysis was conducted.

Results: There is a prominent need for collaboration and cross-sectoral action in cancer, encompassing clinical disciplines, communication strategies, and professional attitudes. The need and demand for collaboration responds to a highly fragmented cancer landscape in Switzerland, with a hierarchical organization of medical care entities and much competition. COVID-19 made these gaps more visible and highlighted the need to develop a new systematic approach and contingency plan to protect the most vulnerable.

Conclusion: Pressing developments are occurring in the health care system given the increasing prevalence of some cancers, the demographics of the Swiss population, the growing number of cancer survivors, and the consequences of the COVID-19 pandemic.

Policy summary: More fundamental solutions and policies should be developed and implemented to meet patient needs and increase health outcomes: are providers and patients taking responsibility for change? Will business interests and the power play boycott policy development? Change must start now, with policymakers, patients, providers and insurers joining forces.

1. Introduction

Now is the time for a game changer in cancer treatment in Switzerland and globally. COVID-19 has made this more evident than ever. Urgent action must be taken under the coordinated leadership of Swiss key opinion leaders (KOLs) who have a say in the decision-making process, to shape the future of cancer care, research and prevention for the next ten years. The question is clear: how will stakeholders, patients, care providers, as well as organisations, universities and companies deal with the new scenario of the post-COVID era to achieve the best quality of life for patients?

Cancer is, and remains, one of the most critical challenges for the Swiss health care system. Around 40,000 people in Switzerland are diagnosed with cancer every year. One in three people are diagnosed with cancer in their lifetime and one in four deaths are due to cancer [1]. The overall cancer prevalence is very similar amongst the French, Italian and German language regions with, however, conspicuous differences in prevalence for a few specific cancer types and patient groups [2].

COVID-19 had devastating effects on patients with cancer, with huge numbers of missed diagnoses and delayed treatments due to health systems under pressure and patients' reluctance to seek medical care [3, 4]. WHO has reported that in the early phase of the pandemic one in three European countries had at least partially interrupted cancer care services [5]. In Switzerland, initial results from the SAKK 80/20 CaSA cross-sectional study of COVID-19 outcomes of Swiss cancer patients show a higher rate of death than for the general population, with age and noncurable cancer strong predictors for mortality [6].

Patients, their families, and health care team face many issues when cancer is diagnosed. Good communication can help patients, families, and doctors to make the best decisions together and improve the

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patient's quality of life [7]. Patients' beliefs, values, meaning of the illness, preferences, and needs are fundamental elements in constructing a trusting relationship, being open to discuss and providing information tailored to suit the patient's level of understanding [8,9]. In Switzerland, there is a strong movement at a national policy level towards strengthening patients' rights and involvement in health care decisions. Yet, there is no national program promoting shared decision making. Although Swiss doctors acknowledge that shared decision-making is important, hierarchical structures and asymmetric physician-patient relationships are still prevailing [10].

The cancer path is long and complex; given the wide range and numbers of health-care professionals involved, there is a potential for poor coordinated management and for high competition. Interprofessional approach, effective collaboration, coordination and shared decision-making process among different care providers and the patient are key steps to reduce patients' massive stress, work overload on both patients and professionals' sides, and build trust across the complexities of the care continuum [11,12]. Oncology nurses can play a pivotal role in facilitating interprofessional collaboration, optimizing the care of patients and providing long term follow up [13].

This multifaceted scenario applies not only to cancer patients but also to survivors; in Switzerland, although 10-year post-diagnosis cancer survivors make up only 2.4 % of the general population, the proportion among those aged 70 or older is a staggering 23–25 %. Currently, about 320,000 people with a previous cancer diagnosis are living in Switzerland, among them many "long-term survivors". Thus, it is becoming increasingly relevant to ensure that all long-term and wellness needs are met [14–16]. These needs include monitoring and managing persistent and late physical and psychological effects, prevention and health promotion, surveillance targeting co-morbidity illnesses, health care coordination and social inclusion [2,15].

2. Methods

A qualitative study was undertaken. The study was conducted from September 2019 to June 2021. Selected KOLs were asked to reflect on the need to develop and implement innovative strategies to prevent and treat cancer, and to identify key recommendations to be discussed with politicians and policy makers. In parallel, the authors conducted a literature review on the current situation in Switzerland and worldwide, with a focus on national and international movements aiming to improve the patient experience through the cancer journey (data not shown).

An in-depth analysis of several interview questionnaires assessing the cancer pathway with a focus on patients' perspectives and needs and their relationships with care providers was carried out. The questions were designed by a core group (authors and selected experts) and pretested by a small group of participants (Appendix A). After the initial phase to contextualize the respondents and their relationship with cancer, the questionnaire gathered the perspectives of professionals, patients and support groups working in cancer care or prevention.

Interviewees were invited to express their perspectives and share their knowledge via in-person or telephone interviews. Data collected were analyzed with the outcomes remaining anonymous. Inductive content analysis was conducted [17,18]. First, the interviews were transcribed, and each response was reviewed line by line and coded according to the subject's main categories. Subsequently, similar categories were grouped into themes (inter-sectoral collaboration; communication; patient-doctor relationship; trust; patients' lives beyond treatment; COVID-19 impact – Appendix B). The different themes are described in the Results which summaries the main findings and categories of the selected themes. Selected quotes are provided in Appendix C. Subsequently, a DELPHI-like method was applied [19]. Two Delphi like focus group sessions were held with the KOLs to discuss the outcomes, the potential shared recommendations, and the divergences.

About 30 key opinion leaders (KOLs) from different cancer fields were invited to contribute to the study. Those leaders were internationally recognized, covering head or director position or being experts and very influential in their respective area in Switzerland, both at federal and cantonal levels, and not directly linked to a company. 27 have participated, with a significantly high response rate of 90 %. 59.3 % were from the German speaking area, 29.6 % from the French and 11.1 % from the Italian ones (working area of the experts). The highest participation from the German cantons is to be understood in conjunction with the fact that many cancer organizations are headquartered in Bern or Basel. 11.1 % were cancer patients themselves or had personal experience of close relatives with cancer. Gender was well balanced. Experts covered a considerably broad range of professions and roles such as academic/researcher, doctor, economist, epidemiologist, journalist, lawyer, nurse, patient, patients' rights activist/supporter, pharmacist, politician, social worker, etc. The main jobs of the experts covered most of the key areas of the cancer path including cancer support community, cancer registry, cancer screening program, cancer support association, canton health services, hospital/cancer center, journal, law association, federal and national offices, social services, university, etc.

3. Results

Several cross-cutting issues arose as a result of our analysis. In this article we focus on the patients-care providers relation and on ways to improve health outcomes and quality of life.

3.1. Intersectoral collaboration

It was frequently reported that the integration of different disciplines and the implementation of a multiprofessional approach remains weak and that a more cooperative form of care, including a platform which involves all professionals and the patients, should be developed. A key requirement is the set-up of a multidisciplinary team based on mutual respect, appropriate salary and recognition for all team members, addressing the need of providing a broad overview and personalized information to patients.

Competition among care providers was highlighted as a main barrier to effective collaboration. Several initiatives were suggested by the interviewees: both top down (legal framework) as well as bottom-up approaches were proposed to develop concrete projects and incentivize local initiatives, as well as to put politicians under pressure. Common training of doctors and nurses at university and in the workplace was strongly encouraged to facilitate the development of respect, trust and reduce stress in the workplace. More effective work sharing among doctors and nurses may lead to most effective patient management as well as to a reduction of the bureaucracy load for doctors. Interviewees highlighted that the intersectoral education should be reflected in the set-up of cancer centers hosting all cancer specialists under the same roof, with nurses coordinating the different specialists and being the link with the patients. The team should be able to rely on different types of professionals with an understanding on personalized and genetic medicine and a public health perspective. The multidisciplinary center for breast cancer in Lugano and the Tumor Board at CHUV in Lausanne represent, along with other multidisciplinary tumor boards in the country, interesting examples of applied multidisciplinarity; similar approaches should be available for all cancers in each big canton. This approach should embed also general practitioners that are often the first contact for the cancer patient.

Interviewees agreed that effective multiprofessionalism will also increase patients understanding and confidence, as well as reduce costs and the paperwork overload for patients. Indeed, with the current system, patients must explain and set up with each cancer professional his/her medical dossier, resulting in a considerable loss of time and energy. A possible solution suggested relies on the implementation of an e-dossier shared among all professionals, sustained by a real will of the professionals to read the report from other specialists. The adoption of a common language would assist this task, as often different terminology is used among diverse kinds of professionals.

3.2. Communication: is it focused or fragmented?

It was frequently reported by interviewees that having the right information at the right time is key for patients and for decision-makers. KOLs underlined that while important communication strategies are performed regarding screening by certain cantons, communication on cancer prevention remains weak. Cancer is often stigmatized, and additional awareness within the community is needed. Development of interactive websites and apps as well as appropriate use of social media have the potential to profoundly increase community and patient understanding, create more data and sustain advocacy. Interviewees also underlined that effective use of media and social media will be essential to evaluate and monitor patient needs in cancer centers.

3.3. Patient-doctor relationships

Many lay people simply trust their doctor without having any guarantee on the quality of the service they receive, with doctors often putting pressure on patients to intervene in order to avoid losing patients and income. Moreover, many doctors are considerably worried about making mistakes trying novel approaches outside of standard protocols, with the risks of blocking valuable innovation and knowledge due to concern over legal consequences.

Several interviewees have underlined that increasing patient literacy on cancer is key. Patients should be empowered to understand each step of the path and not merely passively follow doctor advice. However, even if advanced centers start integrating patients in the discussion, including in the clinical trial commission, most patients are not informed nor trained.

Some interviewees have emphasized that language is also a barrier to both effective advocacy and compliance with treatment. Cultural interpreters have been proposed to facilitate the communication and participation of patients at all levels.

3.4. Trust: increasing confidence, efficiency, and adherence through appropriate support

Some interviewees have recommended that the first person a cancer patient should meet in hospital is the head nurse that then remains the reference along the cancer path. This could lead to reduced stress and an increased sense of trust and the feeling of being listened to, heard, and cared for. This approach should not only be limited to information and emotional support, but also applied more widely to practical help to ensure that real needs are met quickly.

Some interviewees have highlighted that in large hospitals there is a certification process that includes a screening for psychosocial distress to recognize this suffering and provide needed support. This was considered a very effective measure with a high impact on long term. In addition to this screening, it has been suggested that psychologists and health professionals in general have time to talk with patients and family, especially about their needs on a deeper level. Of note, even when psychological support is proposed by oncologists, which unfortunately is not very common, it is not always welcomed by patients and their family and new schemes to increase acceptability to change this behavior need to be developed. To implement psychological support, a multi-step approach has been proposed with oncologists understanding and proposing to patients this support, hospitals investing more in hiring onco-psychologists and the reimbursement system to be adapted accordingly. An interviewee has proposed to introduce the “Buddy support team”. In Switzerland, this approach is not available due to complex bureaucracy and opposition by psychologists.

3.5. Life beyond treatment: palliative care and survivorship

It was frequently reported that the palliative care provided is an unmet patient need, with important differences among cantons. Interviewees have proposed to increase efficiency through a better and earlier collaboration among oncologists and palliative care providers by training all health professionals dealing with cancer in palliative care, as well as by introducing a palliative care peer group in every unit. Training of health professionals would be key since they often do not feel comfortable speaking about palliative care, thus creating a taboo.

Additionally, patients need better links and coordination among hospitals, general practitioners and home care since nowadays patients don’t spend much time in hospital and most treatments are ambulatory. There is also a lack of understanding of survivorship and of survivors’ problems and needs (medical, at workplace, social, cosmetic, etc.). The survivorship programs should have an integrative oncology and mind-body approach. Not only the health sector was proposed to be part of this long-term re-integration, but the society at whole (i.e. employers can support cancer employees allowing them to participate in social activities thus giving a better sense of belonging and feeling of a normal life).

3.6. COVID-19 impact on cancer path

COVID-19 pandemic deeply impacted the cancer path. Three main concerns were highlighted by interviewees: fear, limited access to diagnosis and treatment, and lack of inclusion of frail people by society as a whole.

Interviewees highlighted that cancer patients had to cope with the need to be treated for cancer and the fear to be infected by COVID-19 in hospitals. This was even more true for screening that were often postponed leading to late diagnosis. Limited availability of medications, including cancer treatments and anesthetics, sometimes caused suboptimal management of the cancer pathway. Patients assume they have immediate access to every step of the path; however, the pandemic has shown that this is not true even in a wealthy country as Switzerland. Lack of knowledge, poor communication, and inefficient management of infrastructure occasionally exacerbated the situation.

Interviewees underlined that during the pandemic cancer patients should be protected by ensuring as much as possible a normal working life for their physical and mental well-being. While private companies often have policies in this regard, public institutions either have no plans to enable such inclusion or the plans are not implemented. This was highlighted as unequal and unacceptable in our society and was perceived by patients as a clear choice by the government to prioritize economics over health.

4. Discussion

As an overall ascertainment from all key opinion leaders, there is a need for change in today’s situation. The recognition of the positive aspects of the Swiss health care system are underpinned by almost all. At the same time, an urgent need for improvement in parts of the system is underlined.

There is a prominent need for collaboration and trans sectoral action in cancer, maybe even more than in other health domains. This should encompass clinical disciplines, communication strategies, bureaucratic continuity, professional attitudes, and many other areas. In almost all interviews, a lack of collaboration and/or a hindrance to optimal collaboration at different levels has been brought up.

The necessity and the wish for collaboration meets a highly fragmented landscape of cancer in Switzerland. On the medical side, collaboration is not in the DNA of all health professionals. There are longstanding traditions that have perpetuated the hierarchical organization of medical care entities. The nowadays well documented benefits of a team-approach in cancer care can take time to be implemented. The difficulty for change is well-grounded in a payment system that does not favor collaboration but fosters individual activities. In such a system the communication is also fragmented. There are losses of both efficiency and humanity as patients, the weakest in the health care system, will have to struggle the most to get their needs fulfilled.

Collaboration is also hampered by the prevailing in-built competition of the current system. The role of competition in healthcare is much debated. Despite a wealth of international experience in relation to competition, evidence is mixed and contested and the debate about the potential role for competition is often polarized [20]. Health as a common good is limited by the prevailing market economy but softened by the mandatory health insurance system. Cancer and its consequences often exceed the possibilities of health insurance, the social system, the workplace, etc.

If a systemic crisis puts cancers on the back burner, there's a big problem; COVID-19 pandemics has made the health and societal systems' critical gaps more visible. An emergency plan that put cancer very high in the ranking, guaranteeing the medical access, supply, treatments but also a society of inclusion and protection that take care of the most vulnerable, is more than ever needed. Urgent policy interventions are necessary, especially to effectively manage the delay in routine diagnostic and their consequences, and to mitigate the long-term impact of the pandemic on cancer patients.

The high level of complexity of Swiss systems hinders understanding. Indeed, it is difficult to have a complete view of the driving forces. This makes attempts at change difficult. An in-depth analysis of the health care system and how the oncology system and its socio-economic and political aspects are implemented in Switzerland and other countries may be the next step. A more complex and integrated view of the cancer pathway and its implications on the health and social system, shared by all stakeholders, needs to be created and nurtured, starting with cross-sectoral training, creating a working environment of respect and trust, and involving more and more patients, politicians and insurers in the discussion.

Ethics approval and consent to participate

The need for ethics approval was evaluated and deemed unnecessary since according to the Human Research Act, approval by IRB, is not required for this project in Switzerland. Written informed consent was obtained from all KOLs.

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CRediT authorship contribution statement

ML participated in the conception and design of the study; acquisition, analysis, and interpretation of data; and manuscript drafting. BB participated in the conception and design of the study, drafted the manuscript, and supervised the whole project.

Role of the funding source

The funder had no role in study design, data collection and analysis. Both authors had full access to all data in the study and had final responsibility for the decision to submit for publication.

Conflicts of Interest

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.jcpo.2022.100343.

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