E.2. Health services

Breast cancer screening in Flanders: How can deprived populations be encouraged to participate?
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Background
Flanders has the highest incidence and mortality rate for breast cancer in the EU. Screening programmes can reduce breast cancer mortality substantially, when participation is adequate. However, the participation rate in Flanders is low, especially in deprived populations. Apart from a public health problem, this also brings up the question of equity.

Methods
Since encouraging women to participate in breast cancer screening by sending a personal invitation letter does not seem to be effective in deprived populations, more tailored methods have to be used. Therefore, a more personal and outreaching strategy was developed. A mobile screening unit was deployed in one of the most deprived city districts of Antwerp in 2010. All social organizations, GPs and welfare officers of the district were involved to inform deprived people not participating in breast cancer screening. Information was given in places where these people meet, posters and brochures in clear and understandable language were spread all over and the local media reported on the intervention. Of the inhabitants of the target group who did not attend in the regular screening programme, as many deprived women as possible received a personal invitation letter to visit the mobile unit. At this unit, a tent was installed where women could have a cup of coffee, people from the organization were present to talk to the participants in several languages and a questionnaire was administered. All participants received a goody bag. In 2012, this procedure was repeated.
The use of cervical, breast and colorectal cancer screening among people with disability living in institution in France, April 2013

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Background
Disabled people constitute a particularly vulnerable population which is often in precarious situations, and cancer screening constitutes a major concern. This population tends to participate in screening and cancer prevention programs at lower rates than the rest of the population. Numerous studies have been published in people with disabilities living at home but little is known about screening use in those living in institution. Does hosting in institution plays a protective role? This article aimed to explore the relationship between degrees of disability and the probability of cervical, breast, and colorectal cancer screening use in disabled people living in institution.

Methods
The data source was the French national Health and Disability Survey- Institution section, collected in 2009 (n = 9104). Weighted logistic regressions were conducted in 2013. The three dependent variables were: whether or not (1) a Pap test was performed in the last 3 years, (2) a mammography was performed in the last 3 years; (3) a FOBT was performed in the last 3 years and/or a colonoscopy in the last 5 years. Age, gender, corpulence, level of education, income, marital status, perceived health status, chronic diseases, visits to the general practitioner and the type of impairments were included into the models as potential confounders. Degrees of disability were appreciated through the level of functional limitation. We used the Katz Index assessing the ability to perform six activities of daily life.

Results
A significant gradient in screening use in relation to the degree of disability was observed for the three types of cancer studied. Compared to institutionalized individuals with no functional limitation, the most limited were significantly less likely to receive a Pap test (odds ratio = 0.23; P < .0001), a mammography (odds ratio = 0.39; P < .0001), a FOBT and/or colonoscopy (odds ratio = 0.39; P < .0001). Consistency with analysis already done in people with disability living at home, this work demonstrated a significant association between the level of functional limitation and the cancer screening use. The degree of disability is also a barrier to cancer screening use for people living in institution. Results can help formulating appropriate health policy measures to improve access to screening use, and reduce inequalities.

Key messages
- Targeting disabled for cancer screening in institution is important because screening reduces cancer mortality, disabled are often under-screened and little is known about those institutionalized.
- Our study suggests that even in institution, the disability degree is a barrier to screening. Results can help formulate appropriate health policy measures to facilitate access to routine screening.

Do cancer-specific websites meet patient’s information needs?

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Background
Access to appropriate information has been shown to improve psychological well-being, quality of life, and health outcomes for patients with cancer. The primary objective of this study was to evaluate how comprehensively commonly used cancer websites provide information on topics important to patients. To do so, we developed and applied an Information Comprehensiveness Tool to breast and prostate cancer websites and compared how thoroughly different aspects of cancer-information are provided.

Methods
We developed the Information Comprehensiveness Tool by collating questions and concerns from a systematic literature review on patient information needs in the EU. Questions from the resulting typology were grouped thematically to enable detailed analysis. Websites were selected by typing “breast cancer” and “prostate cancer” into the Google (UK) search engine and analysing the first page of websites. Each website was independently assessed on a 3-point scale by two researchers to evaluate the comprehensiveness of its information.

Results
The inter-rater reliability was strong (interclass correlation = 0.76 (95% CIs 0.73-0.78)) and the internal consistency of the Information Comprehensiveness Tool was investigated using Cronbach’s alpha (α = 0.77). Overall our satisfaction with information provision on breast and prostate cancer websites was “partial”, scoring 51% for breast and 55% for prostate cancer. The websites varied in comprehensiveness, with scores ranging from 18 to 73%. Overall, research-based websites’ average were best (72%), followed by charity websites (58%). For both cancer types, “basic details” of the disease were most commonly and thoroughly discussed. Least commonly discussed themes included “future planning”, “monitoring”, and “decision-making”. Biomedical questions received the highest scores. Hypothetical/experiential questions scored lowest. This pattern was true for both cancer sites and across all website providers.

Conclusions
This web-analysis describes and evaluates the scope of online information available to the public about breast and prostate cancer. This tool can improve the provision and use of publicly available information on cancer and enable patients to more actively engage with their health care providers about their information needs.

Key messages
- This tool can be used to help improve information provision on line and encourage doctor-patient dialogue.
- There is an uneven distribution of online information related to breast and prostate cancer and a patient’s lived experience of illness does not appear to be sufficiently explicit.
Incentives for health: What factors determine an enrolment in financial incentive programmes of insurance funds? Results of the study ‘German Health Update’ from 2009

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Background
Financial incentives of insurance funds should motivate insured persons to live a healthy lifestyle and to use early medical detection services. To this purpose, the German statutory health insurance funds offer financial reward programmes for their insured. These programmes give rewards for the use of different screenings for cancer (mostly for persons aged 35 years and above) and for the participation in health behaviour change programmes. What factors determine an enrolment in incentive programmes of insurance funds?

Data and Methods
‘German Health Update’ is a population-wide, representative telephone health survey of the adult population in Germany. 21,262 computer-assisted telephone interviews have been carried out from July 2008 to June 2009. Our study included 11,849 persons being covered by statutory health insurance funds, who are at least 35 years old. The analysis is based on the analytical framework of the ‘Behavioural Model of Health Service Use’ developed by Andersen (1995, 2007). Accordingly, in the logistic regression model different factors are simultaneously analysed: predisposing factors (e.g. sex, age, education, health awareness, social support), enabling factors (e.g. income, health insurance, use of prevention programmes), and need factors (e.g. sport activities, diet, health status).

Results
20.2% are enrolled in an incentive programme (95% CI = 19.3-21.2). Considering all factors simultaneously, different enabling, predisposing and need factors show significant results for enrolling in an incentive programme. Relevant are the predisposing factors ‘taking very much care of own health’ (OR = 2.03, 95% CI = 1.32-3.10) and ‘having strong social support’ (OR = 1.73, 95% CI = 1.37-2.20). Furthermore important is the enabling factor ‘use of prevention programmes’ (OR = 2.37, 95% CI = 2.04-2.75). The need factor ‘obesity’ reduces the chance to participate (OR = 0.71, 95% CI = 0.56-0.89) and ‘non-smoking’ increases the chance (OR = 1.21, 95% CI = 1.01-1.45) (preliminary results).

Conclusions
The results show that health awareness, strong social support, use of preventive services, and good health behaviour are crucial to the use of incentives programmes of health insurance funds. That might be a hint for cream skimming effects.

Key messages
• Users of financial incentive programmes of insurance funds show strong health awareness and partially above-average health behaviour.
• With regard to the reduction of health inequalities, incentive programmes should be designed to motivate population groups with a low level of health awareness and healthy behaviour.

The status of generic prescribing in Europe
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Background
Prescribing of medicines is the predominant treatment strategy in Europe. This implies high costs to society and medication risks to the individual. Generic Prescribing of Medicines (GPM) has been suggested as a measure to curb costs and increase safety in medication management, but evidence of status and impact of GPM is very scarce. The objective was to investigate the implementation, experiences with and attitudes to GPM in Europe.

Methods
This was a questionnaire-based e-mail survey to European medicines authorities, pharmaceutical associations and medical associations in 2011. The questionnaire content was based on a literature review and theoretical considerations. The reply categories were yes/no with plenty of space to elaborate on the answers.

Results
Completed questionnaires were received from 26 out of 34 (77%) countries. GPM was allowed and used in all countries, except the Czech Republic, Denmark and Sweden. In 13 countries a specific GPM legislation was implemented. Several countries had implemented this legislation during the last decade. In two countries GPM was obligatory. Certain medicines were exempted from GPM (combinations, controlled-release preparations, medicines with a narrow therapeutical interval, biosimilars and biologics). Participating organizations were generally in favor of GPM, few were neutral and only the Czech Medical Association against. There were no reports of medication errors associated with GPM. Reported advantages were: decreased work load; increase of patients’ understanding of medicine management; reduced risk of medication errors. Barriers reported were: uncertainty about therapeutic equivalence; length of generic names; influence of the pharmaceutical industry.

Conclusions
GPM is in use in most European countries. Stakeholders’ experiences and attitudes are positive. Some specific medicines should be exempted from GPM. The long generic names are a challenge and the pharmaceutical industry’s pressure a main barrier. There is need for research that provides evidence on the impact of GPM in practice setting

Key messages
• GPM is in use and favored in most European countries. The pharmaceutical industry is a barrier to GPM.
• There is need of research that evaluates the impact of GPM.

Economic burden of medical error: the Italian situation. A scientific literature review
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Background
Medical errors represent one of the most common public health issues. In Italy it was estimated that over 8 million people each year are hospitalized, 32,000 may suffer damage that could be avoided and a number between 14,000 and 50,000 persons could die for errors made by doctors. The aim of this study was to evaluate economic burden of medical errors and its impact on Italian public health system.

Methods
A literature search on the spread of medical errors in Italy was performed by using specific key words and MeSH terms. To this purpose, the main electronic databases (PubMed, Cochrane Library and Embase) and the Italian institutional websites were accessed and the grey literature was also examined.

Results
Medical errors, which mainly regard surgery (53%) and misdiagnosis (26%), would lead to a National Health Service economic damage of about 260 million €/year related to the extension of the length of stay in hospital, without considering
the increase in public health insurance costs. Italian regions spend annually about 30 million € on average for insurance policies and in 2010 legal proceedings were 12,000, with claims for compensation amounting to about 2.5 billion €. All this resulted in the widespread issue of defensive medicine. In particular, it was calculated that 8 doctors out of 10 adopted at least one behavior of defensive medicine during their last month of work. In particular 69.8% of medical doctors added avoidable notes to the medical record; 61.3% prescribed unnecessary diagnostic tests and 51.5% unnecessary medications.

Conclusions
Based on these evidences, errors in medicine affect not only patients’ health status, but also the sustainability of the whole public health system. So a better formation of medical doctors, a higher attention to healthcare and the implementation of governance tools and processes (guidelines and protocols; risk management; clinical audit) would result in considerable advantages in terms of health outcomes and resources saving for healthcare facilities.

Key message
• Error is a cause of waste in health care. A pro-active clinical risk management would allow not only the improvement of healthcare quality but also a considerable reduction in healthcare costs.