Comparative analysis of treatment objectives within the National Cancer Control Programmes in France and Germany

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Abstract: The National Cancer Control Programme is a public health strategy developed by the WHO to guide member states in organising the fight against cancer. This paper compares the treatment objectives stated by France and Germany in their NCCPs, using the DEPLESET analytical framework to explore the positioning of actors and facilities in the health systems to achieve the stated objectives. France has an older national strategy for cancer control and has gone to greater lengths to communicate and measure achievement of these objectives. Germany on the other hand is trialling a more efficient approach for delivering cancer treatment. There is increasing reliance and development of cancer registries as a source of information on patient outcomes in both countries. Opportunities exist for improvement through continuous appraisal and comparison of efforts in the battle against cancer.

Keywords: national cancer control programme, DEPLESET analytical framework, health system

I. INTRODUCTION

Cancer is a disease characterized by uncontrolled abnormal cell division. The global economic burden of cancer in 2007 was estimated to be about 895 billion USD [1] exclusive of the costs of treatment. An estimated 12.7 million cancer cases and 7.6 million cancer deaths occurred in 2008. By 2030, there will be approximately 26 million new cancer cases and 17 million cancer deaths per year [2].

To address this global public health issue, the World Health Organisation developed the National Cancer Control Programme (NCCP). “This is a public health programme designed to reduce the number of cancer cases and deaths and improve quality of life of cancer patients, through the systematic and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment, and palliation, making the best use of available resources” [3]. The WHO 2000 report declared that the ultimate goal of a health system is the health of the population it serves. Financial risk protection from impoverishment due to health expenditure and satisfaction with health services were also identified as goals of the health systems.

This paper aims to compare the treatment objectives within the NCCPs of France and Germany. It will analyse using the DEPLESET framework how the health systems are positioned to deliver the goals of health, financial risk protection and satisfaction to those who receive cancer treatment.

The choice of countries was influenced by the source of healthcare funding. Both health systems employ the Bismarck model, where healthcare funding is dependent on income related contributions. Over 85% of the German population is covered by statutory health insurance (SHI), private insurance (PI) playing substitutive and complementary roles. This is similar to France where 95% of the population is covered by SHI and PI plays a complementary role [4]. They are also both classified as high income countries, with similar levels of health expenditure/capita and public percentage of health expenditure; 4691USD (77.8%) in France and 4668USD (77.1%) in Germany [5]. In spite of the similarities between them, France ranked first for overall health system performance in the WHO 2000 report whilst Germany ranked twenty-fifth [6].

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1 Several definitions exist for a health system. For the purpose of this paper Roemer’s definition of a health system will be used. He defined a health system as “the combination of resources, organization, financing and management that culminate in the delivery of health services to the population” (Roemer, 1991).

2 See Methodology for detailed description of DEPLESET framework
The following sections of the paper will outline the methodology of the research, analytical findings, discussion, limitations and the conclusion.

II. METHODOLOGY

A. National Cancer Control Programme

Secondary research using publicly available data obtained from internet based searches conducted in the official languages of the respective countries was used. Information being sought was converted using Google translate into the language of the country being researched, this improved the quality of information produced by the search. Sources included government and public policy papers, organizational websites and publications, academic papers and other related sources of data relevant to the NCCP as shown in Table I, subsequently translated to English when necessary.

Table I: Source of NCCP information

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Available from</th>
<th>Language</th>
<th>NCCP Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>Le Plan cancer (The Cancer Plan) 2009-2013</td>
<td>Institut National du cancer (INCa)</td>
<td>French (full English version)</td>
<td>Yes</td>
</tr>
<tr>
<td>Germany</td>
<td>National Krebsplan: National Cancer Plan (NCP)</td>
<td>Bundes ministerium fur Gesundheit; German ministry of health (BMG)</td>
<td>German</td>
<td>No</td>
</tr>
</tbody>
</table>

The DEPLESET framework (see Fig I), described in further detail below was used to analyse the health system positioning to deliver the objectives of the NCCP.

For the purpose of this paper the stated treatment objectives within the NCCP were analysed within the context of the health systems. Specific questions were designed to uncover the link between the health system functioning and the delivery of the NCCP treatment objectives.

B. Health System Analysis

The NCCP states actors involved in the execution of the objectives for cancer treatment. To understand the context in which these actors would fulfil their roles according to the NCCP, it was essential to have a clear overview of the health system within which they were performing. The framework used for health system analysis was the DEPLESET framework developed by Atun & Menabde [7]. It analyses health systems within the external context that they perform see Fig. I. This consists of the demographic, economic, political, legal, epidemiological, social, environmental and technological constraints which bind actors within the health system.

Two factors out of eight contextual factors were chosen for this analysis. The Epidemiological context was chosen because it was cited by the WHO as an important factor for status assessment prior to developing a NCCP as it provides guidance on current disease burden, trends and achievements following implementation of the NCCP objectives [1]. The technological context was chosen because of its increasing relevance in the fight against cancer.

Table II shows the questions, answers to which revealed the epidemiological and technological influences on the health system in developing and achieving the treatment objectives. Several sources of data are available for cancer epidemiology. Publications from population-based cancer registries which collect personal data on newly diagnosed patients within a defined population were available in Germany; published by the Robert Koch Institute in collaboration with the Society of Cancer Registries in Germany (GEKID). In France, epidemiological information is gathered by the Health Watch Institute (InVS). Both InVs and the National cancer Institute (INCa) publish cancer epidemiological data on their websites.

The data published is retrospective however in some of the publications, prospective estimates for incidence are made.

The health system technology plans for cancer treatment were either obtained from the NCCP itself (France) or from the website of the steward of the health system (Germany).

To discover information about the levers of the health system, an initial assumption was made that the steward was called the Ministry of health. This phrase was searched for in association with the country name. The key words were translated into the respective languages and then searched for. This revealed the stewards of the respective health systems. The stewards had functional websites which were useful for identifying partners, obtaining information about health programmes and in some cases for example, technology discussed above announcements of changes to
the health systems that could influence cancer treatment. See Table III for answers sought to uncover the activities in the levers.

Table II: Contextual factors

<table>
<thead>
<tr>
<th>Contextual factor</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology</td>
<td>What is the burden of cancer? At what stages are they discovered? What are the current cancer treatment survival rates? What is the national mortality rate from cancer?</td>
</tr>
<tr>
<td>Technology</td>
<td>What are the attitudes towards adoption of innovation in the treatment of Cancer?</td>
</tr>
</tbody>
</table>

Information about the organization of the health system, the roles of the steward, financing, service provision and resource allocation was obtained from scientific papers analysing health systems as well as publications by organisations promoting health system effectiveness. For example the Institute for the study of Civic society (CIVITAS) has a health unit which analyses health systems to promote learning between countries. The European Observatory for Health in collaboration with the WHO publishes thorough analytical reports on health systems in Europe as well as around the world in the Health systems in Transition series. These examples are not exhaustive and other sources are referenced.

Table III: Levers

<table>
<thead>
<tr>
<th>Levers</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stewardship &amp; Organisation</td>
<td>Who is the steward of the health system? Who is the steward for the NCCP? What are the treatment objectives of the NCCP? Are they clear, time-bound, measurable? What is the organization of NCCP? What is the extent of integration of financing and health provision?</td>
</tr>
<tr>
<td>Resource Allocation</td>
<td>How are human, financial and infrastructural resources allocated for treatment of cancer? Which agency is responsible for allocation?</td>
</tr>
<tr>
<td>Financing</td>
<td>How is the health system funded? What agency is responsible for the pooling of funds? Is there an agency responsible for the funding/pooling of funds for cancer treatment? How are funds allocated for the treatment of Cancer? What provider payment mechanisms are used? Are there other agencies involved in sponsoring cancer treatment? Is there additional funding for providers to cover capital costs incurred in providing cancer therapy?</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>What is the role of the different levels of health provision: primary, secondary and tertiary? Is there a mixture of public and private providers? Is there an environment for contestability between public and private providers? How is service delivery organized re role of: specialists, trained specialist medical assistants? How autonomous are the providers in deciding the modalities of treatment available at their facilities?</td>
</tr>
</tbody>
</table>

Data see Table IV. Effectiveness and Efficacy were based on the available modalities for treatment and the treatment outcomes including survival rates where published. Choice was based on the autonomy given in each country to patients to make decisions about their own cancer therapy. Equity was assessed using the distribution of health geographically in the form mortality rates across geographies where published. This information was obtained from the cancer registry publications, assessments of outcomes of previous NCCPs (only available in France).

Table IV: Intermediate Goals

<table>
<thead>
<tr>
<th>Intermediate Goals</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency, Equity, Effectiveness, Responsiveness &amp; Choice</td>
<td>What are the current treatment modalities? What evidence is there of effectiveness of treatment modalities? How are the treatment plans organized and delivered? What is the level of treatment for cancer available and how is it distributed? Do the rich and poor as well as different ethnic groups have equal opportunity to access cancer treatment facilities? How much choice do patients have in the selection of facilities where treatment is received?</td>
</tr>
</tbody>
</table>

Attainment of the intermediate goals effects the achievement of the end goals of health, satisfaction and financial risk protection from impoverishment secondary to health expenditure for the population served by the health system. Health is assessed based on both the level of health available and the distribution of health across the population. Measures of level of health attained include mortality rates, Years of life lost, composite indicators like Disability or Quality Adjusted life years (DALY/QALY). The distribution of health is measured by parameters like life expectancy, survival rates following cancer diagnosis etc. The criteria used to evaluate the level of health attained for cancer patients differed based on the manner in which the information was published. The information sought is shown in Table V and was obtained from the population and hospital based cancer registry publications and national health surveillance publications or websites.

Table V: End Goals

<table>
<thead>
<tr>
<th>End Goals</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Are there areas of the country significantly more burdened than others?</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>Is satisfaction with treatment for cancer measured? If so what are the results?</td>
</tr>
<tr>
<td>Financial Risk Protection</td>
<td>Is Cancer treatment covered? To what extent?</td>
</tr>
</tbody>
</table>

Assessment of financial risk protection was focused on how the NCCP and health systems are organised to ensure that cancer diagnosis does not lead to impoverishment for the patient.
Satisfaction was the most subjective to measure as it is based on the individual’s expectations from the health system. No publications were found that had measured satisfaction with cancer treatment in either country.

III. FINDINGS
A. CONTEXTUAL FACTORS

1) Epidemiology
Both countries have a network of cancer registries which submit cancer epidemiological data that is validated prior to publication: FRANCIM; France Cancer Incidence and Mortality and GEKID; Society of Cancer Registries in Germany respectively. The incidence of cancer in Germany exceeds that of France by 69,100 cases. Mortality rate is higher in Germany than in France 210,930 [8] and 146,800 [9] per 100,000 people respectively. Cancer 5-year survival rate is comparatively lower in Germany ranging from 35 – 49% [8] than in France with 44-63% [9]. The strongest focus of the NCP is the financing of improved data collection and registration by the Association of population based Cancer Registries.

2) Technology
In Germany, the Federal Ministries for Education and Research (BMBF), Economics and Technology (BMWi) and Health (BMG) are developing a cross-departmental strategy process "Innovations in Medical Technology". Aimed at developing a coherent innovation policy in medical technology, to further enhance patient treatment and to quicken the rate at which research findings from the lab are introduced into medical practice [10]. In France, several objectives of the plan include the use of information technology as well as quicker inclusion of biomedical devices in reimbursement schedules furthermore; calls for proposals are made by INCa to support the purchase of technology for cancer treatment [11].

B. LEVERS
1) Stewardship and Organisation
The Ministries of Health are the stewards of the health system in both countries. In Germany, no singular agency is responsible for the NCP it is however overseen by the BMG [12]. In France, INCa is responsible. For each of the stated objectives, there are actors responsible for the achievement of outcomes. The actors are listed on the cancer plan website [13].

The treatment objectives in the NCCP are shown in Table VI. The organization of the NCP is such that working groups have been assigned to the four areas of action identified; two goals (goals 2 and 3) address cancer treatment, recommendations are submitted by working groups to the BMG and a steering committee made up of key stakeholders approves the recommendations made. There are 5 areas in French plan, Patient care is the 4th and pertains to cancer treatment. It aims to guarantee each patient individualized and effective care management. There are seven measures in this section (from 18-24). Four directly pertain to patient treatment. The French Plan is explicit about actionable plans and agencies responsible for executing the objectives. Furthermore, indicators for assessment of outcomes of the plan are updated and published on the Cancer Plan 2009-2013 website. The steering committee in France is made up of the heads of all agencies involved in the execution of the plan and headed by the Director General of Health. Quarterly meetings are held to monitor execution of the plan and make recommendations where necessary.

The NCP is a work in progress as recommendations for some treatment areas are under development by the working groups. In both plans some objectives are time bound. The approach to evaluating the achievement of objectives differs. The NCP outcomes will be evaluated through analysis of data collected from cancer registries. Whereas evaluation of the French plan, will occur twice in the 5 year span of the plan.

<table>
<thead>
<tr>
<th>Table VI: Treatment Objectives in NCCP of France and Germany</th>
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<tbody>
<tr>
<td>Objective</td>
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<tr>
<td>------------</td>
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<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
</tr>
</tbody>
</table>

2) Resource Allocation
In Germany for the ambulatory care sector geographic distribution of physicians is the responsibility of the Ambulatory Health Nationwide Association (KVB). Financial resource allocation is done by the National health Fund, which uses age-, sex-and risk-adjusted capitation to allocate resources to SHI based on number of enrollees [14]. The financing of medical equipment is by providers except the hospital’s plan is included in the state’s budget and the purchase is funded. Purchases of large medical equipment (both public and private providers) must be approved by the coordinating committee; otherwise, the purchase is rendered illegal and operating costs generated from its use may not be reimbursed by the SF [15]. No supplementary capital is provided for cancer treatment devices in the NCP. However approved oncological centres of excellence receive supplementary funding from the DKH of €3M, use of which is not prescribed [16].

In France, the planning of resources and capacity is done by the ministry of health and Regional Health Agencies (ARS). The National Observatory of Medical Professionals (ONDPS) keeps records of physicians, their specialties and
regions where they work. Hospital employment is dependent on where openings are available whereas self-employed physicians have the freedom to establish practices where they wish. The French cancer plan discusses the training, support and distribution of two clinical specialties that are judged to be of importance to quality of treatment; surgical pathology and radiology. Although a budget of €402,772,000 has been assigned to the Patient care section of the plan, how and what it will be spent on is unclear. No additional funding is provided for the purchase of expensive cancer treatment devices. They are funded from hospital budgets. However the government through hospital plans has made funding available to support capital investment. This is mainly sponsored by SHI either directly or through long term loans following the approval of tendered proposals [4].

3) Service Provision
In Germany cancer treatment is organized in three tiers which integrate ambulatory and in-patient sectors of care. Primary providers are responsible for screening and diagnosis. Care is then transferred to oncologists who decide the patient care pathway and refer further when necessary. Most physicians providing ambulatory care are privately employed whilst majority of those who provide hospital care, are publicly employed [17]. Due to free choice of healthcare providers given to patients, they must remain competitive in delivering services. The Oncology Program Guidelines (lentilinienprogramm Onkologie) has been awarded the responsibility of compiling and distributing oncology guidelines in Germany. In France, regional cancer networks disseminate best oncology practice information to physicians in the region, facilitate of information sharing between specialists on an individualized patient basis (with consent), provide access to information, collect and evaluate data. Family practitioners are responsible for diagnosis of cancer and subsequent referral. Following referral, the patient plan is formulated at a multidisciplinary meeting of all specialists required for managing the case. The patient plan is decided based on guidelines and the patient’s presentation and is disclosed to the patient in a special meeting handled by the doctor in charge of the patient which may be a specialist or general practitioner [13]. Care is integrated between all oncology specialists and medical staff that provide psychosocial support.

4) Financing
Financing in both countries is through SHI funded through wage based contributions by employers and employees. Public funds are pooled at a national level before redistribution to sickness funds. Provider reimbursement is based on the sector in which care is delivered and the reimbursement schedule for that sector³. PI contributes to health system financing but plays different roles in each country⁴. Neither plan separates an agency responsible for the financing of cancer treatment. Funds allocated to pay for cancer treatment are allocated in the same way with other disease areas except for breast cancer in Germany which follows the Disease Management Programme (see next section). Provider payment mechanisms are also sector based. In France; public hospital based providers are reimbursed with salaries, private hospital and non-hospital based providers by fee-schedules. Several agencies are involved in the execution of the cancer control plans of both countries however how or if any of the organisational budgets will be deployed for the achievement of NCCP objectives is unclear.

C. INTERMEDIATE GOALS
1) Efficiency, Equity, Effectiveness, Responsiveness & Choice
Treatment modalities in France include surgery, radiotherapy, and chemotherapy. This extends to include molecular therapy and hyperthermia in Germany. Both countries provide supportive and palliative care. Independent agencies in both countries define certification criteria which must be fulfilled for oncology treatment facilities to render services. Responsibilities of the agencies include the assessment, review and publication of approved centres. Furthermore both countries have included the development and dissemination of oncology best practice guidelines in their cancer plans. This information will be developed through international guidelines, translational research in conjunction with local knowledge gained from monitoring patient outcomes.

In France, each patient is to receive an individualized plan for treatment and the preferred doctor (to whom the patient is registered) coordinates patient’s care. Each patient is entitled to multidisciplinary specialist input in the planning of their care. The equitable distribution of cancer care remains a goal of the current cancer plan. The indicator of its achievement will be a comparison of the number of patients who receive personalized care plans against the incidence of cancer in the same timeframe.

In Germany care provision is divided into ambulatory and hospital care sectors. Oncologists have a pivotal role; they design patient treatment plans subject to patient consent. An innovative approach called the Diagnosis Management

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³ Germany: Two sectors; Ambulatory care reimbursed based on the German Uniform Value Scale(EBM) Inpatient care reimbursed by Diagnosis Related Group classifications (G-DRG)

France: Three sectors; Ambulatory care, reimbursed by , Home care reimbursed by, and inpatient care reimbursed by DRG called homogènes de malades (GHM) codes

⁴ In France Private Insurance is used to cover co-payments and in some cases underprovided services in the SHI scheme. In Germany, citizens who earn above €48600 annually, have the freedom to opt out of the SHI and use PI instead
Programme (DMP) was introduced in Germany to improve care coordination (see Table VII). The pioneer cancer site was the breast and it is anticipated that it will be rolled out for the other sites in the future.

Table VII: Overview of Breast Cancer Disease Management Programme

<table>
<thead>
<tr>
<th>Partners</th>
<th>Patients*, Association of Regional Physicians, Hospitals, SF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roles</td>
<td>Patients: Responsible for attending information sessions and prescribed hospital visits&lt;br&gt;Association of Regional Physicians: a Gynaecologist coordinates the clinical activities within the DMP&lt;br&gt;Hospitals: Partner with the ambulatory sector to provide inpatient care for the patients&lt;br&gt;SF: Responsible for formulating of the quality and administrative criteria for the DMP</td>
</tr>
<tr>
<td>Enrollees</td>
<td>Only patients under the SHI scheme can be enrolled, privately insured patients are excluded</td>
</tr>
<tr>
<td>Incentives</td>
<td>SF: Under the RSC, SF receive extra funding for all DMP patients enrolled with them&lt;br&gt;KVB: Receive additional funding for activities outside of medical services in addition to the global budget used to reimburse medical services&lt;br&gt;Patients: Co-payments for doctor visits are waived for patients who enrol in the DMP&lt;br&gt;Hospitals: Certification protocols analyse the quality of evidence based care delivered to patient</td>
</tr>
</tbody>
</table>

All patients covered by SF are entitled to receive services listed in the EBM schedule for ambulatory cancer care and those included in the DRG scheme for inpatient care. Privately insured patients will receive coverage for services included in their premium package. Equitable distribution of cancer care is the 4th objective of the NCP. This objective is still under discussion.

Patient Choice exists at several levels in Germany. Choice of SF to join is free and patients may switch between SFs. Patients have free choice of provider. Furthermore they have the opportunity and are financially covered to seek a second opinion about diagnosis and treatment plans. In France, patients can choose the doctor and facility where they will receive care even without referral. It is unclear what the process is, for getting second opinions. In both countries patients can freely opt in for clinical trials.

D. END GOALS

1) Health

There are variations in incidence and mortality in all regions of Germany and these variations are not uniform across gender. Incidence rates in the regions were not matched with mortality rates so it was not possible to assess the relationship between both [8]. In France the variation of cancer incidence by region was higher in males than in females. The incidence rate was higher in the northern regions of the country than the south and this was matched by the mortality rate except for the centre of the country [9].

2) Satisfaction

Neither plan mentions assessment of patient satisfaction with treatment. However an indicator used to judge outcomes of health systems in the Euro Healthcare consumer index is cancer deaths relative to incidence. Both countries scored 3 (scale is 1 to 3, 3 being the highest) [18].

3) Financial Risk Protection

In France, the National Insurance scheme covers patients 100% for cancer treatment expenses. Co-payments are not required [19]. Cancer treatment is covered by SFs in Germany. Capping of co-payment at 1% of annual income protects from impoverishment secondary to out of pocket expenditure.

IV. DISCUSSION

France is in the second five year session of its national cancer plan. The plan lays out specific objectives, which are time-bound and have laid out indicators to assess achievement. This layout of the plan is commendable, responsible players for each objective can be identified and held accountable for the achievement of outcomes. The German plan is in early phases of development and execution. It is however not time bound, has no clearly defined accountable actors and no pre-determined indicators of success. The increasing use of technology as a tool for communication and care planning, as well as innovative therapeutic methods shows the indispensable value investments in technology have in improving the outlook for cancer patients. Although both countries have established cancer registries efforts are still being put in place to expand the coverage and information collected by theses registries. This improved data collection is cited to be important to improve both equity in access to cancer care and to assess the outcomes of medical intervention. Equitable distribution of health is identified by both countries as important and addressed in both cancer plans. However improvements to the objectives can be made to achieve this outcome. For example the KVB in Germany plans the distribution of ambulatory Physicians, a similar strategy can be used to plan the distribution of oncology specialists. Setting a target number per region and ensuring that the number required is available and based on future projections of need, can be met and sustained over the years. In both countries cancer care provision requires certification of centres, which is commendable as it implies that a governing body oversees activities and is likely to promote the provision of high quality care. This improves the possibility of approaching standardization of care across facilities and regions. Except for the DMP for Breast cancer in Germany, provider reimbursement has not been adapted.

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5 Members may change SF after 18 months of enrolment or at any time if the SF raises contributions. This may happen if SF finds that funds assigned by the National Fund are insufficient, it is legally allowed to raise contributions by members.
to incentivize best practice cancer treatment. Both countries could plan provider reimbursement such that it incentivizes the use of best practice guidelines.

Cancer treatment and the quality of life thereafter should be considered satisfactory by patients. Neither country includes assessment of patient satisfaction in its NCCP. Patient satisfaction must however be sought and gaps where improvements can be made identified. It is laudable that both countries have financially protective measures for cancer patients. Germany would benefit from reviewing the effect of co-payments, although capped, due to other non-treatment related costs of cancer treatment.

V. LIMITATIONS
The translation of documents could have resulted in lost meanings. Another limitation was the timing as neither plan had reached a point in implementation whereby the outcomes of the plan were quantifiable. Future research should be based on analysis of achieved objectives.

VI. CONCLUSION
This analysis has been useful for identifying the steps being taken by both countries to improve cancer treatment. It serves as a source of learning not only for both countries from each other, but also for other countries who seek knowledge that can assist in developing the treatment pillar of their NCCP. Such comparisons are particularly important for policy makers and indeed academics who wish to visualize the state of affairs and identify areas for improvement.

Valuable time can be saved by having an understanding of what has been shown to work, how it was executed and what has failed with reasons as well. Cancer is a global public health challenge. However the efforts to battle cancer remain bound by the efforts of health system stewards in respective countries or regions as the case may be. Assessment of efforts being made and communication of such assessments can sharpen the learning curve and potentially improve outcomes.

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