

## Volume 8 - Issue 1, 2008 - Special Focus Section: Mammography

### Breast Centre Management: How to Provide Quality and Cost-Effective Care

---

#### Author

**Dr. Uwe Heindrichs**

*Director*

*Department of Breast*

*Surgery*

*University Hospital*

*Aachen*

*Aachen, Germany*

[uheindrichs@ukaachen.de](mailto:uheindrichs@ukaachen.de)

**In Germany, up to two out of every ten women will suffer from breast cancer during her lifetime. Around 17,000 out of 50,000 of these affected women will go on to die of the disease each year. In order to address this situation and to improve diagnosis and therapy procedures, breast cancer centres have been established throughout the country during recent years. This article explores the ways we structured these national breast centres in order to optimise patient treatment while maintaining cost-effectiveness.**

#### How to Provide Quality and Cost-Effective Care

The certification of breast centres in Germany has gone through much development. Initially, hospitals had the power to designate themselves as centres, irrespective of any existing certificate. Particularly, in the state of Land Nordrhein-Westfalen (NRW), which has a high population density, breast centres that require special certification are nominated and supervised by the state government which is then overseen by the General Medical Council (Ärztammer). In addition, several other forms of certification exist depending on the institution or society offering it (e. g. the German Society of Senology; the German Cancer Society, ISO 9001: 2000, OnkoZert, etc.).

#### European Society Provides Standards

Moreover, the European Society of Mastology (EUSOMA) offers accreditation (initially and fully) depending on facility equipment, patient numbers, levels of interdisciplinary collaboration, quality assurance, application of diagnostic and treatment protocols and follow-up. For initial accreditation, the centre is visited and audited by an international group. The requirements for a specialist breast unit were finally published in the year 2000 in the European Journal of Cancer, concretising the essential standards to which these units must work.

Several main health insurance companies have installed a Disease Management Programme (DMP) that also aims to optimise the diagnosis and treatment of women suffering from breast cancer. The programme's statutes were established in the year 2000. To enter this programme, patients can be enrolled either by participating hospitals or by the primary physician, which is usually the gynaecologist. A special form was developed for enrollment, which must be updated at least once every six months for five years.

#### Facing Budgets and Figures

Parallel to those efforts, breast cancer hospitals were then accorded the opportunity to process payments using the Diagnosis Related Groups (DRG) System. This led to a reduction in the time patients spent in the hospital, and consecutively to a condensation of work whose impact was mainly felt by the nursing personnel during the in-patient time.

EUSOMA recommends that breast centres should each cover from one-quarter up to one-third of a million of the total population. It also advocates that a breast unit's budget should be separate, rather than drawn from a number of more general budgets within the hospital. The recommendation was made to ensure a caseload sufficient to maintain expertise for each team member and to ensure cost-effective operations for the breast unit.

From that point of view, the national and regional aims in the NRW were comparable, but still ongoing. In the NRW region, which has the highest density of population, out of 250 hospitals, 50 centres should be designated. Meanwhile, 51 centres with approximately 128 operating locations have been nominated by the local government, which means a recruiting area of around 141,000 inhabitants per operating unit.

An Italian study (Pagano et al.) came to the conclusion that at least 200 primary cases of breast cancer have to be treated in a breast centre in order to reach a balanced budget. This is mainly due to the essential need for a high-quality service, which by necessity demands a highly specialised team working in an interdisciplinary setting. In other words, in statistical terms we have already come halfway towards achieving this benchmark.

### **Dealing with Rising Costs**

Factors that will inevitably drive costs upwards include:

- New staff, e.g. breast-care nurses, psycho-oncologist, quality- and data-managers
- Doctors have to be specialists
- Additional conferences/clinics have to be organised and worked out
- Time pressure (“all in one visit”) requires more specialist staff at all times

In order to address this, the following recommendations will ensure that a high-quality service can be provided, while remaining within budgetary targets:

- All facilities should be contained under one roof;
- An excellent IT department that can ensure information flow without talking or walking; help to compose medical reports quickly and easily and optimise the interface with the treating physician;
- Team spirit is of great importance, also in an interdisciplinary setting;
- Continuity of staff guarantees stability in human interactions;
- Responsibility of the treating team, with a dedicated contact person for that patient

The process for the patient is comparable to a chain with a number of links being in danger of breaking at the weakest point: this could lead to higher costs and damage trust. The above-mentioned factors will ensure a tightly organised path for the patients and by this save time and money.

### **Conclusions**

In summary, breast cancer centres are confronted with parallel demands. Economic pressures require changing procedures in hospitals such as DRGs and quality management systems. Yet these centres have to operate within tight financial constraints to establish high-quality breast cancer centres according to national and European demands.

There is no other way, because optimising the treatment of breast cancer has been shown to lower both morbidity and mortality of the afflicted women. For example, a Scottish study (Gillis et al, 1996) demonstrated that there were 16% fewer deaths when patients were handed into the care of these types of specialist settings, a substantial risk reduction.

In terms of local, national and European standards and regulations, existing differences must be harmonised in order to avoid redundancies and to enable centres to enhance their optimising process. Thorough quality management protocol, data management systems and certification procedures will effectively lead to the kind of reliable benchmarking that will enhance sustainability. In areas with an unfavourable inhabitant- to-hospital ratio, the centralisation process should be accelerated in order to allow hospitals already offering high quality to operate at a cost-effective level.

Published on : Sat, 1 Mar 2008