

Overcoming resource and reimbursement barriers to best practice in the care of chronic wounds

Despite growing consensus on wound care best practice, patients with chronic wounds continue to experience delayed escalation, suboptimal treatment and prolonged healing times (Guest et al, 2020; Ahmajärvi et al, 2022). Chronic wounds pose significant clinical, social and economic implications worldwide (Frykberg and Banks, 2015), representing a strain both on individual patients and healthcare systems (Mahmoudi and Gould, 2020). In November 2024, the Advanced Wound Management (AWM) Chronic Wounds Global Advisory Board convened to discuss these concerns. This is the final article in a series drawing on insights from that advisory board.

The first article identified clinical inertia as a central challenge in provision of best-practice wound care (Probst et al, 2025a); the second explored the behavioural and psychological barriers that influence whether clinicians can act on their knowledge (Probst et al, 2025b), while the third focused on empowering generalists to make better wound care decisions (Probst et al, 2025c). The fourth explored how to streamline wound care practices system-wide with scalable solutions (Atkin et al, 2025).

In 2025, another meeting was held to gather expert feedback on the solutions implemented since 2024 and to explore further barriers. Capturing both consensus and dissenting views from the global panel, a live exchange of ideas took place, generating real-world insights from the panel's own clinical settings and specialities.

The objectives of this meeting were to:

- Understand how to navigate and overcome resource and reimbursement barriers and optimise access to advanced wound care solutions
- Explore how to bridge the knowledge gaps in wound care with better medical education access
- Assess how to maximise impact through scientific communication of mode of action of PICO^o single-use negative pressure wound therapy.

This final article addresses another problem that persists even when clinicians are knowledgeable and motivated: access. Across regions, access consistently emerged as a critical determinant of whether best practice is

implemented in routine care.

The advisory panel emphasised that access barriers are rarely the result of unavailable technologies or absent evidence, instead arising from fragmented funding structures, inconsistent reimbursement policies and administrative complexity, as well as resource limitations.

Access as a system-level barrier in the care of chronic wounds

Access limitations are distinct from the clinical and educational deficits presented in previous articles, instead reflecting structural constraints embedded within reimbursement models and healthcare system infrastructure. Moreover, they persist even when clinicians are knowledgeable, motivated and aligned with evidence-based guidelines. There is a lack of focus on patient centred outcomes, such as quality of life, pain reduction, functional recovery and psychosocial impact.

Differences in reimbursement structures across geographies also contribute to variability in access. The advisory board members suggested that strong reimbursement systems are an advantage (such as in Germany), contributing to effective wound care, whereas weaker or less coordinated reimbursement models may be associated with greater access challenges. Not all systems operate on a reimbursement model; some are regulatory- or procurement-led, each presenting its own distinct challenges.

Advanced therapies

According to the panel members, limited access to advanced wound care therapies, including single-use negative pressure wound

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therapy (sNPWT), remains a challenge, due to a combination of resource constraints (including a scarcity of trained professionals) and cost considerations. The panel noted that advanced therapies, such as NPWT, are often evaluated based on upfront costs rather than 'total-episode cost-effectiveness', which creates a financial barrier to evidence-based care, despite the intervention having demonstrated value across the full healing episode.

A 2022 health economic analysis of NPWT illustrates this point: while per-patient costs initially appeared slightly higher (€2,034.98 versus €1,918.91), the cost per closed wound was substantially lower (€4,324.34 versus €8,480.32), representing a saving of over €4,000 per healed wound (Brennfleck and Bongards, 2022). This demonstrates that focusing on initial expenditure rather than total healing episode costs could lead to decisions that ultimately increase, rather than reduce, healthcare spending.

Similarly, in a two-year study of patients with severe chronic wounds and multiple comorbidities, NPWT achieved significantly faster healing (270 versus 635 days, $p=1.0 \times 10^{-7}$) and delivered substantial economic value: an incremental net health benefit of \$9,933 per ulcer-free month at year two (unmatched cohorts). It also generated 68–73% higher quality-adjusted life-year gains compared to standard care by year two (Driver et al, 2016).

Outside hospital settings, clinicians may lack an understanding of how to navigate reimbursement systems for advanced therapies. This indicates that, even when a therapy is approved in principle, frontline clinicians may still be unable to access it in practice due to limited understanding of how to initiate the approval process, complete the required documentation, or identify the appropriate funding pathways for their patients.

Foundational interventions

The panel also identified inconsistent access to and use of foundational interventions, such as compression therapy or offloading, as a barrier to optimal care for chronic wounds.

Even where compression therapy has been approved, organisational factors may prevent consistent implementation. These factors may include heavy caseloads and workforce pressures that delay assessment; lack of continuity of care with different staff attending patients who may not have a comprehensive understanding of treatment history; gaps in knowledge and skills regarding compression application and monitoring; limited access to training due to time constraints and high

staff turnover; delays when nurses cannot independently prescribe compression; and variations in available compression systems across different geographical areas (Perry et al, 2022).

Additionally, the absence of specifically commissioned leg ulcer services in some areas means care is often provided within general community nursing services, where competing priorities and resource limitations further restrict access to appropriate compression therapy (Perry et al, 2022).

These findings highlight that access to evidence-based foundational interventions may be determined not just by knowledge or reimbursement approval, but by the operational infrastructure needed to ensure clinical recommendations translate into consistent care.

Similar access challenges exist for offloading in diabetic foot ulcers. Offloading has been described as "arguably the most important of multiple interventions needed to heal a neuropathic plantar foot ulcer in a person with diabetes" (Bus et al, 2019), with international guidelines from the International Working Group for the Diabetic Foot (IWGDF) providing clear evidence-based recommendations for its use (Bus et al, 2020). Despite this robust evidence base and national consensus documents on offloading practice, implementation remains inconsistent across the UK (Chadwick, 2021).

In a series of online discussion groups, clinicians identified multiple interrelated barriers to effective offloading: poor communication between hospital and community settings; budgets held in departments other than the point of care (such as orthotics or plaster rooms); insufficient or non-existent funding in community settings, forcing use of low-cost, ineffective alternatives; central storage locations and lack of space, restricting device availability; and outdated formularies based on cost rather than clinical effectiveness (Chadwick, 2021).

These challenges are compounded by a global shortage of healthcare workers, particularly specialised wound care nurses. Therefore, even when resources and reimbursement approval are present, the clinical capacity to deliver evidence-based interventions may be insufficient to meet patients' needs.

Best practice principles to address access barriers in the care of chronic wounds

The following recommendations are intended to help overcome access barriers that restrict delivery of evidence-based wound care, from foundational interventions to advanced therapies.

1. Reframe advanced wound care as resource optimisation

When viewed solely through the lens of unit cost, advanced therapies may appear as budgetary pressures. When evaluated based on total cost of care, including longer healing duration, waste of clinician time, complication prevention and resource utilisation, advanced therapies become investments that optimise limited resources (Nherera et al, 2021). Therefore, healthcare systems must shift from asking “Can we afford this therapy?” to “Can we afford the consequences of delaying this therapy or getting the therapy wrong?” in order to address the cost-based barriers that prevent timely access to evidence-based interventions, such as NPWT.

Reframing advanced wound care as resource optimisation should extend beyond financial metrics to encompass patient wellbeing. Healing velocity is not solely a cost determinant; it directly influences pain duration, patient’s suffering, functional independence, the ability to work and overall quality of life.

By recognising that economic efficiency and patient-centred benefit are interconnected rather than competing priorities, healthcare systems can make more balanced and ethically grounded decisions by embracing technology proven to optimise care.

Key actions:

- Advocate to shift evaluation metrics from unit cost to total episode cost or cost per healed wound, to show that interventions with higher upfront costs may deliver cost savings through faster healing and fewer complications
- Use this total-cost perspective to challenge the perception of advanced therapies as budget pressures, repositioning them as investments that prevent downstream costs, including hospital admissions, amputations, infections and prolonged treatment episodes.

2. Generate and communicate data that demonstrates economic and clinical value

Without compelling data presented in accessible formats, even the most cost-effective interventions remain inaccessible and their benefits unseen, as decision-makers lack the justification needed to approve resources or authorise reimbursement. Therefore, there is a need to generate the specific economic and clinical evidence that financial decision-makers require based on their priorities. It is important to communicate this evidence in accessible language that resonates with payers, administrators and budget holders.

Key actions:

- Develop systems and databases that support consistent collection of relevant data. Collaborate with the organisation’s clinical experts, operations teams, procurement staff, suppliers, data analysts and system developers to ensure these data systems meet practical needs. Wherever possible, automate data collection and reporting parameters to improve accuracy and efficiency
- Generate robust data on healing times, complication rates, avoided hospitalisations, and total episode costs across different treatment pathways to enable decision-makers to justify and approve timely access to evidence-based interventions
- Translate scientific evidence into economic relevance by explaining mechanism of action using terminologies that decision-makers understand. This should include connecting the mechanism of action with impact on healing time, patient outcomes and resource consumption
- Strategically tailor communication to each stakeholder group: present return on investment and budget impact analyses to payers; operational efficiency gains and capacity creation to administrators; and clinical evidence with practical application to medical directors who review coverage decisions.

3. Address resource availability and supply constraints that limit access to evidence-based interventions

Resourcing limitations contribute to gaps between recommended and actual care practice, even where clinical evidence and adequate reimbursement coverage exist. Addressing these concerns requires pushing for the infrastructure investments needed to translate ‘approval’ into real-world patient access.

Key actions:

- Simplify supply chains and inventory management to ensure consistent access to reimbursed, evidence-based, foundational interventions (including compression therapy and offloading) across all appropriate care settings
- Build operational capacity by documenting realistic staffing requirements and skills, and by quantifying the impact of workforce constraints on care quality. This can help demonstrate how targeted investment in nursing resources, training and supply chain optimisation may enable improved delivery of evidence-based care.

Bridging knowledge, capability and access

Despite the existence of best practice guidelines, patients with chronic wounds continue to experience suboptimal outcomes. This series has examined why knowledge does not consistently translate into action, highlighting the persistent barriers that contribute to clinical inertia (Harding and Queen, 2019). These barriers have been identified in previous publications in this series:

1. Behavioural and psychological influences:

While evidence-based guidelines provide a rational path forward for clinicians, internal motivations and external pressures ultimately determine their decision-making in practice

2. Knowledge gaps: Inconsistent education and limited awareness of advanced therapies impede effective, timely decision-making

3. System-level variability: Fragmented care pathways and workforce pressures impact consistent application of best practices

4. Access limitations: Even when clinicians know what to do and system-wide solutions are in place to limit variability, resource and reimbursement barriers can prevent timely delivery of advanced wound care.

Conclusions

This article presents three strategies (i.e. reframing cost perceptions, demonstrating economic value and addressing resource constraints) which together offer practical ways to overcome access barriers in the care of chronic wounds.

However, success of strategies depends on the foundations laid throughout this series: the behavioural insights, knowledge frameworks and system-wide scalable improvements that create the conditions for effective access optimisation. By integrating economic thinking, systematic data generation and strategic value communication into routine practice, healthcare systems can begin to close the gap between capability and access.

When access barriers are recognised and addressed alongside the clinical, behavioural and systemic factors explored earlier in this series, the care for chronic wounds can move towards a model characterised by timely intervention, evidence-based resource allocation, improved healing outcomes and better quality of life for patients living with chronic wounds. ●

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