European Partnership for Action Against Cancer (EPAAC)

National Cancer Control Programmes: Analysis of Primary Data from Questionnaires

FINAL PRELIMINARY REPORT

prepared by

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LIST OF ABBREVIATIONS

EPAAC – European Partnership for Action Against Cancer

GLOBOCAN – Global Burden of Cancer Study

NCCP – National Cancer Control Plan

WHO – World Health Organization

WP – Work Package

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Executive Summary

The European Partnership for Action Against Cancer is a five-year initiative taking place under the umbrella of the European Commission to fill a void in cooperation, collaboration and shared experiences among countries with similar needs and diverse experiences in the field of national cancer control policy. Activities and studies will tackle the main challenges of cancer control in Europe and in Member States, including service provision and health system responses, human resources and research.

This report is part of Work Package 10, which specifically deals with National Cancer Control Programmes (NCCPs) in EU Member States, Iceland and Norway. This study aims at providing a comprehensive picture of where different countries are in relation to the development of NCCPs with the object of drawing from these data the necessary indicators to monitor the actions of NCCPs in a minimally harmonized way between countries. Later phases of the study (i.e., in 2012-2013) will also aim at developing guidelines for Member States to use when preparing or evaluating their cancer plans as a complementary part of this report and at proposing a set of indicators to serve during these processes.

The present document is the final preliminary report (out of seven total deliverables over the three-year study period), whose specific aims include consolidating the primary data gathered up to 30 November 2011, directly from Member States through surveys and subsequent follow-up and confirmation of data accuracy.

Part 1 (section 1) examines the background and formulate this report representing an analysis of NCCPs. This section presents a literature review on cancer epidemiology and cancer control policy within health systems and NCCPs, sketching out the main elements (both vertical and horizontal) that these programmes should ideally include. From this basis, a summary of necessary components of NCCPs is presented. Contextual factors (demographic, economic, legal and regulatory, epidemiologic, socio-demographic, ecological and technological) in European countries will also be examined in order to outline the factors that condition NCCP development at a national level. Finally, the EPAAC initiative will be summarized to define the overall aims of the initiative as well as the specific goals in Work Package 10.

Part 2 (sections 2-5) summarizes the primary data gathered from surveys sent out to study participants and should be examined in conjunction with Annex 1, which presents the comprehensive results of the study.

The present report indicates that NCCP development is growing across the region as the principal strategy to face the complex challenges imposed by cancer. While national programmes are heterogeneous, with mechanisms subject to diverse contextual factors including resource availability, systems capacity, organization of services, geography, epidemiology and past experience in cancer policy, all Member States are facing similar challenges in terms of the cancer burden and the need to formulate sustainable, effective and responsive policies for patients and citizens. The EPAAC initiative is based on the fact that shared experiences can strengthen both cancer services and political will to tackle this extremely important and growing public health challenge. While the EPAAC's main aim is to improve cancer policy and services in Europe, a complementary aim includes proactively putting cancer on the European agenda through the close participation of national stakeholders, experts, leaders, patients and citizens. Together, this "cancer

community" can identify the tools which are so needed to facilitate comprehensive cancer control in Europe.

There are the following limitations of the presented survey on the NCCPs:

1. There was a rather varied group of respondents who were appointed to respond to the survey in the respective member states
2. The Questionnaire intended for the UK was eventually completed only by the English Department of Health. However, other constituent countries of the UK also have NCPs, which will all be published on the website of EPAAC.
3. Given the relatively short time available in the preparation of the survey and the resulting ambiguity of some of the questions, answers to all of them are not always as specific as we would have wanted and/or expected.

PART I: BACKGROUND AND RATIONALE

1. Introduction and context

Collectively, modern-day health systems are under enormous pressure in terms of disease burden, demographic trends, the evolving roles of citizens, patients and health professionals, political challenges and financing sustainability. The twentieth century saw a dramatic epidemiologic shift in Europe, in the West in general, where infant mortality and deaths from communicable diseases such as tuberculosis, polio and infectious outbreaks were gradually overcome or controlled by effective public health policies. The deadliest diseases in Europe today are chronic rather than acute, affecting an ageing and predominantly urban population. Furthermore, older populations are not only more susceptible to disease (and therefore more dependent on the health system), they are less able to contribute to already strapped government revenues, the main source of health system financing. In addition to the above, we are facing a situation, where due to the ageing of the population and with it also of the cancer patients, there are more and more co-morbidities, which limit the use of the existing guidelines or, at least, reduce their effectiveness. On top of these factors, the unification of Europe has brought with it challenges such as the harmonization of European legislation and standards, along with opportunities in fields such as medical and health systems research. Finally, the predominance of chronic diseases has highlighted the indispensable role that citizens and patients have in managing their own health, while the globalized communication revolution has equipped them with the tools to make their voices heard louder than ever.

In this broad context, cancer control is in the eye of a perfect storm. Incidence is rising among ageing populations, and patients are increasingly informed, empowered and assertive with regard to their rights and their wishes. At the same time, cancer is one of the non-communicable chronic diseases that require very extensive resources taxing financial and human resources across multiple health services, from primary prevention to palliative care and rehabilitation. European governments are addressing these

challenges as they can, with greater or lesser success, but it is apparent that effective and cost-efficient system-wide policies for cancer control are needed more urgently now than ever throughout the European continent.

Thus, the European Partnership for Action Against Cancer (EPAAC) emerged under the umbrella of the European Commission to fill a void in cooperation, collaboration and shared experiences among countries with similar needs and diverse experiences. The initiative spans five years, from 2009 to 2013, and will draw from the experiences and expertise of a wide range of participants, including political leaders, academic researchers, health professionals and patients. Activities and studies will address the main challenges of cancer control in Europe and in Member States (MS), including research, service provision, human resources and health system responses.

Within this framework, Work Package 10 (WP 10) deals specifically with National Cancer Control Programmes, the subject of the present study. Over the course of three years (2011-13), these national strategies will be analyzed by participants in the Work Package and by Member States themselves. This consolidated body of information will provide the basis for conclusions on programme effectiveness as well as recommendations of ways to enrich national policies with a European added value, represented through multi-country experiences.

In 2012 the work in the WP 10 will focus on the development of guidelines and on the selection of the most appropriate indicators that should serve best to monitor and evaluate NCCPs at the national and EU comparative levels.

1.1 Aims

This study aims to give a comprehensive picture of where different countries are in relation to the development of NCCPs. The research team and the Working Group will draw key indicators from this data to monitor the actions of NCCPs in a harmonized way between countries. While structural, political and financial arrangements may differ greatly between countries, certain aspects (e.g., presence of a population based screening programme for cervical, breast and colon cancer, human resource planning in relation to population needs) are comparable between even the most disparate Member States. By facilitating comparisons between programmes—even to a limited degree—best practices can be identified, which may in turn facilitate the improvement of cancer care in the EU. To achieve this goal work included examining the existing bodies of knowledge, such as publications, reports and work done by WHO and UICC.

1.2 Brief overview of the cancer burden in Europe

1.2.1 Cancer epidemiology in Europe

Although cancer is frequently thought of in terms of a single disease, nothing could be further from the truth. In fact, this umbrella term includes 150 different pathologies and masks dramatic variations in terms of incidence and prevalence among different populations, causality, treatment options and prognoses.

The most commonly diagnosed cancers in Europe are, in order of numerical importance, breast, prostate, colorectal and lung cancers, accounting for around a half of the 3.4 million new cases in 2008. The cancer mortality burden is dominated by the same cancer types (1), although in a different order: lung cancer is responsible for almost 20% of all cancer deaths, followed by colorectal (12%), breast (7.5%) and pancreas (5.4%). The following most common cancers, all responsible for about 1.8%-5.1% of total cancer incidence, include cancers of the pancreas (2.9% of all new cancers), uterus (cervix and body of uterus combined, 4.5%), stomach (4.9%), oral cavity and pharynx (1.8%), kidney (3.1%) and non-Hodgkins lymphoma (2.7%). In addition, a few relatively uncommon cancers are nevertheless quite significant in terms of mortality, namely pancreatic and stomach, responsible for 5.4% and 7.2% of total cancer mortality, respectively.

The cancer burden also varies quite significantly by country, although admittedly, completely accurate data remains elusive given differences in reporting quality. Incidence in Hungary and the Czech Republic is notably higher than in the rest of the EU, including neighbouring countries in Eastern Europe. Some northern European countries, such as Denmark and the Netherlands, also stand out for the high incidence reported.

Perhaps more illustrative of the scope of the cancer burden, though, is the mortality rate in comparison to other causes of death. Overall, it is a leading cause of death in the EU, second only to diseases of the circulatory system (Figure 1). Moreover, in developed countries including France, Spain and the Netherlands, cancer kills more citizens than any other cause[1]. More men die from these diseases than women, due in large part to mortality from lung cancer, but given the levelling of current smoking rates among men and women, there is no certainty that this will continue to be the case in coming decades.

All in all, the threat that cancer represents to population health across the European Union is too serious to ignore. Primary and secondary prevention will be essential in order to address incidence, but given that age is the greatest risk factor of all for developing these diseases, integrated care (including palliative and psychosocial aspects) must be improved in response to increasing prevalence. Research and professional training, cornerstones of all medical progress, must drive improvements in service delivery across these areas.

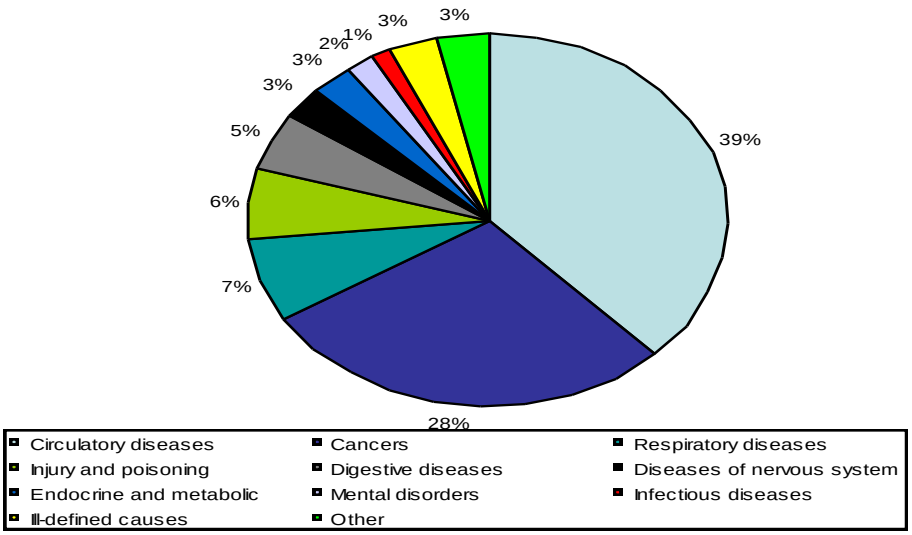
1.2.2 Major health system challenges in tackling cancer (see also publications 'Health in Transition from the European Observatory on Health Systems and Policies, which give excellent summaries on individual member states' health systems)

In general terms, health systems are faced with the same challenges in tackling cancer as those which are present when addressing a wide range of other health threats: achieving the overarching goals of health

[1] Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin DM. GLOBOCAN 2008 v1.2, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon, France: International Agency for Research on Cancer; 2010. Available from: http://globocan.iarc.fr, accessed on 22/04/2012.

gain, financial protection and responsiveness to citizen and patient needs. These are accomplished by means of certain health system *functions*: resource generation, financing and service delivery, all of which are ensured through effective governance (or stewardship) of the system as a whole (Scheme 1). As set out in the WHO World Health Report 2000, the overall effectiveness of a health system can be evaluated by examining five areas: level of health (e.g., disease burden), distribution of level of health (e.g., equity of disease burden), level of responsiveness (e.g., patient satisfaction), distribution of responsiveness (e.g., equity in patient satisfaction among different groups) and distribution of the financial burden (e.g., percentage of out-of-pocket costs in population). However, it can also be assessed by progress on certain objectives related to processes, which may include quality, efficiency, transparency and accountability, accessibility and choice (among others). Governments may functionally address these intermediate objectives in order to achieve the ultimate goals, and an effective government response to any health threat—including cancer—is conditioned by the strength of the links in this chain.[2]

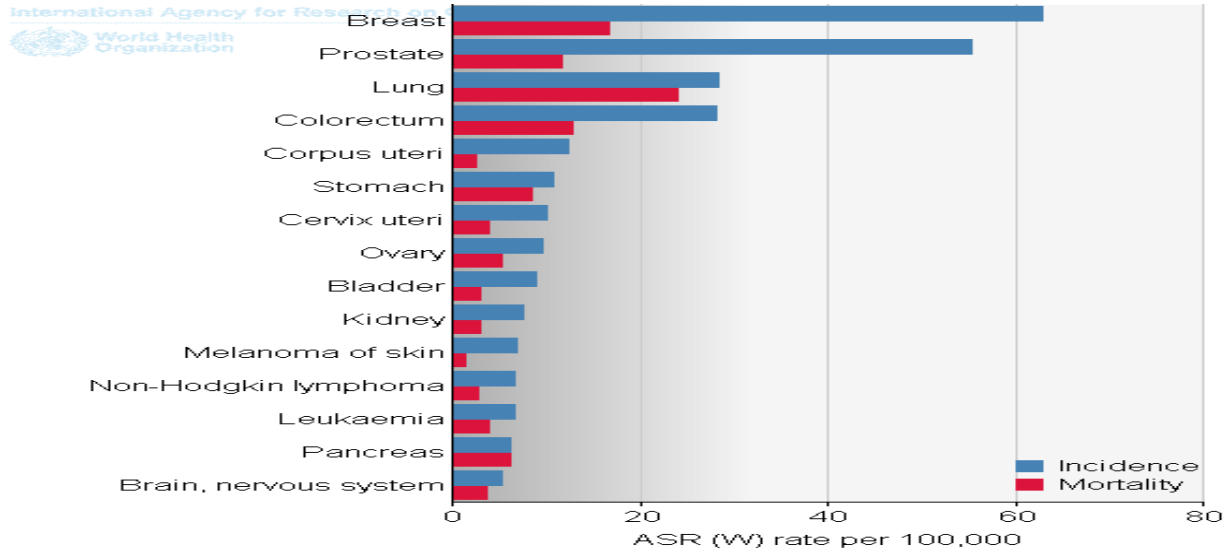
Figure 1. Proportional mortality by broad cause of death in the EU in year 2008



Source: WHO Europe, Health for All database, 2011

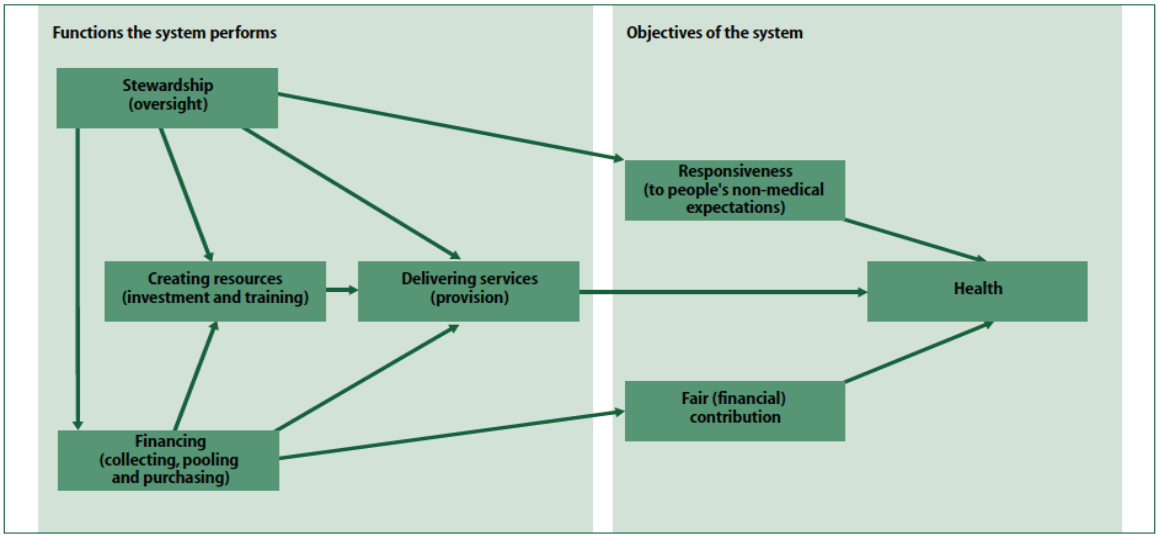
[2] World Health Organization. World Health Report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000.

Figure 2. Incidence and mortality rates per 100,000 population for cancer in Europe in 2008.



Source: Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin DM.GLOBOCAN 2008 v1.2, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon, France: International Agency for Research on Cancer; 2010. Available from: http://globocan.iarc.fr, accessed on 22/04/2012.

Scheme 1: Health system functions and goals



Source: World Health Organization. World Health Report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000.

Stewardship challenges are marked by the fact of cancer being a complex disease, which is marked by different aethilogies and a number of important determinants - because cancer can be caused by behaviours (e.g., smoking), environment (e.g., radiation), infectious diseases (e.g., HPV) or genetic predisposition, cancer policy must encompass a wide range of government policy, from tobacco control to occupational safety to population-based vaccination and screening services in primary care. Moreover, these determinants are not evenly spread among populations but rather concentrated on the lowest rungs

of the socioeconomic ladder, so specific measures to tackle cancer genesis will require special approaches addressing all underprivileged and all those determinant related to the societal groups belonging to the lower socio-economic classes, including an intersectoral approach, which acts beyond the strict borders of the health system to impact health determinants found throughout society, including in health education and communication, labour, housing, environment, agriculture and industry.[3,4]

Likewise, the resource-intensive nature of this mostly chronic disease will present challenges in both securing sufficient resources as well as in distributing them wisely. Health professionals are lacking across all countries and in a number of specialties, but certain specialists required for effective cancer care, such as radiologists, are among the groups with the most gaping deficits between need and availability. Diagnostic equipment and innovative treatments are among the biggest drivers of increased costs, so the generation of these technological resources in a way that balances financial protection for citizens and incentives for industry to spur development is a major issue.[5] Research is the source of virtually all scientific and policy breakthroughs but constitutes another major cost to the system.[6]

Cancer service delivery, in turn, has special challenges in terms of ensuring quick diagnosis and referral to specialists, providing multi-disciplinary care, and guaranteeing a consistent and continuous care pathway for patients who may come from diverse sources within the health services portfolio.[7]

1.3 Overview of National Cancer Control Programmes

Given the above-described complexities of cancer control and cancer control policies, National Cancer Control Programmes (NCCPs) have emerged as a key strategy to articulate a comprehensive, system-wide response to this group of diseases. While there are different ways of understanding these programmes, and all will be subject to structural and contextual peculiarities intrinsic to diverse national settings, it is possible to sketch out the general characteristics of these policies. This section begins by examining the broad aims

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[3] Merletti F, Galassi C, Spadea T. The socioeconomic determinants of cancer. Environ Health 2011;10 Suppl 1:S7.

[4] Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization; 2008.

[5] Sikora K. Drugs for cancer. In: Coleman P, Alexe DM, Albreht T, McKee M. (eds.) Responding to the challenge of cancer in Europe. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2008. p. 93-112.

[6] Cufer T, Sullivan R. Researching cancer. In: Coleman P, Alexe DM, Albreht T, McKee M. (eds.) Responding to the challenge of cancer in Europe. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2008. p. 297-314.

[7] Dobrow MJ, Paszat L, Golden B, Brown AD, Holowaty E, Orchard MC, et al. Measuring Integration of Cancer Services to Support Performance Improvement: The CSI Survey. Health Care Pol 2009; 12:35-53.

and purposes of NCCPs and follows by describing one way of conceptualizing these strategies, a health systems viewpoint described by publications with the participation of the European Union[8] and elsewhere[9,10,11]. Other organizations have taken different approaches to describing the elements of cancer control. For example, WHO contemplates six main domains, as described in the publication *National cancer control programmes: Policies and managerial guidelines*[12], including prevention, early detection, diagnosis and treatment, pain relief and palliative care, cancer control research, and surveillance in cancer control.

1.3.1 Purpose of NCCPs

National Cancer Control Programmes are defined by WHO as "a public health programme designed to reduce cancer incidence and mortality and improve quality of life of cancer patients, through the systematic and equitable implementation of evidence-based strategies for the prevention, early detection, diagnosis, treatment and palliation, making the best use of available resources."

Specific goals vary by country, depending on what cancer services are already in place, how these are linked, how efficient they are and how responsibilities are shared among stakeholders. Thus, countries with strong traditions in central planning, such as France, may include among the aims of their NCCP the concentration of all decision-making, financing, coordination and planning under one body. Decentralized countries such as Spain or Italy, on the other hand, will devote their energies to setting national, minimum standards and interregional harmonization mechanisms that regional health authorities support and enforce in their territories. Countries with few preventive health services (e.g., screening) may aim to establish these, while other countries will pursue homogeneous quality standards among existing services and increased equity and accessibility for citizens wishing to make use of them. Significant investments in cancer research may be out of reach for some countries, so increasing coverage of national cancer registries may be a more feasible priority. + include the different definitions used by the countries

The list of potential differences could go on, and in fact this study will examine the main contextual factors that condition NCCP development in section 2. In essence, however, these programmes are conceived to provide essential cancer services to the population, reduce fragmentation among them, increase efficiency

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[8] Martin-Moreno JM, Harris M, García-Lopez E, Gorgojo L. Fighting against cancer today: A policy summary. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2009.

[9] Atun R, Ogawa T, Martin-Moreno JM. Analysis of National Cancer Control Programmes in Europe. London: Imperial College of London; 2009.

[10] International Agency for Research on Cancer. Summary Report of the Eurocan+Plus Project: Feasibility Study for Coordination of National Cancer Research Activities (Study funded by the 6th Framework Programme of the European Union Contract No. LSSC-CT-2005-015197). Lyon: International Agency for Research on Cancer; 2008.

[11] International Agency for Research on Cancer. Eurocan Plus Report: Feasibility Study for Coordination of National Cancer Research Activities. Ecancermedicalscience 2008: 1; DOI: 10.3332/eCMS.2008.84

[12] World Health Organization. National cancer control programmes: policies and managerial guidelines. 2nd ed. Geneva: World Health Organization; 2002.

and ensure coherency among programme elements in line with present and projected citizen and patient needs.

1.3.2 Health systems approach to NCCPs: the vertical/horizontal functional matrix

The approach taken to cancer control under the Slovenian presidency of the EU consisted of a health systems matrix to develop and implement NCCPs, calling for effective coordination and integration between vertical and horizontal elements of cancer control (Scheme 2). The four vertical pillars of cancer control comprised primary prevention, secondary prevention (screening), integrated care (including psychosocial care and palliative care) and research (including surveillance and the establishment and maintenance of cancer registries). The horizontal health systems elements, described in the WHR2000, were governance (including aspects of transparency and patient and professional participation), financing, resource generation (including human, technological and physical resources) and service delivery.

Scheme 2. Vertical and horizontal aspects of cancer control.

↓ → **Governance**	**Financing**	**Resource generation**	**Service delivery**
Primary prevention	Authority responsible for planning, implementing and evaluating effectiveness of services; multisectoral cooperation with other ministries or authorities	Specific revenues generated and reserved for each service identified in planning stage	Issues of training and provision of material resources (facilities, equipment, etc.), including distribution at regional/local/ centre levels	Inventory of specific, evidence based services required (and where)
Secondary prevention (screening)			
Integrated care			
Research			

Source: Martin-Moreno JM, Harris M, García-Lopez E, Gorgojo L. Fighting against cancer today: A policy summary. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2009.

1.3.2.1 Vertical elements of cancer control

Primary prevention

Primary prevention is aimed at preventing the manifestation of disease by addressing its determinants. Thus, the known determinants of cancer constitute the basis of all cancer prevention policy. These can be divided into three broad groups: (1) behavioural, (2) occupational and environmental, and (3) other determinants, which include genetics, infectious diseases, hormonal and immunological factors.

The main behavioural determinants of cancer (smoking, harmful alcohol intake, diet and physical inactivity) are the same as those that cause or exacerbate virtually all other major chronic diseases, including heart disease, stroke, diabetes, COPD, mental illness and others. Alcohol entails other significant risks, especially for young people, pregnant women and drivers, contributing to a range of health threats including domestic violence, road accidents and foetal alcohol syndrome. In fact, alcohol has recently been identified as the substance that causes the largest and most negative effects on society as a whole, above tobacco, heroin and crack cocaine[13].

Thus, while the cancer burden already justifies rigorous initiatives to tackle behaviours associated with this disease, these policies will also reap benefits in other health indicators and for societal wellbeing. As a result of this fact, a number of population-based disease prevention policies favour addressing behavioural risk factors comprehensively, without specifying a single disease that the policies are meant to tackle. Among these, WHO has put forward the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases.[14] Also of note is the European Code Against Cancer, called the "11 Commandments for Cancer Prevention" by the European Cancer Leagues (http://www.europeancancerleagues.eu); these recommendations constitute a good tool to use in educating citizens on the most important steps they (and their governments) can take to prevent cancer (Box 1). Below, we review the known risk factors for cancer along with some programmes that tackle these at an individual level. Section 1.3.4 will tie these individual programmes together in a summary of the necessary elements of an NCCP.

Behavioural risk factors: tobacco, alcohol, diet and physical activity

Tobacco is by far the greatest cause of avoidable cancer, responsible for approximately a quarter of total incidence in developed countries[15]. The carcinogenic effects of this substance most commonly attack the

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[13] Nutt DJ, King LA, Phillips LD, on behalf of the Independent Scientific Committee on Drugs. Drug harms in England: a multicriteria decision analysis. Lancet 2010; 376: 1558-65.

[14] World Health Organization. The 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. Geneva: WHO; 2008.

[15] Boyle P, Gray N, Henningfield J, Seffrin J, Zatonski W (eds). Tobacco and public health: Science and policy. Oxford: Oxford University Press; 2004.

lungs, but also the trachea, bronchus, oesophagus, larynx and oral cavity; in addition, tobacco is an important risk factor for cancers of the urinary tract, bladder and pancreas and contributes to cancers of the kidney, stomach, cervix and nose as well as myeloid leukaemia.[16]

Because both active and passive exposure to tobacco products is positively known to increase the risk of cancer, and because cost-effective, evidence-based policy instruments exist to combat tobacco use and protect non-smokers, including the seminal Framework Convention on Tobacco Control[17], primary cancer prevention policies inevitably feature anti-tobacco programmes. These should include *legislative* measures to ban smoking in closed public spaces, limit advertising and promotion of tobacco, raise taxes on tobacco products, regulate cigarette content and public disclosure thereof, and regulate packaging and labelling requirements to include health warnings; *health promotion* measures such as health education, reimbursement of tobacco cessation therapies, and health communication and public awareness campaigns; and *enforcement* measures to tackle illicit tobacco trade, sales to minors and compliance with other anti-tobacco legislation. Finally, there should be certain *economic* support measures to facilitate viable alternatives to those whose livelihood depends in whole or in part on the tobacco industry: tobacco workers, farmers and sellers.

The next most important behavioural risk factor is harmful alcohol intake, which contributes to cancers of the oral cavity, pharynx, larynx, oesophagus, breast, liver and large bowel.[18] Altogether, about 9% of all cancers are attributable to alcohol[19]. Unlike tobacco control, however, alcohol policies have not found their place onto most national agendas in Europe—the WHO Region that consumes the most alcohol per capita in the world. Sweden is among the few countries that have successfully reduced alcohol consumption—by 15%—by pursuing policies loosely modelled after tobacco control initiatives[20]. Estonia also began enacting stricter laws on alcohol availability and affordability in 2005 and has seen subsequent decreases in consumption; however, since some of the biggest changes coincided with the beginning of the global financial crisis, the influence of new Estonian alcohol policies on intake has been somewhat conflated with the influence of a declining GDP[21].

The European Commission as well as international organisations, including WHO, have been more active on this issue. The first WHO European Alcohol Action Plan was created in 1992 to guide Member States in the development of policies to reduce alcohol intake, and the European Commission has also been active,

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[16] Boyle P, et al 2003 (ibid).

[17] World Health Organization. Framework Convention on Tobacco Control. [Online]. Available at: http://www.who.int/fctc/en/

[18] Pöschl G, Seitz HK. Alcohol and cancer. Alcohol 2004; 39:155–165.

[19] Boffetta P, Hashibe M, La Vecchia C, Zatonski W, Rehm J. The burden of cancer attributable to alcohol drinking. Int J Cancer 2006;119:884–887.

[20] Mäkelä P, Tryggvesson K, Rossow I. Who drinks more or less when policies change? The evidence from 50 years of Nordic studies. In: Room R, editor. The effects of Nordic alcohol policies: analyses of changes in control systems. Helsinki: Nordic Council for Alcohol and Drug Research; 2003. p. 17–70.

[21] Lai T, Habicht J. Decline in Alcohol Consumption in Estonia: Combined Effects of Strengthened Alcohol Policy and Economic Downturn. Alcohol and Alcoholism 2011; 46:1-4.

publishing its *EU strategy to support Member States in reducing alcohol-related harm* in 2006.[22] In 2010, the EU and WHO collaborated to produce a joint guide on national alcohol policy[23], integrating recommendations from the 2006 EU Strategy and the WHO-EURO Framework for Alcohol Policy[24]. The latter provides a basis for evidence-based policies on pricing, promotion, health education, safety measures and workplace interventions.

Finally, diet and physical activity levels (considered separately and as jointly manifested by overweight and obesity) are significant behavioural risk factors in cancer genesis. The protective effect of a diet rich in fruits, vegetables, fish and whole grains has not been conclusively proven, but it is widely credited and cited as a factor contributing to the lower incidence rates of some epithelial cancers in the Mediterranean region. Likewise, physical activity in and of itself has been identified as influential on cancer incidence, regardless of the individual's weight[25]. However, the evidence suggesting that overweight and/or obesity contribute to the manifestation of cancer is overwhelming[26]; thus evidence-based policies directed at promoting a healthy diet and moderate exercise regimen emerge as the best way to tackle this determinant.

Occupational and environmental risk factors

The main occupational risk factors for cancer are passive smoking and sun exposure (UV radiation), but other agents include, among others crystalline silica, diesel exhausts, radon, wood dust, pesticides, benzene and asbestos (among others). Together, these carcinogens account for at least 5% of all cancers and affect above all workers in manufacturing industries, making occupational factors an important source for the large health gap between European populations. [27,28] While the situation has improved considerably since the 1990s, when it was estimated that approximately 23% of workers were exposed to carcinogenic agents

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[22] European Commission. Communication from the Commission to the Council, the European Parliament, the European Economic And Social Committee and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol related harm. Brussels: European Commission, 24 October 2006 (COM 2006; 625).

[23] Worl Health Organization. The European Commission's Communication on alcohol, and the WHO framework for alcohol policy – Analysis to guide development of national alcohol action plans. Copenhagen: WHO; 2010.

[24] WHO Regional Office for Europe. Framework for alcohol policy in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2006.

[25] Melzer K, Kayser B, Pichard C. Physical activity: The health benefits outweigh the risks. Curr Opin Clin Nutr 2004; 7:641–647.

[26] Boyle et al., 2003 (ibid).

[27] Boyle et al., 2003 (ibid).

[28] Siemiatycki J, Richardson L, Straif K, et al. Listing occupational carcinogens. Environ Health Perspect 2004; 112:1447–59.

above the natural level[29], many European workers in industries as diverse as agriculture and hospitality are still obliged to choose between their health and their livelihood.

Fortunately, significant progress has been made in many European countries, which can be translated to other contexts where important challenges still remain. Among praiseworthy initiatives within Europe, the ASA registry in Finland[30] and the THOR network in Britain[31] are two programmes that track exposure to carcinogens and other occupational health threats. The first is a mandatory surveillance registry focused exclusively on carcinogens in the workplace; it requires companies to report what carcinogens are used and which workers are exposed to them and has been credited with significantly reducing and fostering the substitution of carcinogenic substances in occupational settings.[32] On the other hand, the THOR network is made up of over 2,000 specialist physicians who report occupational exposure to health threats anonymously, contributing to a large body of research and acting as an observatory in the field of occupational health and safety. Their reports inform national policy through the Revitalising Health and Safety and Securing Health Together programmes.

Likewise, the European Commission as well as international organisations, including WHO, have been very active in occupational health and safety, and their guidance and support can prove a boon to governments and enterprises interested in developing policies to protect worker health. In 2007, the World Health Assembly approved the Global Plan of Action on Workers' Health 2008–2017, sparking a number of satellite initiatives among WHO regions, including the European office[33], as well as in Member States. European authorities have also taken steps through the European Agency for Safety and Health at Work; for example, in September 2011, this agency launched the Online interactive Risk Assessment (OiRA) project, a free, web-based risk assessment tool for small businesses to use in improving worker safety[34]. It is also active in risk surveillance, in the formulation of binding European Directives on worker safety, in the elaboration of guidelines and in the dissemination of best practices to solve practical problems associated with occupational health.

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[29] Martin-Moreno JM, Soerjomataram I, Magnusson G. Cancer causes and prevention: A condensed appraisal in Europe in 2008. Eur J Cancer 2008; 44: 1390–1403.

[30] European Agency for Safety and Health at Work. OSH Monitoring Systems: Finland Exposure Database. [Online]. Accessed 14 Sept., 2011. URL: http://osha.europa.eu/en/topics/osm/reports/finnish_system_007.stm

[31] The University of Manchester Centre for Occupational and Environmental Health. THOR: The Health and Occupation Research Network. [Online]. Accessed 14 Sept., 2011. URL: http://www.medicine.manchester.ac.uk/oeh/research/thor/

[32] Kauppinen T, Saalo A, Pukkala E, Virtanen S, Karjalainen A, Vuorela R. Evaluation of a National Register on Occupational Exposure to Carcinogens: Effectiveness in the Prevention of Occupational Cancer, and Cancer Risks among the Exposed Workers. Ann Occup Hyg 2007;51:463–470.

[33] WHO Regional Office for Europe. Occupational health. Berlin, Copenhagen and Rome: World Health Organization; 2007.

[34] European Agency for Safety and Health at Work. Online interactive Risk Assessment. [Online]. Accessed 14 Sept., 2011. URL: http://www.oiraproject.eu/news/#mainContent#title

As for environmental risk factors, air and water pollution, as well as ionizing and solar radiation, contribute to some cancers, although their impact on incidence is relatively low in Europe (with the exception of solar radiation, the greatest avoidable risk factor for both carcinoma and melanoma). This fact can be attributed to fairly robust regulations enforcing air and water quality in comparison to developing countries such as China, where the Ministry of Health cites pollution as the top determinant for lung cancer among urban populations[35]. Thus, environmental protection remains extremely relevant for cancer prevention policy. Both national legislation and European Directives, including the EU Directive on Ambient Air Quality and Cleaner Air for Europe (Directive 2008/50/EC of the European Parliament and of the Council of 21 May 2008), the EU Water Framework Directive (Directive 2000/60/EC of the European Parliament and Council) and the Water Information System for Europe (WISE), should be further developed and strengthened.

As for ionizing and solar radiation, the first is effectively regulated by European Council Directives 96/29/EURATOM and 2003/1227EURATOM, and further recommendations are available from the International Commission on Radiological Protection and the International Atomic Energy Agency. Solar radiation, on the other hand, requires proper health promotion and health education to warn citizens on the dangers of over exposure and the preventive measures (e.g., adequate SPF protection) necessary to address them.

Secondary prevention

After primary prevention, the next link in the chain of comprehensive cancer control is early detection, accomplished through population-based screening programmes of non-symptomatic individuals who, because of age and sex, may be at risk for certain cancers. The rationale for these programmes as a policy tool is founded on several important prerequisites: (a) that the cancer is of a common variety; (b) that the cancer can be detected easily and safely; and (c) that clinical prognosis improves with early detection. The first prerequisite responds to health system realities: in a context of scarce resources, screening entire populations for rare diseases, which may only affect a handful of individuals, is a poor use of health resources; likewise, these cancers are often also difficult to treat, as generally they are not a high research priority either. The second and third prerequisites can more accurately be described as policy extensions of the Hippocratic oath to do no harm. While this is not strictly possible (all screening may have potentially negative side effects), it is important that the positive effects of screening clearly outweigh adverse effects such as pain/discomfort, false positives and clinical risk. Moreover, screening for cancers whose prognosis does not improve with early detection (e.g., lung cancer) or whose treatment may in fact be worse than the

[35] Kahn J, Yardlely J. As China roars, pollution reaches deadly extremes. New York Times 2007 Aug 26. [Online]. Accessed 15 Sept., 2011. URL: http://www.nytimes.com/2007/08/26/world/asia/26china.html

cancer itself (e.g., prostate cancer), is detrimental to the patient both psychologically and physically as well as inefficient from a health system perspective. [36]

Currently, three cancers meet the above requirements to justify population-based screening programmes, meriting also the explicit recommendation of the Council of the European Union[37]: cervical, breast and colorectal cancer.

Integrated care

One of the most important advances in cancer care is the move towards integrated care. By integrated care in cancer we mean the totality of all activities related to all phases of the disease and all stages of its natural and/or modified course. In particular, this refers to the integration of all those levels of care, which are involved in the specific cancer's treatment and management. The nature of cancer that characterises both its natural and medically modified course is its long span of development and complex management. The impact that cancer has spans from health promotion and its lifestyle management (as referred to above) through screening as the most important activity in secondary prevention to all aspects of clinical and post-clinical care. The former focus relying too much on purely medically oriented care has gradually been replaced by a strive for care that would support complex needs that different categories of cancer patients have, ranging from psycho-social care and support to rehabilitation and palliative care.

Research

The conceptual vertical-horizontal matrix approach described in the current section (1.3.2), which envisages four vertical pillars for cancer control, understands cancer research to include both cancer information (i.e., health and health system surveillance aspects) as well as traditional fields of cancer research (i.e., clinical oncology, translational research, health policy research, etc.). On the one hand, these two areas differ enormously, as the first is concerned with documenting existing trends and the second with making innovative discoveries; as a result, many international health organizations, including WHO, treat them as separate areas for analysis. On the other hand, though, the areas share the common thread of aiming to generate evidence for controlling cancer, whether at a population or clinical level. Thus, national health surveys analyzing smoking prevalence at a population level and clinical studies linking tobacco use to cancer aetiology are inextricably linked. The main difference is that while the first type of

[36] Hakama M, Coleman MP, Alexe DM, Auvinen A. Cancer Screening. In: Coleman P, Alexe DM, Albreht T, McKee M. (eds.) Responding to the challenge of cancer in Europe. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2008. pp. 69-92.

[37] Council of the European Union (16 December 2003). Council Recommendation of 2 December 2003 on Cancer Screening (2003/878/EC). OJ L 327: 34-38.

study simply examines *if* progress is being made, the second type aims to provide evidence on the *what, why* and *how* of cancer control.

While both of these aspects are invaluable to policymakers seeking effective ways to reduce cancer incidence and increase survival, adequate cancer surveillance should be understood as a precursor to more specific and innovative cancer research programmes. Without health surveillance, it is impossible to understand the epidemiologic characteristics of the disease burden, the prevalence of known risk factors (behavioural, socioeconomic or otherwise), the effectiveness of current policies and programmes, or even the basic health needs of the population. These aspects are relevant to the population as a whole and provide the foundation and justification for health system action to address the cancer burden. In a context of scarce resources, then, surveillance aspects should take precedence over research. If resources are sufficient to make investments in research, these should be allocated carefully, avoiding overlaps and seeking synergy with complementary initiatives and disciplines.

Cancer information and surveillance

Cancer has a huge impact on the population health (it is the second cause of death in Europe), and requires a large amount of resources in public health, technology and research. Also, cancer is an extremely complex disease, requiring lot of detailed information to be studied in depth. Population based information is much more available for cancer than for most other diseases, due to the existence of registries and to a long tradition of epidemiological research. It is important that such information is used at best, since non-optimal use of existing data has direct negative implications on public health. All these considerations point to the *need to build a cancer-specific information system in Europe.* This work is especially developed by the activities of the EPAAC's WP9.

Population-based registries provide, in the field of cancer, an added value as a disease-specific source of data are not available for any other major disease. Use of cancer registry data is involved in all phases of cancer control activities, from aetiology and prevention, to early diagnosis, care and rehabilitation of cancer patients, planning and evaluation of health care services. The EUROCOURSE project has provided a detailed analysis of the potential role of population-based registries in cancer information. *Population-based cancer registries should provide the core component of a cancer information system.* Several other relevant and potentially available data can be added or linked in order to implement a comprehensive information system. First of all, detailed mortality data at the regional level, as available from Eurostat, could provide a valuable information of uniform quality which presently is not sufficiently known and adequately utilized. Furthermore, it is particularly important to consider clinical databases containing detailed and updated information (not systematically available to population-based registries) on diagnosis, treatment and patients' follow-up, which however may be not fully representative of the whole population of cancer patients. Consensus-based lists of the most relevant indicators needed for public health and, more specifically, for cancer control activities have been developed by the EU projects ECHI and EUROCHIP. In addition to those previously cited, these lists include indicators derived from population surveys (such as life style factors), census (education and deprivation), and administrative sources (such as those related to health care organization). In Annex 1, a list of these indicators is reported together with their present degree of availability.

PART II: STUDY RESULTS

2. General Situation

2.1 Number and type of NCCPs in Europe

Twenty-four out of 29 countries (83%) reported having some type of NCCP: Belgium, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovenia, Spain, Sweden and England. We only analysed national cancer control plans and all the numbers presented related only to them and not to regional cancer plans.

Fifteen (51%) are described as National Cancer Plans; five are National Cancer Strategies, and the remaining plans use mixed terminology (e.g. National Cancer Plan and Strategy, National Cancer Prevention and Control Programme). For the purposes of internal coherence within the present study, it is useful to differentiate between the terms *policy, strategy, plan* and *programme*, even while recognizing that these definitions may vary among different countries. Particularly, *plan* and *programme* are used somewhat synonomously by Member States; however, the authors of this report hope that the below definitions (also contained in the Glossary) contribute to a more harmonized use of the terms, at least in international policy discussions.

A *policy* reflects a vision (usually contains a vision statement, explaining the way a government, institution or organization will look in the future...), with inspirational dimensions related to what is it that the government wants to achieve for its population –in this case regarding cancer prevention and control--, both in public health and healthcare system terms. Such statements are often tied, even if only indirectly, to other national goals.

A *strategy* spells out the mission to be accomplished and the generic roadmap to achieve this mission. This is articulated through a mission statement (in essence, outlining the “raison d'etre” or fundamental purpose of an the initiative), succinctly describing why it exists and what it does to achieve its vision. The strategy also includes the layout, design, or concept used to accomplish the vision and mission. A strategy is usually understood with underlying flexibility, being open to adaptation and change when needed in order to fulfil the mission and ultimate goals.

A *plan* is a precise arrangement, following a defined pattern, for a definite purpose according to a value chain coherent with the policy and the strategy. It is concrete in nature, although it does not necessarily contain all the details, which in fact are further developed and explained through more specific programmes and projects.

Finally, a *programme* implies the arranged selection of systematic steps, activities and tasks and deliverables coherently within the plan. The programme addresses the entire set of desired changes to achieve in the field. A programme can be monitored or evaluated in the dimension of the achievement of the goals /deliverables, or the process followed in order to achieve these operational goals, and the resources allocated to facilitate the process. As these activities are often based on arbitrary definitions, it is possible that there are also different combinations of goals and deliverables.

For the sake of simplicity, this report will use the acronym NCCP (National Cancer Control Programme) to refer to all plans described in the report; this umbrella term is the same one used by the World Health Organization to describe all national initiatives that tackle cancer control in a comprehensive way.[38,39]

See Table 1 for more detailed information.

2.2 Countries without NCCP; general situation

Five countries (Austria, Bulgaria, Iceland, Luxembourg and the Slovak Republic) reported having no NCCP at present (Table 1). Both Austria and Luxembourg are in the process of developing one; the former country expects implementation to begin by the end of 2012 or in the first months of 2013. In addition, Iceland has incorporated cancer-related goals into the Icelandic Health Plan for 2010 (cancer prevention is listed as a priority). Different obstacles are impeding the completion of a plan in Bulgaria (lack of funding) and the Slovak Republic (pending political consensus).

2.2.1 Provision of cancer services within health system

In countries with no NCCP, cancer services are provided through different channels unrelated to the specific activities outlined by the NCCP (Table 2). All of these countries have some separately identified cancer services—particularly screening programmes. In the case of Austria, cancer screening is opportunistic rather than population-based. There are also different prevention programmes, such as smoking cessation campaigns in Luxembourg or public awareness campaigns on the prevention of colorectal cancer in the Slovak Republic. As mentioned above, Iceland has incorporated cancer prevention and control activities (e.g., promotion of healthy lifestyles, drafting of clinical guidelines on diagnosis and treatment) directly into its National Health Plan. Finally, Bulgaria reported a number of different cancer-related programmes, such as Cancer Risk Assessment for Children, the Current Draft of a National Programme for Integrated Control of Cancer Diseases, and different studies on genetic markers.

2.3 Timeline of latest developed plans; authorities to adopt, implement and monitor it

Most current NCCPs have been adopted fairly recently (Table 3), although many countries also mentioned previously implemented programmes, plans and/or strategies in their responses. The earliest adopted programme which is still current is in Norway (1997), although it is important to note that this has been

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[38] World Health Organization. National cancer control programmes: policies and managerial guidelines. 2nd ed. Geneva: World Health Organization; 2002.

[39] World Health Organization European Region. Noncommunicable diseases: Cancer. WHO: 2007. Available: http://www.euro.who.int/noncommunicable/diseases/20050629_18

complemented by subsequent strategies laid out in 2004 and 2006; the latter was originally envisaged to cover services from 2006 to 2009, but this period was later extended to 2011. Half of all NCCPs have been adopted in the past four years (2008-11), and of these, three were adopted in 2011.

The Ministry of Health often has a leading role in adopting, implementing and monitoring the NCCP. However, ministries are by no means the only major stakeholder at a national level, particularly in countries with decentralized competencies. Other key actors include professional oncologic associations, patient associations, major hospitals and regional authorities. Other ministries, health care purchasers and providers as well as local health boards also have an important role, especially in terms of adoption (in the case of government authorities) and implementation (in the case of health care and insurance providers).

2.4 General elements of cancer control plans

In general, most NCCPs include the main elements identified as central to a comprehensive approach (Table 4). These services include primary prevention (whether this is aimed at environmental protection or health promotion), secondary prevention (screening), integrated care and organization of services, palliative care and/or psycho-oncology. Most also have made provisions for research. Training and quality control elements were slightly less apparent than the other vertical programmes.

Other elements vary across programmes, but include patient empowerment and social support for families (in Belgium, Denmark, Germany, Hungary, Malta, the Netherlands, Spain, Sweden and England), addressing inequalities (in the Czech Republic, France, Ireland, Spain, and England), and cost control mechanisms (Czech Republic and England).

2.5 Methodology and timeframe for development

Different methods were employed in the development of NCCPs (Table 5). By far, the most common were expert opinions (21/24 - 87%) and round tables (19/24 – 79%). Sixteen counted on the participation of health administration(s), and 14 countries used focus groups; 6 countries sent out electronic surveys, and 4 countries were supported by external organizations. Finally, 7 countries used different *ad hoc* methods, such as steering committees, in the development of their programme.

The development time period ranged from three months in Belgium and the Czech Republic to six years in Poland and Romania. Generally speaking, the remaining countries developed their programme over a period of approximately one to two years, although this period was somewhat longer in the case of Estonia, Greece, Ireland, Malta, Slovenia and Spain (three years) and a bit shorter in Denmark and England, where the plan was complete within eleven and six months, respectively. In Germany, where implementation, evaluation and drafting of new elements of the German National Cancer Plan are ongoing in parallel, no concrete development time period can be specified.

2.6 Current stage of process

At present, a number of different processes are ongoing among countries, including the concept development, consultation and drafting, implementation, evaluation and drafting of a new programme (Table 5). However, for the most part, countries are carrying out implementation and evaluation.

2.7 Stakeholder involvement

2.7.1 Patients

Patient involvement during the development process was generally less intense than for professionals and governments; this was reported to be the case in Belgium, Denmark, Estonia, Ireland, Italy, Latvia, Lithuania, Norway, Poland and Romania. In a few cases (Cyprus, Finland, France, Germany, Greece, Hungary, Malta, Netherlands, Spain, Sweden and England), patients were as involved or almost as involved as other stakeholders (Table 6). The Czech Republic, Portugal and Slovenia did not report any patient involvement in their programme development processes.

2.7.2 Professionals

In most cases, external professionals participated closely with the government in the formulation of the NCCPs (Table 6). However, in two countries (Belgium and Portugal) governments had a clearer lead role throughout the planning process, and in a few cases (Czech Rep., Estonia, Finland and Poland), the role of professionals was considerably larger than that of government.

2.7.3 MoH/Gov't

The Ministry of Health or other government authorities had a central role from the concept to the implementation and evaluation of the NCCPs in most countries, although as noted above, in a few, professionals had greater responsibilities (Table 6).

2.7.4 Payers/reimbursers

Because many countries use a Beveridge model health system to provide healthcare for the population (in which the MoH or central government directly finances services), payers/reimbursers (such as health insurance funds) do not exist as a separate stakeholder in all countries. However, the term can also be understood to mean regional health authorities, funding agencies, or other bodies in charge of raising or distributing funds to healthcare providers. The role of these bodies in programme formulation was the largest in Belgium, Germany, Hungary, Ireland, Lithuania, the Netherlands, Poland and Sweden (Table 6).

2.8 Challenges

2.8.1 Methodological

Respondents cited different methodological challenges during the process of drafting and implementing their programmes (Table 7). Belgium and Denmark cited a short planning period as a challenge, while Germany mentioned the devolved nature of its health system as a specific feature influencing the processes in the development and implementation of the National Cancer Plan. Resource availability, lack of available evidence

on population needs, professional disagreements and the production of quality guidelines were also named as challenges by different countries.

Over half of the countries (13) reported no methodological challenges.

2.8.2 Political

Political challenges were often very similar to methodological challenges, particularly with regard to the devolution of regional powers (in Belgium [for ceratin topics such as screening], Italy, Germany [which stressed the need to balance interests between the relevant stakeholders] and Spain [which has to establish harmonization mechanisms for homogeneous implementation across the regions]). Sweden also experienced these challenges to some degree, as the strong involvement of the central government in the national cancer strategy was not congruent with the decentralized organization of healthcare. Disagreements among stakeholders occurred in Denmark, France, Greece, the Netherlands, Poland and Sweden (Table 7). In Poland, politicians were sceptical of the benefits and cost-effectiveness of preventive programmes. A few countries (Latvia, Malta and Romania) reported that resource availability was an issue as well, although the degree of resource limitations varied. Portugal reported that there were both methodological and political challenges, but no details were given. Finally and as previously mentioned, the lack of political consensus has prevented the Slovak Republic from finalizing a national cancer control programme.

Eleven countries responded that there were no political challenges to NCCP development.

2.8.3 Strategies to overcome challenges

All countries have made efforts to overcome their challenges (if they experienced any), although in the case of the Netherlands and Romania, these have not yet been entirely overcome (Table 7). In Belgium, Denmark, Germany, Lithuania, the Netherlands and Sweden, resolving challenges has meant energetic stakeholder involvement in order to harmonize goals and create a sense of ownership and commitment to action. Malta generated cost-effectiveness evidence to gain support among stakeholders concerned about resource use. Poland had to create a monitoring organization for its screening programme, which had not existed until then. Latvia and Portugal underwent a process of priority-setting in order to make the most of scarce resources, while Italy and Norway harmonized competencies at a regional and national level to ensure that all major providers were on board. Cyprus and Greece explicitly mentioned EU guidance (in the form of general EU recommendations or the 2009 Communication on Action Against Cancer) as an aid to overcoming the challenges they experienced. For those countries where timing was an issue, different tactics were used. In Belgium, some elements of the programme (development of indicators) were formulated after adoption; in France, a strict timetable was set to ensure timely resolution of outstanding issues.

2.9 Budgetary considerations

Twelve countries (Belgium, Cyprus, Finland, France, Germany, Greece, Hungary, Latvia, Lithuania, Malta, Romania and England) said that budgetary considerations were taken into account during the development of their NCCP (Table 8). Although the questionnaire allowed countries to specify where budgetary considerations were most relevant (in the structure, priorities or topics of the programme), most did not differentiate between these areas. However, three countries did refer to priority issues based on budgetary availability: Finland prioritized palliative care and cancer medicines; Greece prioritized cancer information and data, education, quality control and

prevention; and Hungary reported prevention as a main goal. Apart from that, only Finland listed manpower and the age structure of the population as topics which were shaped, in part, by budgetary concerns.

Those countries which took into account budgetary issues did so in order to best allocate resources. In some cases, including in Cyprus, Romania or Latvia, programmes were scaled back in order to bring them in line with budgetary feasibility. In other countries (Belgium, France), the budget was used to ensure generation and allocation of resources where needed. In Malta and England, budgetary considerations were set within a framework of guaranteeing the most cost-effective services for the money, and cost analyses were an important part of the decision-making process. Finally, it is worth noting that not all programmes were conceived as stand-alone initiatives requiring extra resources. In some cases, such as Finland, Germany and the Netherlands, the NCCP is envisaged more as an efficiency plan, conceived to best use resources which have already been allocated to cancer services. However, in the case of Germany there is a separate budget for administrative and organisational tasks/issues as well as a separate budget for research activities within the Cancer Plan. The Belgian Cancer Plan listed all actions and measures that required additional funding. In the plan a significant amount of funding is allocated to innovation and research, reimbursement of medicines (accessibility of treatment) and support to the patients and family (psychologists, nurses, social workers, datamanagers, specialised staff for paediatric oncology) and screening.

3. Goals, objectives and related indicators

Most Member States describe general goals and specific indicators for their respective NCCPs, although there is great variation in the way these key ingredients are formulated (Table 9).

The below description of NCCPs is not exhaustive, as it includes only those responses which were provided on the questionnaire. Some countries, such as the Netherlands, provided supporting documents that described NCCP contents in detail rather than restating all programme elements in the space provided. Thus, until the research team has examined all complementary sources and all countries have had a chance to review the report and confirm NCCP contents, the below information should be interpreted cautiously.

3.1 Goals

3.1.1 Assessment of cancer burden

Most countries use their national cancer registry structures to gather and analyze the corresponding cancer data (Table 10).

3.1.2 Cancer data and information

All countries state that they systematically gather cancer data in the country. The reference centres responsible for this task are detailed in Table 10.

3.1.3 Health promotion

All respondents state that health promotion activities were included in the NCCP, except Germany and Finland. Finland points out that this information "will be included in the second part of the plan", while Germany indicates that a variety of activities outside the cancer plan already exist to tackle common risk factors for noncommunicable diseases, including smoking, harmful use of alcohol, poor diet and physical inactivity; in this country, planners concluded that additional activities in health promotion would have led to unnecessary duplication of ongoing work (Table 10).

3.1.4 Primary and secondary prevention

With the exception of Finland (which will tackle this area in the second phase of the NCCP), all Member States (MS) explicitly include cancer prevention in their programmes (Table 11). The organisations responsible for overseeing these programmes vary by country.

3.1.5 Integrated cancer care (including palliative and psycho-oncologic care)

All MS include cancer care as a central pillar of their NCCPs (Table 11). Among the specific elements listed by countries as included in the portfolio of additional investments, those having to do with quality of life (including palliative care and psycho-oncologic services), were mentioned by 20 survey respondents: Belgium, Cyprus, Denmark, England, Finland, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Portugal, Romania, Slovenia and Spain. Several countries also explicitly mentioned improving access to and financial protection for diagnosis and treatment services, including equal access to innovative health technologies: Cyprus, Denmark, Finland, France, Germany, Hungary, Latvia and Poland. Examples of other initiatives that countries highlighted included the following:

- Developing Comprehensive Cancer Centres (CCCs) or similar centres to concentrate cancer care (Belgium, Czech Republic, Greece, Ireland, Hungary, Slovenia and Spain);
- Improving care pathways (Belgium, Denmark, England, Germany, Hungary, Ireland, Italy, Malta and the Netherlands);
- Investing in radiotherapy, cancer drugs or other costly treatments (Belgium, Cyprus, Denmark, England, Estonia, France, Hungary, Ireland, Italy, Latvia, Malta, Norway and Poland)
- Investments in improving rehabilitation services for recovering cancer patients (Belgium, Hungary, Denmark, Latvia and the Netherlands)
- Extending services to cancer patients' families (Belgium, Cyprus, Denmark, Germany and Lithuania)

Other specific areas, mentioned by fewer countries, included improving treatment for patients with rare cancers and empowering patients.

3.1.6 Quality of care

All countries except Slovenia envision new mechanisms to ensure quality in cancer care (Table 12). The main levers to do so are strengthened procedures for accreditation and certification (Cyprus, Czech Republic,

Germany, Greece and Hungary, Romania); development of clinical guidelines and protocols (Denmark, France, Germany, Greece, Latvia, Malta, Norway and Portugal); dissemination of best practices (Finland, Germany and Portugal); and improvements in monitoring and evaluation (Cyprus, Czech Republic, England, Germany, Hungary, Italy and Latvia). In addition, England has introduced a number of market-based reforms, such as financial incentives for clinicians, in order to improve care quality.

3.1.7 Cancer Research

All the MS replying to the questionnaire included research in their current programmes, except Finland, which will include research in the second part of the programme (Table 12).

3.1.8 Other elements of NCCPs

Different MS include specific and diverse comments with regard to other aspects of their national programme. Below, a bullet point list highlights some of these initiatives:

- Belgium: creation of the Belgian Cancer Centre
- Cyprus: existence of an implementation structure for the NCCP, including a National Cancer Committee made up of seven distinguished experts.
- England: A package of measures on reducing inequalities led by the Department of Health.
- Finland: existence of the Cancer Society of Finland, explicitly including the concept of patient pathway and its related research.
- France: creation of a societal observatory on cancer
- Italy: attention to equity and emphasis on knowledge and communication for cancer prevention and treatment
- Malta: integration of different health care stakeholders aiming to optimize the oncologic care to patients
- Netherlands: integration of all key institutions in order to support their Educational Pilot Programme on Communication Skills for Cancer Physicians and Other Professionals; Intensive quality monitoring of care annually through published indicators.
- Norway: Norwegian Directorate of Health: What is cancer, challenges in cancer care – a description, administrative and political framework, structures and processes in cancer care.
- Portugal: educational pilot programme on communication skills for cancer physicians and other professionals.

4. Budget and Capacity

4.1 Budget

Most countries (18/29; 62%) allocated specific resources for NCCP implementation; however, a detailed budgetary analysis of Member State spending is quite problematic given the extremely varied channels through which funding is allocated in different countries. As noted above, some countries did not formulate a programme that envisaged the creation of new services, but rather which streamlined and organized existing services more effectively. Other countries developed their programme and negotiated the implementation timetable afterwards, in accordance with the availability of resources. Relatively few countries (e.g., France, and Malta) developed their programme as a stand-alone plan and allocated specific resources to each element. Several countries developed comprehensive programmes based on technical standards, which were then adapted to fit budgetary availability, or vice versa (budget was allocated based on technical needs detailed in plan).

Given the above heterogeneity in funding mechanisms, the results detailed below should be interpreted with caution.

Eighteen countries devoted additional resources to the implementation of their programme: Belgium, Cyprus, the Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Ireland, Lithuania, Malta, Norway, Poland, Romania, Spain, Sweden and England (Table 13).

4.1.2 Activities receiving increased funding

Only Denmark, France and Malta reported that all aspects of their programmes had been allocated specific funding. In addition, Malta indicated that the NCCP financial package is complemented by other funding means, which are enabling the construction of a new cancer hospital, among other initiatives.

Other respondents listed specific programmes within each plan (Table 13). For example, the Czech Republic allocated additional funds to their screening programme and National Cancer Registry, whereas Poland allocated funds to update equipment. The Netherlands allocated 100,000€ for the coordination of cancer activities, but this had only been partly implemented as it was dedicated to joint efforts thus reducing the total amounts when looking at all participating partners individually, while Germany set aside extra funding for administrative and organisational tasks and cancer-related research within their Cancer Plan. The Belgian Cancer Plan listed all actions and measures that required additional funding (see also 2.9).

While the above countries listed only one or two areas to receive extra financing, Hungary, Ireland, Latvia, Lithuania, Romania, Sweden and England listed several. Among these, England was the most specific, stating that it had allocated £750 million over four years for new programmes ranging from improved primary care access to key diagnostics to the introduction of flexible sigmodoscopy for colorectal cancer screening.

Cyprus, Estonia, Greece, Italy and Spain did not specify programmes which would receive extra financing for different reasons. Specifically, Spain allocated money at a national level, but the regions have the responsibility for deciding how to distribute the funding among services. This is also true to a certain extent in Italy, another country with a decentralized system; funding for the Italian NCCP is assured through two different programmes: one general plan to assure the targeting of health benefit packages (in which cancer services are grouped together with other health services), and another specific to cancer screening and governance. On the other hand, the budget for the NCCP in Cyprus is pending completion of the action plan; in the meantime, additional services will be funded by the MoH and the Bank of Cyprus.

4.1.3 Adequacy of funding level

Six countries (some where additional financing has been allocated and others where it has not) stated that funding was insufficient to carry out their plan as drafted (Table 14): the Czech Republic, Finland, Hungary, Latvia, Lithuania and Romania.

Belgium, Denmark, France, Ireland, Malta, the Netherlands, Norway, Poland and England stated that they had the financial resources they needed to reach the defined objective.

A few countries (Cyprus, Estonia, Germany, Greece, Italy, Portugal, Slovenia, Spain and Sweden) did not answer the question, stated that this was not applicable to their national situation, or indicated that this issue was under discussion.

4.1.4 Influence of budgetary restrictions on plan

Eleven countries reported that budgetary considerations and availability had influenced several or all aspects of NCCP drafting (Table 14): the Czech Republic, Estonia, France, Germany, Latvia, Lithuania, Malta, Poland, Romania, Spain and England. A number of both high-income and medium income countries stated that the budget had had no influence on the plan: Denmark, Hungary, Ireland, the Netherlands, Norway, Portugal and Sweden. Finally, for some countries this was not applicable to their plan as they had previously allocated sufficient funding: Belgium, Finland, Italy, Norway and Slovenia. Cyprus and Greece did not answer this question.

4.1.5 Specific budget allocated to implementation of different measures within plan? Are these sufficient?

Independently of possible budgetary restrictions that affected the drafting process (see 4.1.4 above), 16 countries responded that a specific budget had been allocated to different measures for implementation: Belgium, the Czech Republic, Denmark, Estonia, France, Germany, Greece, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Spain, Sweden and England (Table 15). Hungary noted that this was true in part. Of these countries, however, only 6 deemed that the allocated funds were sufficient: Belgium, Denmark, France, Lithuania, Malta and England. Germany had yet to determine whether there were sufficient funds. On the other hand, Italy, the Netherlands and Norway did not respond to the question on sufficiency of funds, and the rest expressed some concern about insufficient financing.

However, the lack of allocated funds within the NCCP does not necessarily preclude the presence of additional resources. Among the countries that did not answer this question or which noted that no additional funds had been allocated, there were several comments alluding to the nature of funding schemes in these countries, which may or may not go directly through the NCCP. For example, in the Netherlands, privately managed insurance companies partnered with the government in plan development, and providers committed to

allocating additional funds on an individual basis (though unspecified in quantity). In Ireland and Latvia, on the other hand, health expenditures are decided at the government level on an annual basis; thus the expenditure projected for the full term of the programme cannot be precisely quantified in advance.

4.2 Implementation capacity

4.2.1 Timeframe

While a few countries do not have a precise window of action, choosing to implement comprehensive cancer control policies on a continuous basis (this is the case in Germany, Ireland and Norway), most countries have set a specific time period for completion of their programme (Table 16). Slovenia has the shortest time period for implementation (two years), followed by Belgium and Italy (three years); Portugal, Spain and England (four years); Cyprus, France, Greece, Malta and the Netherlands (five years); Sweden (six years) Latvia and Hungary (seven years); Estonia (eight); and Finland, Lithuania, Poland and Romania (ten). Finally, Denmark envisages different stages of implementation for its plan, with a gradual rollout over 2, 3 and 10 years.

4.2.2 Measures taken according to planned activities

Eighteen MS (75%) noted that there were specific objectives for each measure in their plan; this is not the case in the Czech Republic, Norway and England. Cyprus and Slovenia did not respond to this question, while Poland noted that specific objectives existed, but these were not always measurable (Table 16).

4.2.3 Alliances with stakeholders

The exact nature of these alliances was not precisely defined in response to this question; however, only the Czech Republic, Finland, Malta and Norway did *not* make some type of strategic alliance with key stakeholders in their country. Slovenia did not answer this question, and the rest of the countries made strategic alliances according to the national situation and healthcare structures in place (Table 15).

4.2.4 Implementation structure, responsibility and human resources dedicated to that end

Ten respondents reported that a single structure (or type of structure, in the case of regional health authorities) oversees NCCP implementation (Table 17). Among these, Cyprus, France, Malta and Romania were the only ones that established a separate entity for this purpose only. In other cases, regional health authorities (Italy, Spain), healthcare providers (Finland, Norway) or the Ministry of Health (Czech Republic, Slovenia) have sole responsibility for implementation.

However, most countries (Belgium, Denmark, Estonia, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, the Netherlands, Poland, Portugal, Spain and Sweden) share the responsibility among health authorities, providers, cancer organizations, and other stakeholders. Denmark, Poland and England have established (or are in the process of establishing) independent bodies or task forces to assist implementation (although their authority will not be absolute).

Only three countries (Belgium, France and Romania) made explicit mention of additional human resources to assist in implementation; it is understood that this staff is not directly involved in delivering services, but rather

in overseeing the NCCP as a whole. While in France there is team consisting of 160 people, Romania has taken on a working group of experts. However, Ireland, Sweden and England note that extra resources have or soon will be available, and that this aspect was taken into account. Germany has not yet decided if additional human resources will be taken on.

4.2.5 Presence of a national/regional cancer centre to coordinate action

Ten countries reported the presence of a national/regional cancer centre to coordinate action: Belgium, Denmark, France, Hungary, Latvia, the Netherlands, Poland, Portugal, Romania and Sweden (Table 18). Fourteen countries have no such centre in place at present: Cyprus, the Czech Republic, Estonia, Finland, Germany, Greece, Ireland, Italy, Lithuania, Malta, Norway, Slovenia, Spain and England; however, in the case of Malta, a national cancer centre will be established once the new cancer hospital is open.

4.3 Communication

Most countries have disseminated the basic outline of their plan to the public; however, only a few have mechanisms to provide periodic reports on its development (Table 19).

4.3.1 Dissemination of plan to public at initiation

The Ministry of Health website was, by far, the primary medium chosen to disseminate information on the existence of an NCCP, used by twenty countries. Twelve countries disseminated the plan through another government website; six through a (national) cancer centre; four through a regional website and/or through a National Institute of Public Health. Nine countries also used some other means to communicate the initiation of a cancer programme.

Most countries used a variety of the above methods to publicize their plan; Denmark and Hungary stand out as the countries which used the most methods (four). Nine other countries used at least three different media to carry out this task.

4.3.2 Periodic reports

Periodic reports specifically targeted to communicating progress to the public were not as common; only 14 MS have formal mechanisms to report on progress: Belgium, Cyprus, Denmark, Estonia, France, Germany, Italy, Lithuania, the Netherlands, Poland, Romania, Slovenia, Spain, Sweden and England. Malta has envisaged a mid-term report and a final report on programme implementation, as well as the use of some informal channels through which the public is kept abreast of progress (mainly through mass media).

4.4 Evaluation

All countries reported having envisaged a final evaluation upon completion of their programme, with three exceptions: Ireland, Germany and Norway, whose programmes do not have a set finalization date. These countries have, however, planned interim or periodic reports to monitor progress (Table 20).

Eight countries stated that their evaluations would be based on structure, process and outcomes: Belgium, Czech Republic, Finland, Latvia, Malta, the Netherlands, Norway, Romania, Spain and Sweden. Denmark, Estonia, Greece, Ireland, Italy and Slovenia will only evaluate process and outcomes, while Cyprus, Hungary, Lithuania,

Portugal, Poland and England will only evaluate outcomes. A few countries (France, Germany and Sweden) either did not or could not answer because this aspect of the programme is still under discussion.

As for indicators, these varied greatly among those countries that provided detailed responses to this question. The most frequent indicators dealt with global outcomes such as incidence, mortality and survival for both specific cancers susceptible to prevention or early treatment (e.g. lung cancer, breast cancer) and cancer incidence or mortality as a whole. In addition, a number of countries track health system indicators such as screening coverage or health determinants like smoking prevalence in the population. On the other hand, some countries noted that concrete indicators are still pending development by policymakers or health managers. The full details collected are described in Table 20.

5. Strengths, weaknesses and results

5.1 Strengths

Of the 23 responses received for questions under this heading (including one—Bulgaria—without a formal programme), 22 describe some self-perceived strengths in the drafting or implementation process of their NCCP or cancer services.

5.1.1 Drafting

The strong points in the NCCP design process are detailed in Table 21. Among the common strengths identified by respondents, 14 countries (Belgium, Cyprus, Denmark, France, Germany, Hungary, Ireland, Italy, Latvia, the Netherlands, Romania, Spain, Sweden and England) cited the participation of experts and relevant stakeholders during programme formulation. Greece also highlighted the positive contributions of patients and NGOs.

A strong basis in epidemiologic information and analysis as well as scientific evidence was also listed as an asset during the drafting process by Estonia, France, Germany, Hungary, Italy, Lithuania and Malta, while the availability of international guidelines from WHO were mentioned by two (Estonia and Hungary). Portugal and England also mentioned strong political support as a strength; in the case of Portugal, this was explicitly attributed to awareness on the burden of cancer as one of the main health threats to the population. Latvia also mentioned this strength, but under the category of “strengths in plan implementation”.

Finally, three countries (Malta, the Netherlands and Poland) indicated that another strength was the awareness of a specific budget to support implementation right from the start. Given that a number of other countries also allocated additional funds for programme implementation, this strength (like others mentioned) is presumably not exclusive to the above three countries. However, due to the varied avenues of funding allocation, not all countries allocated a specific budget prior to the drafting stage but rather afterwards or throughout the implementation process. This fact would have introduced some uncertainty into the planning process; thus the availability of additional funding would not necessarily have constituted a strength in preliminary stages for all countries.

5.1.2 Implementation

Compared to the drafting process, there is more variation in the strengths observed during NCCP implementation. In addition to the countries that did not respond to this question (Cyprus, Czech Republic, Finland and Slovenia), some others stated that it was still too early to comment on this aspect.

Belgium, France, Ireland, Lithuania, the Netherlands, Norway and Portugal highlight the importance of specific organisations, structures or committees with clear responsibilities and action plan for monitoring implementation. Belgium and Norway also mention that resource and organizational capacity to implement actions has been a major asset during this process. Germany highlighted a highly efficient step-wise approach to programme development and implementation.

Good clinical practice (Greece, Norway and Portugal) and quality improvement plans for clinical services (Latvia, Lithuania and Romania) also stood out in the surveys as strengths.

Estonia mentions the existing programmes on breast or cervical cancer screening as a good head start, while Poland highlights adequate monitoring mechanisms to track implementation. Finally, Ireland notes the wide public acceptance of the programme, and Spain and Greece highlight the participation of patient associations and other stakeholders.

See Table 21 for more detailed information.

5.2 Weaknesses

There were fewer commonalities among countries in terms of weaknesses than in terms of strengths (Table 22).

5.2.1 Drafting

Most countries experienced some challenges during the NCCP drafting process—all but Hungary and Ireland. Other countries (Finland and Slovenia) did not provide an answer to this question.

Among the most important weaknesses in the drafting process cited by several countries (Greece, Latvia, Lithuania and Spain), the lack of quality information to assess population needs, as well as the insufficient attention paid to existing information, was mentioned. Belgium, Denmark and France said that a short planning period added difficulties to the process, whereas Malta and the Netherlands denounced lack of sufficient time apportioned to planning among different stakeholders, in the former case because the drafting team was not solely devoted to this task, and in the latter case because the range of stakeholders increased the turnover time for comments and remarks. Swedish respondents cited the lack of innovative proposals in prevention, early detection and patient empowerment.

Political challenges were also noted by Denmark (the existence of a deadline for the drafting process), Romania (pressures exercised by certain lobbies) and Italy and England (the health system was undergoing a restructuring process while the NCCP was being drafted).

Appropriate distribution of resources was a challenge for Norway. Finally, Estonia, Greece and Portugal mentioned a lack of adequate infrastructure or organization to carry out the plan, especially for home care and palliative care, as a major limitation to planning. Portugal also mentioned the absence of any European guidance or templates to structure the programme.

5.2.2 Implementation

Latvia provides a broad analysis of potential weaknesses in NCCP implementation that are projected based on its programme (especially those related to financing and service delivery). Most other countries that responded to this question (Belgium, Bulgaria, Denmark, Estonia, Hungary, Ireland, Lithuania, the Netherlands, Norway, Portugal, Poland, Romania and Sweden) make just brief reference to the following points:

- Lack of information on cost-effectiveness (Belgium) or epidemiologic information (lack of a cancer registry in Estonia)
- Pilot nature of certain initiatives, which are globally aimed at health rather than specifically on cancer (France)
- Fragmented nature of some cancer services, such as palliative care, rehabilitation and psychosocial support (Sweden)
- Insufficient participation among important stakeholders (Belgium, the Netherlands)
- Budgetary or human resource restrictions (Bulgaria, Hungary, Lithuania and Sweden)
- Changes in the organization of service delivery (Ireland and Norway)
- Pressures from vested interests (Portugal and Romania) together with the lack of autonomy by the planning structure (Portugal)
- The rigidity of NCCP adoption, which requires annual approval by the government (Poland).

5.2.3 Examples of measures taken to overcome weaknesses

From the information gathered in this section (just 14 countries responded to this question), two groups of strategies emerge in response to weaknesses detected in current programmes.

The first group of strategies has been implemented to correct problems detected in the current programme. Some measures include the following:

- The creation of an evaluation system after implementation had already begun (Belgium)
- Important efforts to make programme development and implementation more efficient (Denmark)
- The creation of a national cancer registry in Estonia, which will be operational in the next two years
- The reorganization of services (Norway)
- Increased autonomy of monitoring structures (Portugal)

The second group of strategies can be defined as solutions envisaged for the future, that is, lessons learned that will be applied in subsequent programmes. The measures taken in this sense include the following:

- The need to establish work plans which are in line with the reasonable time available for drafting (France and Malta)
- Clear and explicit definition of authorities responsible for programme coordination (Lithuania)

- Creation of cancer registries which collect data on incidence at a national level (Spain)
- Longer evaluation periods that allow the generation of data and results in the long term.

See Table 22 for more detailed information.

5.3 Results

In general, few quantitative results are available with regard to the indicators laid out in the national programmes; this is primarily due to the recent nature of programme implementation and the long lead time necessary to produce data on, for example, five-year survival rates. However, some countries did point to past successes (either as a result of past NCCPs or of past efforts in the field of cancer control). Likewise, positive qualitative assessments were made on improvements to services and quality.

5.3.1 Quantitative evaluation

Only a few countries have quantitative results available on improvements as a result of the current cancer control programme, and in some cases, these results are still incomplete (Table 23). Norway, whose programme was launched earliest (in 1997) has the clearest results, with decreases in mortality and increases in survival. The Czech Republic, Estonia and Spain have observed increased participation in cancer screening programmes, and Hungary can point to modest improvements in the Standardized Death Rate (SDR) for all neoplasms as well as a slight but noticeable reduction in incidence for cervical and breast cancer. Cyprus also recorded improvements in cervical cancer incidence as well as earlier detection of breast cancer due to its screening programmes. Romania indicates that progress has been made by increasing the coverage of the national cancer registry and by bringing screening programme coverage up to 20% in one region of the country.

A second category of countries, comprised by Belgium, Denmark, Ireland, Italy, Latvia and England, have provided data or noted improvements with regard to cancer indicators from past programmes. In some cases, these are quite dramatic and positive. England, while noting that improvements have been achieved (in some cases more rapidly than among its neighbours), acknowledges that challenges remain, particularly the persistent survival gap between itself and a number of other developed countries in Western Europe. Other countries, including Denmark, Ireland, Italy and Latvia, cite improvements both in incidence and mortality due to past cancer control programmes.

Some countries, such as the Netherlands and Latvia, have provided supporting documents to their survey responses with detailed results on aspects of programme implementation. These will be revised comprehensively in the next phase of the study.

Finally, a number of countries (Finland, France, Germany, Greece, Lithuania, Malta, Poland, Portugal, Slovenia and Sweden) state that no information is available yet because not enough time has passed since programme implementation began.

5.3.2 Qualitative evaluation

Despite the lack of quantitative results, respondents were quite positive about the overall effect that NCCPs have had on cancer services. Positive aspects included putting cancer on the national agenda (Belgium and Malta), establishing sustained preventive services (Estonia, France), and implementation of preventive policies such as

indoor smoking bans (Denmark, Portugal). Cyprus mentioned the positive impact of bringing all stakeholders together.

Most importantly, a number of countries have noticed significant improvements in coverage, efficiency and quality of services (Belgium, Denmark, Estonia, France, Germany, Hungary, Ireland, Lithuania, the Netherlands, Norway and Poland).

ANNEX: TABLES

Table 1: CANCER PLANS IN THE EU MEMBER STATES, NORWAY AND ICELAND: General situation

COUNTRY	Cancer Plan	Type of plan (year of adoption)	If there is no plan… Why is this so?
Austria	No		Under development
Belgium	Yes	Cancer Plan (2008) and a cancer strategy (2003)	
Bulgaria	No		Lack of funding
Cyprus	Yes	National Cancer Plan (2009)	
Czech Republic	Yes	National Cancer Strategy (2008)	
Denmark	Yes	National Cancer Plan/Strategy (2010) (The 2010 Cancer Plan supplements earlier cancer plans from 2000 and 2005)	
Estonia	Yes	National Cancer Strategy (2007)	
Finland	Yes	National Cancer Plan (2010)	
France	Yes	National Cancer Plan (2009-2013) The first cancer plan was 2003-2008; the second 2009-2013	
Germany	Yes	National Cancer Plan (2008)	
Greece	Yes	National Cancer Plan (2010)	
Hungary	Yes	National Cancer Plan (2006)	
Iceland	No	The Iceland Minister of Welfare announced on the World Cancer Day, earlier this year that the Ministry of Welfare would start a work on the first National Cancer Plan of Iceland this year. This work is expected to start in June and the Plan will be designed to both reduce cancer incidence and mortality and improve quality of care and life of cancer patients. The Plan will follow the framework of the World Health Organization definition of a national cancer control programme and other evidence-based strategies and experiences of other countries.	
Ireland	Yes	National Cancer Plan (2006)	
Italy	Yes	National Cancer Plan (2011)	
Latvia	Yes	The Onkologic Diseases Control Program for years 2009-2015 (2009)	

COUNTRY	Cancer Plan	Type of plan (year of adoption)	If there is no plan… Why is this so?
Lithuania	Yes	National cancer prevention and control programme 2003-2010 (2003)	
Luxembourg	No		Under development
Malta	Yes	National Cancer Plan (2011)	
Netherlands	Yes	National Cancer Plan (2004)	
Norway	Yes	National Cancer Plan (1997)	
Poland	Yes	National Cancer Plan (2006)	
Portugal	Yes	National Cancer Strategy (2007)	
Romania	Yes	National Cancer Plan and Strategy (2002)	
Slovak Republic	No		Lack of political consensus
Slovenia	Yes	National Cancer Strategy (2010)	
Spain	Yes	National and Regional Cancer Plans (2006)	
Sweden	Yes	National Cancer Strategy (2009)	
England	Yes	National Cancer Strategy (2011)	

Table 2: COUNTRIES WITHOUT A NATIONAL CANCER PLAN: General situation

COUNTRY	How cancer control is integrated into other policies/legislation/ strategies	Specific cancer prevention and control activities that have been adopted
Austria	Definition of individual services into the different segments of health care and its monitoring	Opportunistic screenings for breast and colon cancer
Bulgaria	Definition of individual services into the different segments of health care and its monitoring	(i). Cancer Risk Assessment among children, living in homes where are indicated magnetic fields with a value above 3 mG. 2-3 000 (in compliance with the National Program of the Council of Ministers for Action in the area of Environment and Health (2008 - 2013)); (ii). Current Draft of National Program for integrated control of cancer diseases (in compliance with the Action Plan for National Health Strategy of the Ministry of Health (2008 – 2013); (iii). National screening programs for cancer diseases (as a future priority action according to the Concept for Better Health (Ministry of Health); Aim at improving diagnosis of some forms of inherited (family) cancer (in compliance with the National Program of the Ministry of Health for Rare Diseases (2009 – 2013); Working on "STOP and GO for a Check-Up" Program for raising awareness among the general public about screening for cervical, breast and colorectal cancers (Project BG051RO001-5.3.2002-001-S0001 under the Operational Program for Human Resources Development). Aim at improving the treatment of cancer through the study of genetic markers (in compliance with the National Program of the Ministry of Health for Rare Diseases (2009 – 2013); Introduction of program principle for issues such "application for funding" and "funding of programs" in the area of cancer (as a strategic aim in compliance with the National Health Strategy of the Ministry of Health (2008 – 2013).
Iceland	Integrated into the Icelandic National Health Plan (see: http://eng.velferdarraduneyti.is/media/Skyrslur/heilbenska5mai.pdf). One of the priority areas of the Icelandic Health Plan to the year 2010 is Cancer Prevention. The plan was reviewed in 2007 where three objectives concerning Cancer were added. A work on a new Health Plan to the year 2020 is now under way and the new plan will also have Cancer Prevention as one of its priority areas.	The objectives in the Health Plan to the year 2010 are the following: 1. Reduce by 10% the mortality due to cancer in people younger than 75 years. 2. Reduce by 30% the mortality of prostate cancer in men younger than 75 years. 3. Reduce by 30% the mortality of breast cancer in women younger than 75 years. 4. Reduce the use of sun-baths by 50%.

		The specific cancer prevention and control activities adopted were: • Information on cancer risk factors. • Actions to promote healthy lifestyles. • Drafting of clinical guidelines concerning diagnosis and treatment of cancer. • Systematic screening, monitoring and follow-up. • Strengthening research on the relation between cancer and lifestyles, social status and environment. •Education on the risk of sun-baths.
Luxembourg	N/A	a) Breast screening b) Smoking cessation c) HPV vaccination d) Cervical Screening
Slovak Republic	-A self-standing document defining the actions (operationalisation) related to the outlines in the national cancer plan. -Definition of individual services into the different segments of health care and its monitoring	-Breast cancer screening - Public awareness campaigns for the prevention of colorectal cancer

N/A = not available

Table 3: COUNTRIES WITH A NATIONAL CANCER PROGRAMME: General situation

COUNTRY	Year of adoption	Adopting authority	Implementing authority	Monitoring authority
Belgium	2008	Minister of Public Health	Ministry of Health + National Institute of Health and Disability Insurance	Minister of Public Health, Government, Belgian Cancer Centre
Cyprus	2009	Ministry of Health and all involved stakeholders	National Cancer Committee	Ministerial Board
Czech Republic	2004	Czech Society for Oncology	Ministry of Health	MoH
Denmark	2010	Government (Ministry for the Interior and Health)	National Board of Health + the regions	National Board of Health + the regions
Estonia	2007	Social minister's regulation no. 87 of May 10, 2007	National Institute for Health Development	Ministry of Social Affairs
Finland	2010	The Ministry of Social Affairs and Health	The University Hospital Districts	The Institute of Health and Welfare
France	2003	President of the French Republic	Department of health and national cancer institute	Department of health
Germany	2008	The National Cancer Plan was initiated by the Federal Ministry of Health together with the German Cancer Society (Deutsche Krebsgesellschaft), the German Cancer Aid (Deutsche Krebshilfe) and the Joint Working Group of German Tumor Centres (Arbeitsgemeinschaft Deutscher Tumorzentren) on 16th June 2008. The German health care system is characterised by the diversity of its federal system. In particular purchasers and providers enjoy considerable autonomy in the way health-care services are organised and managed. The National Cancer Plan takes these special structural characteristics into account. The Cancer Plan is therefore designed as a programme of coordination and cooperation. The Federal Ministry of Health has got	In 2010 and 2011 recommendations for most but not all objectives of the German National Cancer Plan were adopted. At the beginning of 2012 the Federal Ministry of Health and the stakeholders concluded the development of an implementation strategy. There is no single organisation responsible for its implementation.	Federal MoH + other implementing authorities

COUNTRY	Year of adoption	Adopting authority	Implementing authority	Monitoring authority
		the overall responsibility in coordinating the activities.		
Greece	2010	Ministry of Health and Social Solidarity	Ministry of Health and Social Solidarity in collaboration with other Bodies and Organisations	Ministry of Health and Social Solidarity
Hungary	2006	Ministry of Health	National Public Health and Medical Officers' Service, Oncology centres and 198 medical facilities.	- National Institute of Oncology - National Public Health and Medical Officers' Service
Ireland	2006	Minister for Health and Children	Health Service Executive	Department (Ministry) of Health and Children
Italy	2011	Conferenza Stato-Regioni (State-Regions Governing Body)	MoH	MoH
Latvia	2009	Cabinet of Ministers of the Republic of Latvia	Ministry of Health of the Republic of Latvia and institutions subordinated to the Ministry of Health (the Health Payment Center, the Centre of Health Economics, the Health Inspectorate, the Sports Medicine State Agency, the State agency, Infectology Center of Latvia"), Ltd "Riga East Clinical University Hospital" Latvian Oncology Center, line ministries (Ministry of Education and Science, Ministry of Agriculture, Ministry of Welfare) and professional associations..	MoH
Lithuania	2003	MoH	MoH + hospitals	MoH
Malta	2011	Ministry for Health, the Elderly and Community Care	Steering Committee for the Implementation of the NCP, Ministry for Health, the Elderly and Community Care	Steering Committee for the Implementation of the NCP, Ministry for Health, the Elderly and Community Care
Netherlands	2004	MoH, VIKC (Dutch association of Comprehensive cancer centres IKNL), KWF (Queen Wilhelmina Foundation	Same	Same

COUNTRY	Year of adoption	Adopting authority	Implementing authority	Monitoring authority
		Cancer League) ZN (national association of health insurance companies) NFK (national federation of cancer patients associations).		
Norway	1997	The Norwegian Directorate of Health, The Regional Health Authorities, County Governors, counties	The Norwegian Directorate of Health, The Regional Health Authorities, County Governors, counties	Norwegian Board of Health Supervision
Poland	2006	Polish Parliament, Ministry of Health, National Health Fund	MoH, Cancer Control Council, National Health Found – Polish health insurance institution, National Consultants.	MoH and Cancer Control Council
Portugal	2007	National Coordination of Oncological Diseases (NCOD) - MoH	NCOD and Regional Health Administration	High Commissariat of Health-MoH
Romania	2002	MoH	Cancer Commission	MoH
Slovenia	2010	Government of the Republic of Slovenia	Ministry of Health of the Republic of Slovenia	MoH
Spain	2006	Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations.	Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations.	Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations.
Sweden	2009	MoH	National Board of Health and Welfare, Swedish Association of Local Authorities and Regions	MoH
England	2011	Department of Health NHS Commissioning Board Public Health England	Department of Health NHS Commissioning Board Public Health England	Department of Health NHS Commissioning Board Public Health England National Audit Office

Table 4: ELEMENTS INCLUDED IN CANCER PROGRAMME/PLAN/STRATEGY: General situation

COUNTRY	Cancer Prevention		Control Activities		Supportive functions			
	promotion/ primary prevention	secondary prevention (screening)	integrated care, incl. organization	Palliative/ psycho-oncological care	Research, registries	Training	Quality control	Others
Belgium	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Data management; paediatric cancer care; geriatric cancer care; rare tumours; improved insurance coverage; Comprehensive Cancer Centres; patient and family support, translational research; implementation of the Belgian Cancer Centre
Cyprus	Yes	Yes	No	Yes	Yes	N/A.	N/A.	
Czech Republic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Cost control and HTA; International co-operation and harmonization in EU and WHO partnership; Network of Oncocentres; Equity
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Support for relatives of cancer patients
Estonia	Yes	Yes	Yes	Yes	No	No	No	
Finland	Yes	Yes	Yes	No	Yes	Yes	No	Human resources; communication
France	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Equal Access
Germany	No	Yes	Yes	Yes	Yes	Yes	Yes	Comments: Currently primary prevention is not an Area for Action during the first phase of the Cancer Plan. However, there is already a wealth of initiatives outside the National Cancer Plan that aim at

COUNTRY	Cancer Prevention		Control Activities		Supportive functions			
	promotion/ primary prevention	secondary prevention (screening)	integrated care, incl. organization	Palliative/ psycho-oncological care	Research, registries	Training	Quality control	Others
								improving health promotion and primary prevention by focusing on common non-disease-specific risk factors such as smoking, alcohol, poor diet and lack of physical activity. However, for the next phase, it must be determined whether there is a need to take action in additional areas in order to combat cancer (particularly in relation to primary prevention, cancer research, environmental, occupational and consumer-oriented cancer protection).
Greece	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Hungary	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Patient empowerment; Epidemiology; Paediatric oncology
Ireland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Health inequalities; licensing and accreditation; information
Italy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Epidemiology; cancer in elderly people; cancer in childhood; rare tumors; health technology; information and communication; rehabilitation
Latvia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

COUNTRY	Cancer Prevention		Control Activities		Supportive functions			
	promotion/ primary prevention	secondary prevention (screening)	integrated care, incl. organization	Palliative/ psycho-oncological care	Research, registries	Training	Quality control	Others
Lithuania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Malta	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Patient empowerment
Netherlands	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The plan included 150 different activities
Norway	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Long-term effects of cancer treatment
Poland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Hereditary factors programme for families; Quality control in diagnosis and treatment of malignant neoplasm in children; replacement of equipment for treatment
Portugal	Yes	Yes	Yes	No	Yes	Yes	Yes	Report on the oncology and psycho-oncology national capacity; Legislation on the maximum waiting time for treatments; Best practices
Romania	Yes	Yes	Yes	Yes	Yes	N/A.	Yes	
Slovenia	Yes	Yes	Yes	Yes	Yes	Yes	No	
Spain	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Patient empowerment and social support for families Child and adolescent care; quality of life

COUNTRY	Cancer Prevention		Control Activities		Supportive functions			
	promotion/ primary prevention	secondary prevention (screening)	integrated care, incl. organization	Palliative/ psycho-oncological care	Research, registries	Training	Quality control	Others
								Reducing inequalities
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Improved system for second opinion; Patient empowerment; (list non-inclusive) Restructuring (concentration) of parts of cancer care Establishing six regional cancer centres
England	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Information and choice; Quality of life and patient experience; Reducing inequalities; Autonomy, accountability and democratic legitimacy: commissioning and levers; Better treatment

*Poland: Have a research but outside the oncology program

N/A= not available

Table 5: CANCER PROGRAMME/PLAN/STRATEGY: Methodological issues

COUNTRY	Methodology used in planning							Development process timeframe	Current stage of process					
	Round tables	Focus groups	Electronic Surveys	Expert opinions	External organization	Administration(s)	Other		Idea	Consultation and drafting	Plan	Implementation	Evaluation	Drafting new plan
Belgium	✓			✓		✓		2007			✓	✓	✓	✓
Cyprus	✓	✓		✓		✓		2008-2009						
Czech Republic	✓			✓				Nov.03- Feb. 04					✓	
Denmark	✓			✓		✓		Jan.-Nov.10				✓		
Estonia	✓	✓	✓	✓	✓	✓		2004- 2007	✓	✓	✓	✓	✓	
Finland	✓			✓		✓	✓	Feb.09- Feb.10				✓		✓
France	✓			✓		✓	✓	Jan. 2008- Jun. 2009						
Germany	✓			✓	✓	✓	✓	2008- ongoing	✓	✓	✓	The implementation, evaluation and drafting of new elements of the plan are under discussion / on-going in parallel		
Greece	✓	✓					✓	2007-2010			✓			
Hungary	✓	✓	✓	✓	✓	✓		2005- 2006				✓		

COUNTRY	Methodology used in planning							Development process timeframe	Current stage of process					
	Round tables	Focus groups	Electronic Surveys	Expert opinions	External organization	Administration(s)	Other		Idea	Consultation and drafting	Plan	Implementation	Evaluation	Drafting new plan
Ireland				✓		✓	✓	2003-2006				✓	✓	
Italy	✓		✓	✓		✓		2009-2011			✓			
Latvia	✓	✓		✓		✓		Jan.-Dec. 2008			✓	✓		
Lithuania	✓	✓						2002-2003					✓	✓
Malta		✓		✓		✓*		2007- 2010			✓	✓		
Netherlands	✓	✓	✓	✓	✓			2002-2004					✓	✓
Norway							✓	1997- 1998				✓	✓	
Poland		✓		✓		✓		2000- 2006				✓	✓	
Portugal			✓	✓		✓	✓	2005-2007				✓	✓	
Romania	✓	✓		✓	✓			2002- 2008				✓		
Slovenia	✓	✓		✓				2007-2010				✓		
Spain	✓	✓	✓	✓		✓		2003- 2006					✓	
Sweden	✓	✓		✓		✓		2007-2009				✓		

COUNTRY	Methodology used in planning							Development process timeframe	Current stage of process					
	Round tables	Focus groups	Electronic Surveys	Expert opinions	External organization	Administration(s)	Other		Idea	Consultation and drafting	Plan	Implementation	Evaluation	Drafting new plan
England	✓	✓		✓				6 months				✓	✓	

*Malta: Implementation started soon after launch in Feb 2011

Table 6: CANCER PROGRAMME/PLAN/STRATEGY: Stakeholder involvement in the Plan in different stages (see footnote)

COUNTRY	Patients	Professionals	MoH/Gov't	Payers/reimbursement
Belgium	1, 4, 5	1, 4, 5	1, 2, 3, 4, 5	1, 2, 3, 4, 5
Cyprus	1, 2, 3, 4	1, 2, 3, 4	1, 2, 3, 4, 5	
Czech Rep.		1, 2, 3, 4, 5	3	3
Denmark	2, 3	1, 2, 3, 4	1, 2, 3, 4, 5	
Estonia	2	1, 2, 3, 4	2, 3	2, 3
Finland	1, 2, 3, 4, 5	1, 2, 3, 4, 5	2, 4, 5	4
France	1, 2, 3	1, 2, 3	1, 2, 3	
Germany	2, 3, 4, 5	1, 2, 3, 4, 5	1, 2, 3, 4, 5	2, 3, 4, 5
Greece	2, 3	1, 2, 3	1, 2, 3	
Hungary	1, 2, 3, 4	1, 2, 3, 4	1, 2, 3, 4	1, 2, 3, 4
Ireland	2	2, 3	2, 3, 4	2, 3, 4
Italy	2	1, 2, 4	1, 2, 4, 5	2
Latvia	2	1, 2, 3, 5	1, 2, 3, 4, 5	3, 4
Lithuania	3	1, 2, 3, 4, 5	1, 2, 3, 4, 5	2, 3, 4, 5
Malta	1, 2, 3, 4	1, 2, 3, 4	1, 2, 3, 4	
Netherlands	2, 3, 4, 5	2, 3, 4, 5	2, 3, 4, 5	1, 2, 3, 4, 5
Norway	2	1, 2, 3, 4	1, 2, 3, 4	
Poland	3	1, 2, 3, 4	2, 3	1, 2, 3, 4
Portugal		2, 3, 5	1, 2, 3, 4, 5	
Romania	2, 3	1, 2, 3	1, 2, 3, 4	3
Slovenia		1, 2, 3	1, 2, 3, 4	3
Spain	2, 3, 4, 5	1, 2, 3, 4, 5	1, 2, 3, 4, 5	
Sweden	1, 2, 3	1, 2, 3	1, 2, 3	1, 2, 3
England	1, 2, 3	1, 2, 3, 4	1, 2, 3, 4	

Different stages: 1: Idea; 2: Consultation drafting; 3: Implementation; 4: Evaluation; 5: Drafting of a new plan.

Table 7: CANCER PROGRAMME/PLAN/STRATEGY: Challenges

COUNTRY	Methodological challenges	Political challenges	Overcome these challenges (comments)
Belgium	Short planning process; establishing specific needs-based measures	Regional vs. federal competencies to be decided	Indicators developed after plan was complete; round tables and discussions with experts and stakeholders; interministerial conferences
Cyprus	Every stakeholder wanted to emphasize his own issue, therefore, we had to face some disagreements and endless discussions	No	The Ministry of Health was the coordinator and we have followed…strictly the EU recommendations
Czech Republic	No	No	
Denmark	Short planning process; professional disagreements, lack of evidence	Timing; content	Round table talks with stakeholders; broad and deep involvement to give a solid and nuanced basis for defending the decisions and content of the plan in political discussions
Estonia	No	No	
Finland	No	No	
France	No	Yes; The national cancer plan is an inter-ministerial presidential plan	Having strict time table including validation by the Elysée cabinet of the President
Germany	Devolved structure of the German health care system (see also Table 3)	Devolved structure of the German health care system. Balance of interests between the relevant stakeholders.	Involvement of relevant stakeholders and creating a sense of ownership and commitment to action.
Greece	No	Not all stakeholders were happy with the development/ implementation of a national cancer	Discussions and consultations and by referring to the 2009 Communication on Action against Cancer

COUNTRY	Methodological challenges	Political challenges	Overcome these challenges (comments)
		plan	
Hungary	No	No	
Ireland	No	No	
Italy	No	Regional vs. federal competencies to be decided	Guidance approach was followed rather than prescriptive operational edicts
Latvia	No	Global financial crisis	Priority setting
Lithuania	Yes	No	Round tables discussion, working groups, meetings with patients and other organizations
Malta	Long political clearance period; Political, financial context and resource availability	Same	Detailed economic evaluations were presented to political leaders to justify screening and vaccination programmes.
Netherlands	Yes. It was difficult to get all medical specialists in oncology on board at the beginning	Yes. Different interests	Meth. Chal. has been overcome as the radiotherapists, oncological surgeons and the medical oncologists have set up a federation to support strategic plans as an active partner. Pol. chal.: The partners have to deal with their own interests within a collaborative and comprehensive way. They formed a steering committee with the partners and were the plan was discussed. It works well.
Norway	No	No	Comment: Starting from the report in 2005 they implemented a national strategy at regional level. The previous report identified areas of action and resource demanding.

COUNTRY	Methodological challenges	Political challenges	Overcome these challenges (comments)
Poland	-initial lack of monitoring system for screening tests are invited women in specific age group (screening tests for cervical cancer - women between age 25-59, a survey carried out every 3 years; screening tests for breast cancer - women between age 50-69 years, survey carried out every 2 years). Because of that we are able to obtain information about women who took part in the screening tests. -two-year delay in publication of national cancer registry data	No	- establishment of a full monitoring system for screening
Portugal	Yes	Yes	Establishing priorities; organizing the existing health structures to ensure the implementation of the NCS; creation of National Coordination of Oncological Diseases to ensure political will
Romania	Evaluating resources. Quality guidelines.	Mostly regarding the lack of resources in the health system	Not entirely overcome.
Slovenia	No	No	
Spain	No	No	

COUNTRY	Methodological challenges	Political challenges	Overcome these challenges (comments)
Sweden	Innovative methods in cancer prevention Early detection of cancer in clinical practices	National strategy with strong involvement of central government not congruent with traditional decentralized organization of healthcare. Concentration of parts of cancer care questioned by many stakeholders.	National cancer coordinator at MoH having dialogues with local and regional decision-makers, patient organizations and professionals.
England	No	No	

Table 8: CANCER PROGRAMME/PLAN/STRATEGY: Budgetary considerations during plan formulation

COUNTRY	Structure	Priorities	Topics	Comments
Belgium	Yes	Yes	Yes	All health policy decisions and priorities are influenced by budget possibilities
Cyprus	No	No	No	In our National Plan we describe the ideal. The budget did not influence our decisions on setting the priorities. It did influence our action plan. We had to prioritize the actions, according to the available budget. Therefore, we set immediately, midterm and long-term applicable actions
Czech Rep	No	No	No	
Denmark	No	No	No	
Estonia	No	No	No	
Finland	No	Pal. care; cancer meds	Manpower; age structure of population	The plan is as cost neutral as possible.
France		No	Yes	Budgets were restricted but there was a strong political will to ensure that each measure is supported by an adequate budget which was negotiated with the cabinet

COUNTRY	Structure	Priorities	Topics	Comments
Germany	Yes	Yes	Yes	There is a separate budget for administrative and organisational tasks/issues within the Cancer Plan (e.g. organisation of steering committee meetings or working group meetings). There is also a separate budget for research activities in connection with the Plan. As a Cooperation and Organisation Programme the overarching aim of the National Cancer Plan is to coordinate more effectively the activities of all those who are involved in combating cancer, to promote a more focused approach and to use more efficiently resources that are already dedicated to the prevention and control of cancer. Budgetary issues are being addressed in the objectives of the German National Cancer Plan. Thus, the relevant stakeholders will provide funding for the implementation of specific objectives depending on their responsibility and accountability, within their budgetary constraints. Therefore, the Cancer Plan has not got an overall budget as such.
Greece	No	Yes; priorities set were: Data and info.; Education and prevention Quality of care		
Hungary	No	Yes; prevention is a key priority.	No	
Ireland	No	No	No	
Italy	N/A	N/A	N/A	N/A

COUNTRY	Structure	Priorities	Topics	Comments
Latvia	No	Yes	No	At the time of drafting, budget was not a problem, but with the onset of the financial crisis, a priority setting process had to take place
Lithuania	Yes	Yes	Yes	
Malta	Yes	No	No	Authors had to assure that proposal and corresponding financial demands were reasonable given the local financial and human resources constraints
Netherlands	No	No	No	
Norway	No	No	No	
Poland	N/A	N/A	N/A	During the implementation of the National cancer control program for accomplishment of the tasks included in the program, the Minister of Health has to guarantee every year stable budget, or reserves of 250 000 000 PLN of the budget. Moreover, in the article 7 of Act on foundation of long-term National Cancer Program it is written: 1)The Program will be financed from the state budget and non budget funds. The total outlays for the Program throughout its duration have been set at 3 000 000 000 PLN. 2) Budget funds channeled to projects foreseen under the Program in consecutive years may not amount to less than 250 000 000 PLN.
Portugal	No	No	No	
Romania	Yes	Yes	Yes	Yes; For this reason they only started with: cancer registration, pilot screening for cervical cancer and treatment resources
Slovenia	N/A	N/A	N/A	

COUNTRY	Structure	Priorities	Topics	Comments
Spain	No	No	No	
Sweden	Yes	Yes	Yes	Financial support from central government for selected initiatives in the cancer strategy, including regional cancer centres (RCCs). Additional regional financing of establishment of RCCs.
England	No	Yes	Yes	The activities outlined in Improving Outcomes had to be clearly evidence-based and cost-effective.

N/A= not available

Table 9: CANCER PLANS: Goals, objectives and related indicators

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
Belgium	Reduce cancer incidence, morbidity and mortality and improve quality of life for cancer patients	Each action has a specific objective (described under the heading 'objective' in the Plan in attachment). Development of specific indicators for each action is in progress.	Yes (see tables 10 and 11)
Cyprus	The goals are very clearly defined in the action plan, the list of the objectives and the indicators are listed in the action plan, which is in the process of being formed now.		Yes (see tables 10 and 11)
Czech Rep	Lowering of incidence and mortality rates of tumor diseases. Improvement of quality of life of oncologically ill. Nationalization of diagnosis and treatment costs of tumor diseases in the Czech Republic.		Yes (see tables 10 and 11)
Denmark	The goals and objectives of the cancer plan are not closely related to specific indicators.		Yes (see tables 10 and 11)
Estonia	1. Permanent decreases in the incidences of preventable malignant tumors among population 2. The increase in cancer patients survival, improved quality of life and decrease in death rate.	1. Incidence 2. Survival (FRS – five-years relative survival) 3. Quality of life 4. Mortality	Yes (see tables 10 and 11)
Finland	N/A	N/A	Yes (see tables 10 and 11)
France	The plan has 5 areas, 30 measures and 118 actions. The goals objectives and the indicators are very clearly defined in the plan, for each area and action. There are 6 "flagship" measures: <u>RESEARCH</u> Measure 1 Increase resources for multidisciplinary research. Accredit five multidisciplinary cancer research integrated sites. These sites will be selected on a competitive basis and should help to transfer scientific research to patient care more quickly. Increase patient participation		Yes (see tables 10 and 11)

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	in clinical trials by 50%. Efforts will focus as a priority on the most vulnerable populations: children, elderly people, rare types of tumour and serious forms of cancer. Measure 3 Define environmental and behavioural risks. Devote more than 15% of the research budget associated with the plan to analysing environmental and behavioural risks. Contribute to the full genome sequencing of the five most common cancers. This target forms part of the cooperative efforts being made worldwide on tumour genome profiling. <u>OBSERVATION</u> Measure 6 Produce and communicate information on cancer and cancer research and treatment on an annual basis. Produce an analysis of cancer distribution across the country each year. <u>PREVENTION – SCREENING</u> Measure 14 Tackle inequalities in access and up-take of screening. Increase participation by the whole of the population in organised screening programmes by 15%. The level of increase should be 50% in the departments experiencing most difficulties. <u>PATIENT CARE</u> Measure 18 Individualise patient-care and expand the role of the referring doctor. Ensure that 80% of patients benefit from at least one individualised care plan. This plan should involve the referring doctor on a systematic basis. <u>LIFE DURING AND AFTER CANCER</u> Measure 25 Develop individualised social support during and after cancer. Ensure that 50% of patients benefit from at least one post-cancer plan. This plan will take account of individual needs in terms of medical supervision and psychological and social support.		
Germany	Overall aim: Improvement of the health care provision in the prevention and control of cancer. Areas for Action and objectives: <u>I. Area for Action 1: Further Development of the Early Detection of Cancer.</u> Objective 1: Better information and improving attendance in the early detection of cancer Subobjectives/Indicators: The informed attendance in programmes for the early detection of cancer that have been introduced through legislation and proven to be effective will be increased: − Improvement in the availability of information on the benefits and risks of the early detection of cancer. The target population is able to make well-informed decisions with regard to attendance or non-attendance		

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	− Increase of the attendance rates in screening programmes that have proven to be effective Objective 2: Further organisational development of programmes for the early detection of cancer Subobjectives/Indicators Tests for the early detection of cancer that have been shown to contribute to lowering mortality rates from the targeted diseases refer to the European recommendations for a systematic, population-based screening programme. a) Rapid adaptation of cervical cancer screening to the quality requirements of the current "European Guidelines for Quality Assurance in Cervical Cancer Screening" b) Rapid adaptation of bowel cancer screening, to the quality requirements of the recently published "European Guidelines for Quality Assurance in Colorectal Cancer Screening and Diagnosis" . Objective 3: Evaluation of programmes for the early detection of cancer Subobjectives/Indicators The programmes for the early detection of cancer will be evaluated with regard to their benefits (particularly the reduction of mortality) by involving the epidemiological cancer registries of the Laender − Creation of a legal basis (on the level of the Laender, if necessary also in the SGB V, Fifth Book of the Social Code) for a uniform evaluation of the statutory early detection programmes − Ensuring sustained funding and organisation of an ongoing, comprehensive, and comparative mortality evaluation of the cancer screening programmes − Timely publication of the evaluation results II. Area for Action 2: Further Development of Oncological Care Structures and Quality Assurance Objective 4: All cancer patients will receive high quality care, regardless of age, sex, origin, place of residence or insurance status. Objective 5: Standardising certification and quality assurance of oncological treatment facilities		

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	Subobjectives/Indicators There are standardised concepts and designations for quality assurance and certification of oncological treatment facilities − Service providers and decision makers will agree upon standardised quality requirements, data sets, certification procedures and designations for all oncological centres − All oncological treatment facilities will agree to transparently demonstrate quality standards, e.g. through certification Objective 6: Evidence-based guidelines for the treatment of cancer Subobjectives/Indicators For all common types of tumours there are evidence-based treatment guidelines of the highest methodological standard (known as S3 Guidelines). These guidelines are implemented in oncological treatment facilities − Development and continuous updating of oncological guidelines of the highest standard (S3) for all common types of cancer − Ensuring the appropriate dissemination and application of the guidelines − Evaluation of the effects of the guidelines through critical analysis of the treatment data in regional and national quality conferences Objective 7: Cross-sector, integrated oncological care will be guaranteed. Objective 8: High quality health care data from clinical cancer registries Subobjectives/Indicators Representative high quality oncological health care data are available for service providers, decision makers and patients - Expansion of the clinical cancer registries in order to achieve complete surveillance of quality of the care data - Enhancement of networking between regional clinical cancer registries - Enhancement of networking between clinical and epidemiological cancer registries and integration of cross-sector quality assurance according to § 137 SGB V (Article 137 of the Fifth Book of the Social Code)		

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	- Feedback on the data to all of the participating service providers in the form of a structured, critical assessment of the results - Transparent reporting of the treatment results for clinics, doctors, patients and their families, and the public - Uniform data sets to document cancers Objective 9: Appropriate psycho-oncological care according to patients' needs Subobjectives/Indicators All cancer patients are entitled to appropriate psycho-oncological and psycho-social care if needed − Improved identification of the need for psycho-social support and therapy for psychological disorders in cancer patients and their families − Ensuring the necessary psycho-oncological and psycho-social care in outpatient and inpatient care <u>III. Area for Action 3: Ensuring Efficient Oncological Treatment</u> Objective 10: A fair and fast access to innovative cancer therapies – All patients will be entitled to a fair and fast access to innovative cancer therapies that have proven to be effective <u>IV. Area for Action 4: A More Patient-Centred Approach</u> Objective 11a/b: Quality assured information (objective 11a), advice and support (objective 11b) For all cancer patients and their families as well as for specific target-groups there is low-threshold, quality assured information, advice and support Subobjectives/Indicators − Ensuring the quality and reliability of the available information, advice and support options.		

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	− Establishing better networks and more uniform standards in the case of existing options for cancer patients and their families by using quality orientated data on treatment and care. − Creation of low-threshold, well targeted measures to improve the management / guidance of cancer patients through the health care system Objective 12a: Communicative competence of the service providers All service providers involved in oncological treatment and care have a command of the communicative abilities needed in dealing with cancer patients and their families appropriately: Subobjectives/Indicators: − In the training and continuing professional development of health care professionals the teaching of adequate communication competences will be improved − The communication competencies will be continuously tested and trained as part of quality assurance Objective 12b: Strengthening the competence of the patient Objective 13: Shared Decision Making The patients will be actively involved into making decisions regarding their care Subobjectives/Indicators − Provision of evidence-based information to patients during therapy and care to support them in making decisions − Implementation of "shared decision making.		
Greece	Tackle and manage cancer efficiently. Depict cancer burden in Greece based on accurate and reliable data. Reduce cancer incidence and cancer mortality. Improve quality of care	None developed	Yes (see tables 10 and 11)

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	Improve quality of life of cancer patients.		
Hungary	Given the extremely unfavourable conditions in Hungary compared to other countries, the government of the Republic of Hungary is determined to permanently reduce malignant neoplastic diseases (hereinafter: cancer) as quickly as possible. Its goals are to cut back the burden caused by tumours, reduce morbidity and mortality indices, and to improve quality of life for patients and their families. List objectives and related indicators OBJECTIVE 1: Controlling the occurrence of factors that play major roles in the development of malignant neoplasms by raising the effectiveness of primary prevention and through promoting public awareness and acceptance OBJECTIVE 2: Diagnosing malignant neoplasms at the earliest possible stage in order to enable effective treatment, through increasing the efficiency, public awareness and acceptance of secondary prevention (screening) OBJECTIVE 3: Improving the quality of care of cancer patients by bringing cancer care services in line with the European system through evolving a unified system of cancer treatment centres OBJECTIVE 4: Preparing primary health care to assume a role in cancer care in order to enhance the efficiency of early detection of cancer OBJECTIVE 5: Developing the conditions for state-of-the-art tumour diagnosis in order to improve the effectiveness of medical treatment OBJECTIVE 6: Improving the quality of life of cancer patients by introducing state-of-the-art tumour surgery techniques OBJECTIVE 7: Improving radiation therapy possibilities and upgrading radiation therapy equipment stock in order to increase disease free survival, improve quality of life and decrease waiting times OBJECTIVE 8: Improving conditions of drug and biological therapy in order to enhance treatment outcomes and improve the quality of life of cancer patients OBJECTIVE 9: Integrating, from a professional point of view, oncological continuing care facilities with cancer care centres at the county level, in order to ensure seamless care for cancer patients and to enhance the efficiency of patient management OBJECTIVE 10: Enhancing equal opportunities for cancer patients through developing county-level and regional centres OBJECTIVE 11: Creating conditions necessary for the nationwide coordination of cancer care services, including the development of information technology and data provision systems related to cancer care activities and tumour incidence, in order to deliver univied high-standard and effective patient care and to enhance the reliability of cancer morbidity and mortality statistics OBJECTIVE 12: Evolving a comprehensive rehabilitation scheme for cancer patients in order to enhance their reintegration into society and the family OBJECTIVE 13: Creating a countrywide hospice network in order to improve the quality of life of cancer patients OBJECTIVE 14: Providing education that conforms to European standards for health professionals (specialist doctors, nursing and allied health personnel) who are involved in cancer treatment activities in order to enhance comprehensive care for cancer patients		

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	OBJECTIVE 15: Strengthening quality control in order to create uniform and higher quality standards in cancer care services OBJECTIVE 16: Involving cancer care patients and their relatives and all those taking part in the delivery of cancer care		
Ireland	The Strategy includes 55 recommendations See (*)	1.% population who are smokers by age, sex and social class 2. % adult and childhood populations who are overweight or obese by age, sex and social class 3. % population who consume more than the recommended alcohol weekly limits by age, sex and social class 4. Incidence of major site-specific cancers, to include at a minimum lung, breast, prostate and colorectal cancer 5. Incidence of invasive and in-situ melanoma 6. Uptake of screening and incidence of interval breast cancers in populations covered by Breast Check 7. % women, in the target age-groups, for whom population based cervical cancer screening is available 8. % uptake of screening in areas covered by the Irish Cervical Screening Programme 9. Stage of presentation of common cancers: appropriate stage indicators should be defined for lung, breast, colorectal and cervical cancers 10. % patients with cancer whose care is consistent with national, multidisciplinary guidelines, as developed by HIQA 11. Trends in quality of life for cancer patients, determined by ongoing quality of life measurement, at different stages in the care pathway for major cancers 12. Waiting times from diagnosis to definitive treatment for major cancers 13. % patients waiting for longer than one month from the time of diagnosis to the start of treatment 14. % breast cancer patients undergoing therapeutic surgical procedures who do so in a designated breast cancer treatment centre 15. Survival rates: a. 5-year Relative Survival Rate for Breast Cancer b. 1-year Relative Survival Rate for Lung Cancer c. 5-year Relative Survival Rate for Prostate Cancer	

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
		d. 5-year Relative Survival Rate for Colorectal Cancer 16. Mortality rates: a. Direct Age Standardised Mortality rate (5-year, all ages) for all causes of cancer b. Direct Age Standardised Mortality rates (5-year, all ages) for the top six causes of cancer mortality 17. % cancer patients seen by a member of a Specialist Palliative Care Team 18. % cancer patients dying by place of death (home, hospice, hospital) 19. % cancer patients participating in clinical trials	
Italy	Appendix 1 file (in Italian)		Yes (see tables 10 and 11)
Latvia	The goal of the Oncologic Program is to reduce the cancer morbidity in long term and cancer death, to prolong the survival of oncologic patients and to improve their quality of life. Main indicators are: incidence and prevalence of malignant tumors, mortality of malignant tumors, case – fatality rate, five years survival rate of oncology patients, proportion of registered patients (from the total number of new patients) with malignant tumors at the stage IV, proportion of registered patients (from the total number of new patients) with visually localised tumor at stage III and IV. (See full list of goals and indicators in the original documents)		Yes (see tables 10 and 11)
Lithuania	Major goals: - Organize and perform cancer prevention and early diagnostics of cancer - Reduce incidence of advanced cancer - Reduce mortality from cancer and - Warrant a complete cancer patients treatment - Spread knowledge on cancer within medical community and inhabitants		Yes (see tables 10 and 11)
Luxembourg**			Yes (see tables 10 and 11)

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
Malta	1. To prevent those cancers which are inherently preventable 2. To provide accessible and high quality cancer services geared towards improving survival and quality of life Indicators to be used: trends in incidence, mortality and survival for all cancers and for specific cancer sites and types (quantitative) and patients' and carers' satisfaction and assessment of services (qualitative).		Yes (see tables 10 and 11)
Netherlands	Yes	Yes	Yes (see tables 10 and 11) and website www.npknet.nl as 150 were mentioned
Norway	Yes	Yes	Yes (see tables 10 and 11)
Poland	The Program is especially focus on: 1) the development of primary prevention as a means against malignant cancer, especially caused by tobacco smoking and improper nutrition; 2) the introduction of public early diagnosing programs, especially with regard to cervical, breast and colorectal cancer and some child cancers; 3) raising access to early cancer diagnosing and the introduction of quality assurance in cancer diagnosing and treatment; 4) the introduction of radiotherapy standards; 5) the replenishment and/or replacement of worn-out cancer radiotherapy and diagnosing equipment; 6) the propagation of associated treatment; 7) the introduction and propagation of modern rehabilitation techniques and measures to ease the after-effects of cancer treatment and palliative care; 8) increasing the scope of oncology training in graduate and postgraduate medical, dental, nursing, obstetrical and medicine-related curricula;		Yes (see tables 10 and 11)

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	9) improvements in the cancer data system; 10)public introduction about cancer prevention, early diagnosing and treatment.		
Portugal	Yes The NCS is called “National Programme for the Prevention and Control of Oncological Diseases” has six priority areas: •Epidemiological Surveillance •Health Promotion and Primary Prevention •Organized Screening Programmes •Oncologic Patients Reference Network and Wait Times Management •Education •Research The strategies to accomplish the specific objectives of the Programme are: •To strengthen the activities of the Regional Cancer Registries, aiming to improve data quality and timeliness, and to broaden the scope of its actions. The production of information on cancer incidence, mortality, survival and prevalence should be regarded as the minimal role of a well-functioning registry. Goals: to publish national incidence data for 2005 including quality indicators and comparative analysis between regions; and to publish 5-years national survival data for patients diagnosed between 2001-2003. •Promote connections with the National Programme for Integrated Intervention on Health Determinants Related to Lifestyles (e.g. tobacco consumption, weight control, healthy eating habits and physical activity). Indicators for primary prevention were defined in the National Health Plan as it’s a transversal area to other health programs. •Promote Cancer screening according to EU 2003 Recommendation, extending cervix uteri and breast cancer programs to the whole country and to start an organized program for colorectal cancer screening. Goals: Breast cancer screening – 100% coverage in 2011; Cervical cancer screening – 100% coverage in 2011; Colorectal cancer screening – 100% coverage for north and central regions in 2011. •Improve accessibility and quality of oncologic health care, through the Oncologic Reference Network as an integrated oncology network; Guidelines for diagnose, treatment and follow-up with close monitorization were defined; Maximum Waiting Times were established by legislation.		

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	•Education - pilot program on communication skills for cancer physicians and other professionals •Research: Implementation of a national tumour banking network.		
Romania	Main goals: Decreasing cancer mortality Increasing cancer surveillance capacity Objectives: - increasing population coverage by quality cancer registration - cervical cancer prevention by HPV vaccination - early diagnose of cervical, breast and colorectal cancer - cancer patient treatment - monitor cancer evolution of cancer patient - achievement, implementation and management of national cancer registry	- number of HPV vaccines used - medium cost/ woman vaccinated - medium cost/ vaccine dose - realising regional Cancer Registry - medium cost/registry	Yes (see tables 10 and 11)
Slovak Republic**	To reduce cancer incidence and mortality and improve quality of life of cancer patients.	Yes	Yes (see tables 10 and 11)
Slovenia	To slow down the increase in the incidence of cancer, To reduce the mortality from cancer, To increase the survival, To improve the quality of life of cancer patients	Yes (see the Slovenian Cancer Plan -pag 4 and 5-)	Yes (see tables 10 and 11)
Spain	Main goal is to reduce the burden of cancer and to improve the survival and quality of life of cancer patients, in line with the World Health approach to cancer control.	Yes (see the Spanish National Strategy Plan)	Yes (see tables 10 and 11)

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
	(see the Spanish National Strategy Plan)		
Sweden	To reduce risk of developing cancer. To improve the quality of cancer patient management. To prolong survival time and improve quality of life after a cancer diagnosis. To reduce regional differences in survival time after a cancer diagnosis. To reduce differences between population groups in morbidity and survival time.	Population levels of risk factors, participation in screening programmes, incidence, survival, several patient-reported outcomes.	Yes (see tables 10 and 11)
England	To deliver improved outcomes, by tackling preventable incidence, by earlier diagnosis and by improving the quality and efficiency of cancer services	To increase the number of people surviving at least 5 years beyond diagnosis by 5,000 each year by 2014/15	Key goals of the strategy are: - reducing the incidence of cancers which are preventable, by lifestyle changes; - improving uptake of screening and introduce new screening programmes where there is evidence to justify them; - achieving earlier diagnosis of cancer, to increase the scope for successful treatment; - improving patient experience and support for cancer survivors; - making sure that all patients have access to the best possible treatment, care and support; - supporting commissioners by improving the information available on cancer services and the outcomes they deliver; - improving the information patients receive about the services and treatments available; - promoting the uptake of the latest surgical procedures and reducing regional variation in access to treatment; - stimulating community action through the development of a national partnership scheme;

COUNTRY	Objectives	Indicators	Inclusion of list of goals or objectives/indicators
			- accelerating work to ensure payments incentivise high quality, cost-effective services, including the development of tariffs for chemotherapy and radiotherapy; - piloting a national cancer survivorship survey in 2011; - piloting data collection on the number of women with secondary breast cancer; - implementing HPV testing as triage for women with mild or borderline cervical screening test results; and - supporting cancer research through providing £4.7 million funding over five years for a policy research unit on Cancer Awareness, Screening and Early Diagnosis.

N/A= not available

* Ireland: Under each of the areas in the tables 10 and 11., we have noted the main thrust of the recommendations set out in the Strategy and the main focus of implementation to date. However, it should be noted that for reasons of space this is not comprehensive. A link to the Strategy itself is included in this email and the full list of recommendations is set out therein

** These countries don't have formal Cancer Plans but they carry out related activities

Table 10: CANCER PLANS: Goals, objectives and related indicators

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
Belgium	Yes The Belgian Cancer Registry collects and analyses the data concerning cancer burden in Belgium.	Yes The Belgian Cancer Registry collects and analyses the data concerning cancer in Belgium. The Belgian Cancer Centre was established as one of the actions in the first Cancer Plan and is responsible for gathering and exchanging data and information on the fight against cancer.	No
Bulgaria**	N/A	Yes Bulgarian has developed a National Cancer Register. Among its particular tasks is to collect, analyze and publish annual information on the prevalence of cancer in Bulgaria; to participate in the overall control of the organization of cancer aid; to consult the national institutions about the main priorities in the area of prevention, epidemiology, diagnosis, treatment and monitoring of cancer diseases. In that sense the National Cancer Register is an important source for future cancer plan.	Yes The Ministry of Health is responsible for ensuring effective public health control. The Ministry of Health develops and implements national health policy, defines goals and priorities of the health system, works out national health programmes and develops draft legislation concerning the health sector. It retains responsibility for overall supervision of the health care system. The Minister of Health is responsible for the development and implementation of the National health strategy. This scope of responsibilities has added to the competence of the Ministry of Health the task of cancer health promotion.
Cyprus	Yes	Yes Cancer Registry: Introduction of a new Legislation / Integration of the Cancer Registry in Health Monitoring Unit. Responsible institution for its preparation: Cancer Registry (MOH)	Yes Responsible institution for its preparation: MOH
Czech Rep	Yes National Cancer Registry (Ministry of Health). Indicators: Yearly assessment of Cancer Incidence and Mortality (national publication)	Yes Ministry of Health – Institute of Health Information and Statistics of the Czech Republic Indicators: Publication every year	Yes

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
Denmark	Yes National Board of Health. Data collection and analysis	Yes National Board of Health. Indicators: - General data collection, analysis and information - Specific activities on data collection about screening results - Specific activities focusing on a achieving a closer involvement of the specific clinical databases in the national cancer monitoring programme and national quality development process	Yes (*) National Board of Health. Indicators: - Information campaign focusing on cancer prevention (targeted at children/youth and high risk groups) - Awareness campaign about cancer symptoms - Non smoking campaign (Other cancer prevention activities have been part of the two previous cancer plans)
Estonia	Yes Estonian Cancer Registry: The goal of Cancer Registry is to guarantee the processing of data of all cancer cases in Estonia which forms the basis for general cancer statistics in the Republic of Estonia and also for analysis of cancer incidence and survival for cancer patients, for studying the causes of cancer, for giving prognoses of trends, for developing health care and directing health policy, for planning cancer protection measures and for assessing their effectiveness based on internationally accepted criteria.	Yes Estonian Cancer Registry: Enters in a register primary incidents; provides an overview of the location of cancer and calculated from the five- year survival rates	Yes National Institute for Health Development: training, campaigns, counselling
Finland	Yes The Cancer Registry, The Institute of Health and Welfare: Statistical analysis	Yes The Finnish Cancer Registry, The Institute of Health and Welfare, The University Hospital Districts	No The Cancer Society of Finland, The Institute of Health and Welfare: Will be included in the second part of the plan
France	Yes Gain a better understanding of the reality of cancer in France	Yes Optimise and develop the data monitoring system. Develop social epidemiology for cancer. Improve observation and monitoring	Yes Promote preventive actions on the links between diet, physical activity and cancer. Continue to fight

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
		of Cancers related to the working environment.	smoking.
Germany	Yes Collection and analysis of epidemiological cancer data is part of the routine work of the Robert Koch-Institute (German Centre for Cancer Registry Data, which collates and analyses the data of the 11 German cancer registries at Laender-Level) Therefore, it is not an explicit objective of the National Cancer Plan. However, see below objective 8 concerning the intensified networking of epidemiological and clinical cancer registries. (See also Table 9) Objective 8: High quality health care data from clinical cancer registries	Yes (See also Table 9) In the context of cancer information for Patients: Objective 1: Better information and improving attendance in the early detection of cancer Objective 11a/b: Quality assured information, advice and support For all cancer patients and their families as well as for specific target-groups there is low-threshold, quality assured information, advice and support Objective 12b: Strengthening the competence of the patient Objective 13: Shared Decision Making The patients will be actively involved into making decisions regarding their care	No Currently not an Area for Action. However, there is already a wealth of initiatives outside the National Cancer Plan that aim at improving health promotion and primary prevention by focusing on common risk factors such as smoking, alcohol, poor diet and lack of physical activity.
Greece	No	Yes Hellenic Centre for Disease Control and Prevention: Development and full operation of the National Cancer Registry	Yes Ministry of Health and Social Solidarity in collaboration with various bodies, governmental and non-governmental: - Anti-smoking campaign - Public education campaign for alcohol intake reduction - Public education campaign for healthy diet adoption and physical exercise increase

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
			- Development and adoption of legislation with regard to unhealthy foods - Public education campaign with regard to specific cancer types and associated risk factors
Hungary	No While the current National Cancer Register collects only cancer-specific medical data and provides annual reports and statistics focused on the geographic spread of cancer cases, the National Health Insurance Fund Administration - established in 1991 - collects all the data related to medicine, treatment etc.	Yes National Cancer Register: Accurate information on cancer mortality data is essential to designing an effective Cancer Control Programme. Malignant tumours are reported to the National Cancer Register by the healthcare institutions. Established by the World Bank's "close the gap programme" the National Cancer Register began operations in line with international guidelines in 2000. The National Cancer Register receives regular data on cancer from 198 medical facilities. Thanks to stronger discipline in reporting, the quality of data processing is improving. However, it is extremely necessary to professionally supervise the credibility of the Cancer Register and improve it continuously to guarantee its acceptability on international level. It would be desirable to expand the role of the Register to collect survival figures and begin analyses, and to offer the option of reporting online. From time to time, representative samples should be collected and evaluated to survey the accuracy of Cancer Register data. Furthering professional reporting systems is a fundamental prerequisite of monitoring the results attained during the programme. The data of all children who are cancer patients are registered in a reliable central registry by the paediatric oncology centres, so treatment outcomes may be monitored and evaluated according to type of disease, the centre where treatment is undertaken, and on nationwide level, as well.	Yes National Institute of Oncology: See detailed activities by Objective in the original documents
Ireland	Yes National Cancer Registry: The plan incorporates information about cancer incidence, mortality, morbidity and survival as well as projections and time trends	Yes National Cancer Registry: The Strategy makes recommendations on the further development of cancer surveillance and of information for patients, families and carers and for health professionals. The National Cancer Registry of Ireland has been expanding its role to include cancer intelligence as well as surveillance data.	Yes Health Service Executive-National Cancer Control Programme and a number of other organizations including voluntary bodies: The Strategy makes recommendations in the area of health promotion, including tobacco, alcohol, obesity and diet, physical exercise and the use of sunbeds.

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
		Legislation is being prepared that will provide for mandatory reporting.	Measures taken include the monitoring of compliance with anti-smoking legislation, increases in excise duty on cigarettes, work in relation to the implementation of related strategies on obesity and alcohol, and the preparation of legislation to regulate sunbed use.
Italy	Yes MoH, Istituto Superiore di Sanità: To promote and implement epidemiological research, impact assessment studies	Yes MoH- Istituto Superiore di Sanità and other scientific institutions: To implement information systems and national surveys. To analyse data and to produce new knowledge	Yes Ministry of Health: To manage the programmes " gaining heath" and "health in all policies" according to the related EU initiative
Latvia	Yes Center of Health Economics, Health Payment Center, Ltd "Riga East Clinical University Hospital" Latvian Oncology Center and Ministry of Health of the Republic of Latvia: Assessment of the cancer burden by summarising statistical data and analysing trends in morbidity and mortality in the field of oncology.	Yes The Centre of Health Economics: Latvia started to collect data on cancer patients in 1993. The Centre of Health Economics has been responsible for the maintenance and development of the Web- based Cancer Data Register since 2009. The Register is population based source of data on all cancers. Health care institutions- hospitals and out- patients clinics - provide data collection and input data on the on- line system of the Registers (the PREDA on-line system). Cancer patients data has been registered according to Regulations of Cabinet of Ministers and uses the standardise data register form - including data on all important parameters of a patient concerning his/her disease: anatomical site, histology, date of diagnosis, methods of diagnosis, risk factors, clinical data on stage and treatment, progress of the disease, outcome- The main issues in the field of the Cancer Register are: to ensure accurate and comparable data on cancer burden indicators, such as incidence, prevalence, morbidity, survival and mortality, and to improve the quality of data taking into account available accessible recourses.	Yes Ministry of Health of the Republic of Latvia, Ministry of Agriculture, Health Care Inspectorate: Preparing teaching and methodological materials; 'diagnostic tests' of school children's skills in and knowledge on health related matters related including the impact of harmful habits on health; the legal act in order to provide free access to fruits and vegetables in educational institution (in 2010 there is confirmed An Implementing Plan for Provision Schools with Fruits and Vegetables for Years 2010-2013); evaluation report on the efficiency of Tobacco monitoring state program for 2006-2015; preparing and distribution of methodological materials and "prescriptions" for physical activity that have to be available at general practitioner offices, general practitioners trained on the use of methodological guidelines and issuing "prescriptions" for physical activity; personnel training at the Cardiac Health Office on providing advice regarding physical activity; standards for piercing and tattoo salons; guidelines for hepatitis B and C prevention in treatment

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
			institutions; and others.
Lithuania	Yes Ministry of Health, Centre of Health info of the Institute of Hygiene: Evaluation of Cancer epidemiology.	Yes Centre of Health info of the Institute of Hygiene, National Health Insurance Fund, Cancer Registry in Institute of Oncology: Population based Cancer Registry was established in 1984. There are more than 380000 records about new cancer cases and more than 170000 records about cancer patients death in Cancer registry.	Yes a, b, c and d institutions: a) Vilnius university Oncology institute b) Health Education and Diseases Prevention Centre (M. Health). include training of trainers and development of methodologies for health promotion in fields of healthy nutrition, physical activities, alcohol and smoking prevention, environment pollution protection and so on. c) Hygiene Institute (M.Health) trains of trainers and educates health promotion specialists in field of professional health and labor safety. d) Public Health Bureaus – educate local population, teachers, students, parents, etc. in fields of healthy nutrition, physical activities, alcohol and smoking prevention, healthy lifestyles.
Luxembourg	Yes Ministry of Health: Analyses of cancer mortality data and trends	Yes In Luxemburg exist one National Health Laboratory and for the time being all histo-pathological exams are done there.	Yes Ministry of Health: The Ministry of Health is in charge, but also the Foundation Cancer and Europe Donna Luxembourg asbl. coalition against breast cancer.
Malta	Yes National Cancer Registry, Directorate for Health Information and Research, Strategy and Sustainability Division	Yes The registry will be reinforced with the addition of more staff and with an expansion of its functions such as by starting to monitor the outcomes of cancer treatment (the Registry has been in operation on a population-basis from the early 1990´s)	Yes Directorate for Health Promotion and Disease Prevention (DHPDP), Public Health Regulation Dept. The DHPDP is responsible for the Non-Communicable Diseases Strategy (http://www.health.gov.mt/dsu/news/news_files/NCD_Strat_final.pdf). This strategy is reinforced by the

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
			NCP. Also the NCP is promoting the finalisation of a National Obesity Plan and a Food and Nutrition Action Plan.
Netherlands	Yes Van Integrale KankerCentra (VIKC): IKNL As responsible of the Cancer registries they elaborated a huge documentation (in Dutch) in order to clear up what should be realized.the progress report is in English as the annual summary,on the web	Yes Van Integrale KankerCentra (VIKC), since 01-10-2011 IKNL	Yes Ministry of Health, VIKC ,IKNL and others (See the National Plan)
Norway	Yes Unknown: Probably several institutions: Death, prevalence, incidence, costs to the individual and the society, survival, social costs, national insurance contribution	Yes Cancer Registry of Norway: Better follow up of cancer patients to register late effects of cancer treatment. New report and surveillance system.	Yes Norwegian Directorate of Health: Dietary recommendations stop smoking, promoting exercise, grants for action, advertisements, school material, campaigns and cooperation with the food industry for promoting healthier food.
Poland	Yes Cancer Control Council-Ministry of Health, Nominated Coordinators of program's tasks, National consultants on oncology matters and National Cancer Register: To prepare a proposition of tasks/programs and analyses how to resolve any pointed cancer burden and they prepare a application of the implementation within framework of National cancer control programs new task.	Yes National and Regional Cancer Registries; National Health Found: National cancer register publish every year data with mortality rate and cancer incidence rate with two years delay to the current date. Electronic data system of screening monitoring provides information about current results in breast and cervical cancer screening programs.	Yes Ministry of Health: Implementation of the tasks related to oncology is performed by the subjects who are chosen through a competition organized by the Minister of Health. In case of activities related to the oncology there are Regional Cancer Registries where the data about cancer is collected. The Regional Cancer Registries forwards collected information to the National Cancer Registry where the information about epidemiological data on malignant cancer are collected and they send this information to the Ministry of Health.
Portugal	N/A	Yes 3 Regional Cancer Registries:	Yes NCOD:

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
		Collect, analyse and publish regional and national data, including incidence, prevalence, survival and mortality rates.	Following the National Health Administration Directives to promote healthy life styles (e.g. tobacco consumption, weight control, healthy eating habits and physical activity).
Romania	Yes National Institute of Public Health: Cancer registration Evaluation of resources for prevention	Yes Regional Cancer Registries in the Oncology Institute Regional Centres for Public Health	Yes Ministry of Health: Anti-Tobacco Lifestyle factors.
Slovak Republic	N/A	Yes National Oncology Register	N/A
Slovenia	Yes Cancer Registry at the Institute of Oncology: National portal with data on cancer in Slovenia (SLORA)	Yes Cancer Registry at the Institute of Oncology: National portal with data on cancer in Slovenia (SLORA)	Yes National Institute of Public Health, Ministry of Health, Regional Institutes of Public Health and non-governmental organizations: 1) Activities to ensure the Health in all policies approach; and 2) Activities to increase the population awareness about cancer and its risk factors
Spain	Yes Mortality and morbidity	Yes Regional Cancer Registries, Ministry of Health, National Institute of Statistics	Yes Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations. Smoking prevention, dietary prevention, excessive sun exposure, European code against cancer..
Sweden	Yes Incidence, mortality, patient-reported outcomes, cost-of-illness measurements	Yes Cancer register Cause-of-death register	Yes National Institute of Public Health (tobacco, diet and obesity, physical activity) National Board of Health and Welfare (particularly

COUNTRY	Assessment of cancer burden	Cancer data and information	Health Promotion
		21 national quality registers in cancer care National registers of prescription of drugs and a special register recording anticancer drugs	lifestyle interventions in primary care) National Food Agency (diet) Swedish Radiation Safety Authority (solar exposure) Regional and local public health organisations
England	Yes Department of Health: This chapter at the strategy outlines the challenge of cancer	Yes Department of Health: -Collation and publication of high quality information that commissioners and providers need about incidence, prevalence and survival, as a basis for planning services - Collation and publication of high quality information on different aspects of cancer services and the outcomes they deliver at both a provider and a commissioner level -Investigation of different aspects of cancer care so that trends, patterns and good practice may be identified -Work with regulators to ensure that the information on cancer services which is collected is used to inform effective regulatory oversight and, where necessary, action -Improvement of the quality of the data which underpins expenditure information on cancer services -Provision of transparent information so that policy makers and others may scrutinise the quality of cancer services by inequality/equality group -Encouragement of other organisations, such as cancer charities, to provide information to patients and cares and to help them make informed choices	Yes Department of Health: - Publication of Public Health Responsibility Deal in early 2011 setting out the actions that industry, the voluntary sector, NGOs and local government will take to help people make healthier choices - Publication of Tobacco control plan - Publication of Obesity document in Spring 2011

N/A= not available

* Denmark: Comment about Health Promotion/Cancer prevention: the distinction between Health Promotion and Cancer prevention is somewhat blurry – the same initiatives are therefore mentioned both places.

** These countries don't have formal Cancer Plans but they carry out related activities

Table 11: CANCER PLANS: Goals, objectives and related indicators

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Belgium	Yes The Communities and Regions are responsible for Prevention. The Plan included screening programmes for breast cancer, cervical cancer and colorectal cancer. This was/is being implemented by the Communities/Regions, with cofounding of the federal authorities.	Yes Several actions were included on psychosocial care, mainly in a hospital setting.
Bulgaria(*)	Yes Ministry of Health: Program on "STOP and GO for a Check-Up" which aims to raise awareness among the general public about screening for cervical, breast and colorectal cancers (Project BG051RO001-5.3.2002-001-S0001 under the Operational Program for Human Resources Development). The Ministry of Health is responsible for using different ways for cancer prevention and for the introduction of this issue in different plans, programs and strategies.	N/A

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Cyprus	Yes A). Primary Prevention: 1. Raising awareness on Carcinogenic Factors, such as: Smoking, Alcohol, Infection (HPV, Helicobacter ,Hepatitis), occupational risks (Asbest, PCV, pesticides , UV exposure etc) 2. Raising awareness on immune and genetic Factors that influence cancerogenesis, by educating Health professionals, influence school curricula, promote Healthy life style and intense Vaccination programmes and school medicine. Introduction of new legislation against smoking and control of the environmental and occupational risk factors. B) Secondary Prevention: Continuation of the existing Breast Cancer Screening and gradual application of an organized Cervix and colon screening, which will replace the already existing opportunistic screening Responsible institution for its preparation: MOH (Public Health Services)	Yes 1) Therapy: Diagnostic measures: Introduction of Mechanisms, which ease the accessibility of patients with suspected diagnosis cancer. Introduction of the terminus:" Watchful waiting" Upgraded protocols / individualisation of Chemotherapy Development of surgical oncology centres (Breast/ colon cancer) Radiotherapy: Development of two new Radiotherapy centres in order to minimize waiting time (less than 4 weeks) Alternative / Supportive Therapies (Formation of a group which will be responsible to decide together with the bioethics committee, whether the patient will have a benefit of their use.) 2) Palliative care: Development of a network of Health Professionals and NGOs that will promote palliative care, not as an "add-on extra", but in a comprehensive and systematic manner. (Families included). Improvement of services (offering 24 hours of Home care, Multidisciplinary services and pain clinics hospices, ensuring palliative care support teams in the hospitals) Rehabilitation: Development of REHA –centres. (Cancer as another chronic disease) Responsible institution for its preparation: MOH
Czech Rep	Yes Ministry of Health: Organisation and management of the screening programmes (Breast cancer program, Colon cancer programme and Cervical cancer programme)	Yes Czech Society for Oncology: National workshops and conferences. Establishment of CCCs (see Table 12)

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Denmark	Yes	Yes National Board of Health: - Introduction of a special "fast track diagnosis path way" for patients with unspecific symptoms of severe illness that might be cancer. (to supplement the 34 fast track diagnosis and treatment path ways for patients with a specific cancer diagnosis) - A national programme for rehabilitation and palliative care based on evidence based clinical guidelines - Better end of life care and more hospices - More focus on the relatives of cancer patients – especially when the relatives are children. National guidelines will be developed in this area. (Cancer plan II focused very much on the specific treatment/care and investment in these areas whereas "Cancer plan III" focuses more on initiatives before and after treatment)
Estonia	Yes National Institute for Health: Development: training, campaigns, counseling	Yes Two regional hospitals: cancer care services are performed by oncologist and includes diagnostic, treatment (chemotherapy, radiation therapy, surgical operations). All activities in cancer care are carried out by the specialists on this field.
Finland	No The Cancer Society of Finland, The Institute of Health and Welfare: Will be included in the second part of the plan	Yes The University Hospital Districts (specialized health care), Health centres (primary health care): Control of the waiting times, best practices, palliative care system development, psychosocial measurements during care

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
France	Yes Strengthen prevention programmes for cancers related to the environment, particularly in the workplace. Prevent cancers of infectious origin. Screening: Tackle inequalities in access and participation to screening. Improve configuration of the national organised screening programmes. Involve referring doctors in national screening programmes and guarantee equality of access to the most effective techniques throughout the country. Monitor a scientific watch and improve knowledge on early cancer detection.	Yes Department for Health Care (DGOS): Individualise care management quality and strengthen the referring physician's role. Improve treatment quality for all cancer patients. Support the pathology speciality. Guarantee equal access to innovative and existing treatments. Support radiotherapy. Develop specific treatments for patients with rare forms of cancer or genetic predispositions as well as for children, adolescents and the elderly. Address the health professions' demographic challenges and provide training in new skills. Formalise and implement a plan for providing individualised care and psychological and social support during and after cancer treatment, including during the discharge of a patient with a long-term illness.
Germany	Yes (see Table 9) <u>I. Area for Action 1: Further Development of the Early Detection of Cancer</u> Objective 1: Better information and improving attendance in the early detection of cancer Objective 2: Further organisational development of programmes for the early detection of cancer Objective 3: Evaluation of programmes for the early detection of cancer	Yes (see Table 9) <u>II. Area for Action 2: Further Development of Oncological Care Structures and Quality Assurance</u> Objective 4: All cancer patients will receive high quality care, regardless of age, sex, origin, place of residence or insurance status. Objective 5: Standardising certification and quality assurance of oncological treatment facilities Objective 6: Evidence-based guidelines for the treatment of cancer Objective 7: Cross-sector, integrated oncological care will be guaranteed. Objective 8: High quality health care data from clinical cancer registries Objective 9: Appropriate psycho-oncological care according to patients' needs <u>III. Area for Action 3: Ensuring Efficient Oncological Treatment</u> Objective 10: A fair and fast access to innovative cancer therapies

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
		– All patients will be entitled to a fair and fast access to innovative cancer therapies that have proven to be effective <u>IV. Area for Action 4: A More Patient-Centred Approach</u> Objective 11a/b: Quality assured information (objective 11a), advice and support (objective 11b) For all cancer patients and their families as well as for specific target-groups there is low-threshold, quality assured information, advice and support Objective 12a: Communicative competence of the service providers All service providers involved in oncological treatment and care have a command of the communicative abilities needed in dealing with cancer patients and their families appropriately: Objective 12b: Strengthening the competence of the patient Objective 13: Shared Decision Making The patients will be actively involved into making decisions regarding their care
Greece	Yes Ministry of Health and Social Solidarity in collaboration with various bodies, governmental and non-governmental: National screening programmes for breast and cervical cancers	Yes Ministry of Health and Social Solidarity in collaboration with several bodies, governmental and non-governmental, as well the Church: - Development of Centres of Excellence for Cancer Care (one centre for breast cancer and two for radiotherapy are put forward for the time being). - Development of legislation for hospital at home care and hospices - Development of hospices

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Hungary	Yes National Institute of Oncology: (See for detailed activities by Objective in the original documents)	Yes National Institute of Oncology: (Detailed activities by Objective in the original documents)
Ireland	Yes Health Service Executive-National Cancer Control Programme, some voluntary sector input: The Strategy includes recommendations in relation to cancer screening, specifically breast, colorectal and cervical and in relation to early detection through awareness programmes. National breast screening and cervical screening programmes are in place and a colorectal cancer screening programme is at planning stage.	Yes Mainly Health Service Executive-National Cancer Control Programme with some additional services provided by voluntary organisations: The Strategy makes a large number of recommendations in relation to cancer care, including primary care, acute care, palliative care and psycho-oncology. In relation to acute care, fragmentation of cancer services was identified as a significant issue to be addressed. Eight cancer centres have been identified and significant progress has been made in centralising diagnosis and surgery within these centres and in enhancing services. Radiation oncology capacity has been increased. A programme of work to provide information and education for GPs (family doctors) and community-based nurses and standardised referral forms are in use. Agreement has been reached with palliative care clinicians and service providers to engage in a clinician-led programme in palliative care to improve its cost, access and quality. There will be a focus in 2011 on providing training in psycho-oncology to nurses and other frontline disciplines.
Italy	Yes Ministry of Health: Primary prevention; cancer mass-screening	Yes Ministry of Health: To promote evidence-based care; to make available psychosocial support and palliative care for all citizens/patients in need; to support patient's associations involvement, development on national Networks To improve care pathways To invest in radiotherapy and cancer drugs

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Latvia	Yes Center of Health Economics, Health Payment Center, general practitioners and others: 1) Organized cancer screening based on Population Register where the following screening tests are implemented: a) oncocytological screening for cervical cancer for women aged 25 – 70 every three years; b) mammography screening for breast cancer for women aged 50 till 69 every two years; and c) occult blood screening for colorectal cancer for men and women from the age 50 once a year; 2) Activities for reducing the prevalence of the infectious diseases stimulating the emergence of oncologic diseases (hygiene standards applicable to piercing and tattoo salons; guidelines for hepatitis B and C prevention in treatment institutions; amendments in legal acts to guarantee the screening of risk groups against hepatitis B and C; amendments in legal acts to introduce state reimbursed vaccination against human papilloma viral infection (since September 1, 2010 the vaccination has been started for 12 year-old girls against human papilloma virus) and other activities; 3) Activities for reducing the harmful effect of ultra violet radiation (minimum hygiene requirements to provide sun-bed services; to equip the official bathing sites with protection against the sun and to guarantee the maintenance of the equipment; a study on the sun tanning habits of the residents of Latvia; to prepare legal acts concerning the verification of preventive health check-ups for the employees in road construction, construction and those employed in agricultural objects) and other activities.	Yes Ltd "Riga East Clinical University Hospital" Latvian Oncology Center and several medical treatment institutions and professional associations: Updating legal acts with regulations regarding the payment for inherited cancer diagnostics and treatment services (there are established several preferences for oncologic patients: oncologic patients have a right to turn to the oncologist and oncologist chemotherapist directly without referral of family practitioner, oncologic patients have a possibility to receive health care at home and palliative care without patient fee; the patient fee in oncologic ward is 5 last for one day (in other hospitals patient fee is 9,5 lats for one day)). In oncologic patient treatment multidisciplinary approach is used at present (surgery, radiotherapy, chemotherapy, psychosocial support, rehabilitation and palliative care). Patients who need palliative care can receive it without patient fee according to the medical needs in several medical institutions. There is a mobile palliative team for children in Riga and Riga region. There has been initiated development of guidelines for pain therapy, a shortness of breath, and development of the list of reimbursed medicines for use in palliative care. Other activities included in this chapter: drafting the clinical guidelines for the treatment of oncologic and oncoheamotologic diseases in adults and children; establishing a uniform list of medicines used in ambulatory and hospital treatment of adults and children and the respective system of monitoring; stipulating in legal acts regulating the responsibility of the treatment institution to treat oncologic patients employing a multidisciplinary team of specialists; drafting compulsory requirements for the provision of medical rehabilitation in multiprofile hospitals.
Lithuania	Yes Ministry of Health, Vilnius University, Oncology Institute, National Health Insurance Fund, Public Health Bureau, GP: Cervical cancer screening programme, mammographic breast cancer screening, prostate cancer early diagnostic programme, colorectal cancer screening programme.	Yes Ministry of Health Hospitals (treatment and palliative care): Palliative care services were regulated in 2007 by the Ministry of Health. The goal of palliative care for terminal cases and progressive diseases are extremely concrete: relief from Suffering, Treatment of pain and other symptoms distressing, psychological and spiritual care, a support system to improve the quality of life and the need for bereavement provide patients and their families from the time of diagnosis through final stages of disease and death.

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Luxembourg*	Yes Ministry of Health	Yes Ministry of Health: The psychosocial experts in the hospitals and specialised health care team working in palliative care. A frame work for palliative care is stated in the national hospital plan.
Malta	Yes Superintendent of Public Health: Directorate for Health Promotion and Disease Prevention , Directorate for Environmental Health, and Occupational Health and Safety Authority (OHSA) The NCP reinforces the implementation of the 2nd National Environment and Health Action Plan and is promoting the strengthening of the OHSA so that it will be able to better carry the measures included in the NCP.	Yes Healthcare Services: Almost all sectors and professionals are involved with special reference to the Oncology and Palliative Care, Radiology, Pathology and Surgical Departments. The NCP seeks to continue building on the existing cancer services by promoting the engagement of more specialists and training of existing specialists as necessary, the replacement and purchase of new equipment and the inclusion of new cancer drugs in the Government formulary. The NCP is also promoting concepts such as the multidisciplinary teams, continuity of care (and improvement of communication and coordination (the streamlining of entry and follow-up in the cancer pathway and contact with the necessary entities and professionals) and patient information and empowerment in the clinical decision-making process.
Netherlands	Yes Ministry of Health, VIKC (IKNL) and others (See the plan)	Yes VIKC (IKNL), NFK, scientific associations of the different medical disciplines, national association of oncology nurses, GP association, and many others. To Improve care pathways (See plan)
Norway	Yes Norwegian Directorate of Health: As Health Promotion. In addition prevention of accumulation of radon, screening for cancer.	Yes The four regional health enterprises in Norway: Implementation of new and expensive treatments and experimental treatments. Education and competence. Promoting palliative care. Quality control. Organization of the health care. Increasing

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
		radiation capacity.
Poland	Yes Cancer Control Council: we would like to emphasize that cancer prevention is a broad issue which we have to extend in this report. First of all, cancer prevention is performed from the first year of the program. Secondly, its aim is to educate society towards the popularization of healthy attitudes by promoting the European Code Against Cancer, organization of media campaigns, education, popularization and dissemination of knowledge about cancer prevention. Next, we would like to underline that not less important are the activities related to: - organization of media conferences; - organization of workshops related to risk factors for cancer; - conducting the website about cancer activities, - health campaigns, educational and interventional activities; - popularization of healthy lifestyle including healthy diet; - action on reducing the incidence of malignant cancer; - monitoring of the effectiveness of the program; - implementation of promotional programs by epidemiological centers; - organization of meetings with local co-organizers and committees of experts - conducting telephone medical consultation and giving information about the incidence of cancer, the benefits of giving up cigarettes and information about facilities and clinics where you can do free examinations . Moreover, subjects related to the prevention are selected in the competition. The health services related to the screening programs like: population program of prevention and early detection of cervical cancer for women between age 25-59 and population program of prevention and early detection of breast cancer for women between 50-69, are financed by the National Health Found. The exceptions from above rule are colonoscopies, for people up to	Yes National Health Found (NHF) – (National insurance institution financing health care in Poland) and Minister of Health supervising NHF are institutions which are responsible for cancer care. During the realization of investments related to National Cancer Program, Ministry of Health co-finances the purchase of specialized devices for oncology units chosen in a competition. The input of the unit has to be not les than 15% of total cost. These activities are taken up in aim to replenish and/or replace worn-out equipment for radiotherapy, oncology treatment and diagnosing. Such action is an indirect form which influences cancer care inter alia increasing accessibility to oncology care. Palliative care was an important part of a program until 2009. Improvement of a quality of palliative care was implemented by purchasing specialized devices for oncology and organizing training for nurses. Moreover, psychosocial and psycho-oncological care are connected with treatment of children and teenagers after anticancer therapy. That's why the program of continuation of the evaluation of the quality of life and the health of children and adolescents after completing cancer therapy is recommended. The program consists of: 1. identification of distant repercussions on the health and quality of life of children treated for cancer; 2. improved quality of life and reduced future treatment costs and side effects after finishing cancer therapy; 3. identification of psychosocial problems with functioning at school and work; 4. multidisciplinary teams of specialists who are monitoring health condition; 5. promotion of healthy lifestyles in individuals cured of cancer; 6. reduction of economic barriers for monitoring long-term effects after cancer treatment.

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
	65 years old and genetic tests under specific conditions with genetic predispositions which are paid from the Ministry of Health budget. The tasks of National Cancer Program included: 1. Primary cancer prevention. The funds allocated to the program from 2006-2011 were within the limits 1,5-4 million PLN. 2. Screening programs: a) Population program of prevention and early detection of cervical cancer; b) Population program of prevention and early detection of breast cancer; c) Screening programs for early detection of colorectal cancer; d) Care program for families of genetically conditioned high risk of cancer: Module I breast cancer and ovarian cancer, Module II colorectal cancer and endometrial cancer; Module III prevention and early detection of malignant cancer in families with rare hereditary predisposition for cancer.	
Portugal	Yes NCOD with Regional Health Administrations: Implementation of national population-based screening programs (breast, cervical and colorectal).	Yes NCOD: Preparation of the document for the National Cancer Referral Network; report on the oncology and psycho-oncology national capacity (human resources, equipment, clinical, research and educational activities, etc.)
Romania	Yes Ministry of Health, Cancer Commission and Cancer Institutes	Yes Ministry of Health, Cancer treatment centres, Palliative care and psychosocial NGOs
Slovak Republic*	Yes League against cancer	Yes Ministry of Health

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Slovenia	Yes National Institute of Public Health, Ministry of Health, Regional Institutes of Public Health, Non-governmental organizations and Institute of Oncology: 1) Primary prevention: a. Activities to support healthier life style; b. Activities to ensure healthier choices and environment with control of chemical, biological and other factors in environment 2) Secondary prevention: a. Fully introduce all three cancer screening programs national wide; b. Activities to increase the effectiveness of cancer diagnosis at primary health level	Yes Institute of Oncology, RSK: Concentration of diagnostic and therapeutic locations to ensure better use of available resources and higher quality Prepare clinical guides for specific diagnostic and therapeutic areas Introduce multidisciplinary teams Activities to reduce the inequalities in care between regions Introduce comprehensive bio psychosocial rehabilitation of cancer patients
Spain	Yes Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations. Primary prevention policies focused on European code against cancer. Screening policies for breast, cervix and colorectal cancer. Genetic consultation.	Yes Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations: To exchange best practices from the Autonomous Regions. To elaborate strategic frameworks for cancer care: – Model of cancer care based on MDT – Criteria for concentrating low incidence and complex procedures of care.

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
Sweden	Yes National Institute of Public Health (tobacco, physical activity and diet, including a national strategy to combat obesity) National Board of Health and Welfare (e.g. national guidelines on lifestyle interventions in healthcare) National Food Agency (dietary advice to the general public) Swedish Work Environment Authority (occupational health hazards) Swedish Radiation Safety Authority (advice on solar exposure and use of sun parlours) Regional and local public health organisations National programme for HPV vaccination	Yes Responsibility of regional healthcare providers (20 county councils, coordinated by six cancer centres National guidelines on four common cancers (breast, prostate, colorectal and pulmonary) under the auspices of the National Board of Health and Welfare and on approx. 15 forms of cancer produced by other organizations Psychosocial support (including family members), rehabilitation and palliative care are important elements of the national cancer strategy. Improved care pathways

COUNTRY	Cancer prevention	Cancer care (included psychosocial and palliative care)
England	Yes Department of Health Screening: - Roll-out of 30% coverage of flexi-sig by the end of 2013/14 and 60% by the end of 2014/15 - Roll-out of HPV testing across England as triage for women with mild or borderline cervical screening test results and as a test of cure for treated women. - Full roll-out of breast cancer screening to women aged 47-49 and 71-73 after 2016. - Roll-out of bowel cancer screening to men and women aged 70-75 Others - Continuation of support for skin cancer prevention campaigns - Support to workplace prevention efforts in partnership with others - Use by NHS of the generic long-term conditions model of care and support to promote healthy lifestyles for rehabilitation from cancer and to encourage secondary prevention. - Inclusion of standards on secondary prevention in relevant commissioning packs (and potential consideration by NICE for inclusion in Quality Standards)	Yes Department of Health: - Repeat of Cancer Patient Experience survey. -Building on report by Frontier Economics to provide further evidence to support the NHS to develop new one to one support posts. -Highlighting of issues that service providers and commissioners need to consider as part of workforce planning -Development and testing of new pathways of care which can demonstrate improvements in patient outcomes and experience alongside reductions in unnecessary outpatient appointments and unplanned hospital admissions -Continued development of evidence and good practice principles to support the development of specialist services for patients with long-term effects of cancer and cancer treatment - Development of a national survey of cancer survivors to be piloted in 2011 -Development of recommendations for a funding system that will cover dedicated palliative care provided by the NHS, a hospice or any appropriate provider - Investments in radiotherapy, cancer drugs and expensive treatments

N/A= not available

* These countries don't have formal Cancer Plans but they carry out related activities.

Table 12: CANCER PLANS: Goals, objectives and related indicators

COUNTRY	Quality of care	Cancer research	Others
Belgium	Yes Ensuring quality in cancer care was already integrated in cancer policy and general health policy before the Cancer Plan: in 2003 we established care programs for oncology care, with formal accreditation standards and control. Also, national clinical guidelines for Cancer are being developed by the College of Oncology. Quality in cancer care continues to be an important objective in Belgian Cancer policy. However, this is not specifically mentioned in the Cancer Plan, since these mechanisms were already in place. The Belgian Cancer Centre has been created in the framework of the Cancer Plan, and one of the main tasks is evaluating and monitoring the Cancer Plan and Cancer Policy, which should also contribute to quality of care.	Yes Projects on translational research, onco-geriatrics and the coordination of translational research.	
Bulgaria*	Yes The Ministry of Health is responsible for the control over the medical establishments and monitoring over the quality of the health services offered to the citizens in the country.	N.A	
Cyprus	Yes Quality Assurance/ Monitoring/ Evaluation: Mechanisms, which provide accreditation and quality control Responsible institution for its preparation: MOH	Yes Development of a Coordination Centre that will avoid Duplication of trials. Responsible institution for its preparation: MOH	Implementation Mechanisms and structure: National cancer committee(7 distinguished personalities with special interest in cancer issues) and Advisory committee(Includes all N G Os and stakeholders related to Cancer)./ Time frame / Application /Evaluation
Czech Rep	Yes Ministry of Health: Establishment of the Comprehensive Cancer Centers and their	Yes Ministry of Health:	

COUNTRY	Quality of care	Cancer research	Others
	regular monitoring and reaccreditation	Funding of the national research projects	
Denmark	Yes National Board of Health: - New clinical guidelines for palliative care and rehabilitation - Revision of the fast track pathways for 34 specific cancer forms – the pathways were introduced in 2008	Yes National Board of Health: - Funding of research in palliative.	-Introduction of a national screening programme for colorectal cancer
Estonia	Yes Providers	Yes National Institute for Health Development, Tartu University: We started a survival study for women in the late stages of breast cancer.	
Finland	As above the Cancer Society of Finland, National Institute of Health and Welfare, the Society of Oncology: Best practice – recommendations for all cancers	No All cancer research institutes, the Cancer Foundation, the Universities: This section will be included in the second part of the plan.	The Cancer Society of Finland: The Patient pathway concept and research on it
France	Improve the quality of care for all cancer patients. OBJECTIVES: ・Improve the quality of care for all patients. ・Assist in the setting up of the agreements system regarding cancer treatment and plan its development.	National Cancer Institute, the Ministry of Research, the Department for Health Care: Strengthen resources for multidisciplinary research. Understand through research and reduce inequalities in relation to cancer. Characterize environmental and behavioural risks. Stimulate clinical research. Make France a reference country.	Ministry of Social Affairs (DGCS), Ministry Employment Work and Training (DGEFP): Life during and after cancer (Improve the quality of life during and after the illness and fight any form of exclusion Summary of activities: Develop individualised social support during and after cancer. Obtain the necessary tools and resources for developing individualised social. Improve responses to possible

COUNTRY	Quality of care	Cancer research	Others
	・Gain greater information on waiting times for cancer treatment to reduce unequal access to care caused by delays. ・Provide patients with reference information on cancer.		situations of temporary or permanent disability or loss of autonomy related to cancer. Improve current and former patients' access to insurance coverage and credit. Remove obstacles faced by cancer patients in re-entering the workforce. Create a cancer societal observatory.
Germany	Yes (see Table 9) II. Area for Action 2: Further Development of Oncological Care Structures and Quality Assurance Objective 4: All cancer patients will receive high quality care, regardless of age, sex, origin, place of residence or insurance status. Objective 5: Standardising certification and quality assurance of oncological treatment facilities Objective 6: Evidence-based guidelines for the treatment of cancer Objective 7: Cross-sector, integrated oncological care will be guaranteed. Objective 8: High quality health care data from clinical cancer registries Objective 9: Appropriate psycho-oncological care according to patients' needs	Yes Together with the Federal Ministry of Education and Research, which is also a partner in the German National Cancer Plan, it was agreed that cancer research, especially health care research, is a cross-cutting issue in all action areas during the first phase of the Cancer Plan. The research activities required to achieve the aims/objectives are being identified, and recommendations for the establishment of corresponding research activities have been put forward. There is a separate budget for research activities within the National Cancer Plan.	N/A
Greece	Yes Ministry of Health and Social Solidarity in collaboration with	Yes Ministry of Health and Social Solidarity in collaboration	

COUNTRY	Quality of care	Cancer research	Others
	various bodies, governmental and non-governmental: - Development of clinical protocols and cancer treatment guidelines - Certification of medical units and services according to international quality standards - Supply medical units with the necessary biomedical technology	with various stakeholders: - Linkage of existent networks and databases.	
Hungary	Yes National Institute of Oncology: (See detailed activities by Objective in the original documents)	Yes 1. To evaluate the operation of the National Cancer Registry and to make proposals for changes based on the findings of the evaluation. 2. To review undergraduate and postgraduate training programs in the fields of cancer prevention and cancer treatment related knowledge, ant to formulate a proposal as to how such information and knowledge should be incorporated into different curricula. 3. To evolve a system of continuing education of those involved in the care of cancer patients, to ensure that they have high-level current knowledge, by using state-of-the-art infocommunication technologies, too. 4. To create, on the regional and national levels and by applying telemedicine, consultation possibilities, including familiarisation with novel forms of care and diagnostic procedures as well as the exchange of experience gained in the course of treating rare diseases. 5. To establish a joint consultation system for pathologists and cytopathologists. 6. To create online connections in the system of the	

COUNTRY	Quality of care	Cancer research	Others
		network of cancer patient care settings which may be used for the follow-up of patient pathways in all forms of care delivery, for transferring findings and test results to the attending physician without any time delay, and which at the same time meet the requirements of the health reporting system (including the Cancer Registry). 7. To make sure that the system of 'DrInfo' has relevant information concerning the implementation of tasks spelled out under the objectives of the National Cancer control Programme.	
Ireland	Yes Health Service Executive-National Cancer Control Programme, Health Information and Quality Authority: The Strategy includes recommendations on the quality of care, both in regard to the reorganisation of services and the establishment of systems and structures to support quality. These recommendations are being progressed by the National Cancer Control Programme and by the Department of Health and Children.	Yes Health Research Board, National Cancer Registry and non-publicly funded organisations: Significant progress has been made in implementing the recommendations in this area. The value of high quality research is critical and the establishment of a strategic and continuing process for identifying, overseeing and facilitating cancer research is well recognised.	
Italy	Yes Ministry of Health: To monitor quality and appropriateness of care; to promote continuous quality improvement; to promote and ensure rehabilitation, to support patient's associations involvement	Yes Ministry of Health: To coordinate primary and translational research programmes; to promote research in new fields (i.e. genomics and bio-banks and quality of life); to promote costs analysis	
Latvia	Yes Ministry of Health of the Republic of Latvia, Health Care	Yes Ltd "Riga East Clinical University Hospital" Latvian Oncology Center; Pauls Stradins Clinical University	

COUNTRY	Quality of care	Cancer research	Others
	Inspectorate, Centre of Health Economics, Health payment centre: Drafting the requirements for quality managements system in treatment institutions (in the block of compulsory requirements for treatment institutions); setting quality criteria for the treatment process and results; introduction of quality management systems in treatment institutions; participation of the treatment institutions in the quality evaluation system and other activities.	Hospital, Center of Health Economics, University of Latvia, Riga Stradins University. University of Latvia implement research in framework ESF Project "Early diagnosis and prevention of cancer interdisplinary research group" for example , Organized colorectal cancer screening pilot research in Latvia " (2011).	
Lithuania	Yes Ministry of Health: State Medical Audit Inspectorate. Quality assurance programmes in the hospitals providing multidisciplinary cancer approach.	Yes Lithuanian University of Health Sciences, Vilnius University Oncology Institute: Publications, dissertations in cancer diagnostics and treatment, basic research.	No
Luxembourg*	Yes Ministry of Health: Ministry of Health together with the Health Insurance Fund and the different experts committee working in this field.	Yes Different involved: The Integrated Biobank of Luxembourg – co-founded by the nation's three Public Research Centers: Santé, Tudor and Lippmann and by the University of Luxembourg – holds the promise of becoming an important European hub for advanced biobanking, biotechnology and biomedical informatics.	
Malta	Yes Healthcare Services: The NCP is enforcing the establishment of clinical guidelines that will describe the recommended options for the whole treatment process for various cancers and will establish important landmarks	Yes Directorate for Health Information and Research and University of Malta: Strengthen surveillance, monitor disease prevalence and survival and document the quality of care services	Yes (Patients perspective) All entities in Health: To ensure that the experience of patients and their carers is as positive and empowering as possible (including improvement of the facilities for cancer care (new hospital is

COUNTRY	Quality of care	Cancer research	Others
	in the care of cancer patients such as evidence-based surgery, referral for adjuvant therapy and follow-up criteria and timelines.	and their outcomes. Focusing research on molecular, genetic and laboratory and pathology-based studies and participation in clinical trials.	being built); increase psychosocial support, increasing training in communication skills of health professionals, better access to information.
Netherlands	Yes VIKC (IKNL), NFK, scientific associations of the different medical disciplines, national association of oncology nurses, GP association, and many others (See the plan)	Yes Dutch Cancer Society Koningin Wilhelmina Fonds (KWF) (See the plan)	Yes All institutions: Education and training of professionals Intensive quality monitoring of care annually through published indicators and outcome
Norway	Yes The four regional health enterprises in Norway: In addition better follow up of cancer patients to register late effects of cancer treatment. Establishing national professional guidelines for different forms of cancer, e.g. colorectal cancer, sarcomas, head and neck.	Yes The four regional health enterprises in Norway: The research council of Norway. Basic research, clinical research,. Epidemiological research and research prevention	Yes Norwegian Directorate of Health: What is cancer care, challenges in cancer care – a description, administrative and political framework, structures and processes in cancer care.
Poland	Yes Ministry of Health and National Health Fund	No The research competence is under Ministry of Science. Scientific and educational units of the medical universities, supervise by Ministry of Health are conducting research related to oncological issues. Moreover there are some other institutions of Ministry of Health where research is conducted like: Oncology Centre in Warsaw, Hematology and Transfusiology Institute , Children's Health Institute, |Mother and Child Institute.	

COUNTRY	Quality of care	Cancer research	Others
Portugal	Yes NCOD and experts groups for each cancer pathology: Development of national guidelines for diagnosis, treatment and follow-up (breast, lung; developing colorectal and prostate); legislation on the maximum waiting time for treatments; development of a document on best practices and national strategic plan for radiotherapy.	Yes NCOD and 7 hospitals: Implementation of a national tumour banking network	Yes NCOD: Educational pilot program on communication skills for cancer physicians and other professionals
Romania	Yes Ministry of Health - Cancer Commission, Romanian College of Physicians: Protocols and accreditation of cancer centres. Continuous medical education in oncology.	Yes Cancer Centres: Research on: Epidemiologic, Fundamental, Clinical, Translational, Trials	
Slovenia	No	Yes Institute of Oncology: Support academic research Ensure stabile financing of the research projects Activities to ensure better collaboration between different research groups	Yes MoH in cooperation with the civil society: Including civil society in the processes of decision making and in the activities to prepare and disseminate information for patients MoH and Institute of Oncology: Information and communications technology with standardisation of the health records and electronic patients records at all health care providers and linkage between them
Spain	Yes Institutional Committee of the strategy:	Yes Carlos III Institute and Spanish network of cancer	

COUNTRY	Quality of care	Cancer research	Others
	Psycho-oncology care promoted across Spanish health care system. Survivorship care feasibility study. Indicators of process.	research based on peer reviewed.	
Sweden	Yes 21 national quality registers in cancer care. Open comparisons (benchmarking) of the quality of care cancer in regions and hospitals, publicly available.	Yes (Partly) The Research and Innovation Bill adopted by the Swedish Parliament includes a special commitment to strategic research in the field of cancer. The six regional cancer centres are working closely with universities to serve as hubs in this development.	
England	Yes Department of Health Access and Quality of surgery: - Ensuring commissioners and providers, health and well-being boards, the public and patients are provided with data about regional variations in intervention rates for older people - Investigation of incentives to ensure that clinicians are rapidly trained in new surgical techniques (with continuation, in the meantime, of central funding for any appropriate national training programmes) - Ensuring results from the older people's work are fully disseminated Radiotherapy - Ensuring data on access to radiotherapy services is routinely published and that commissioners and providers are provided with benchmarked data about their performance. Detailed analysis of the RTDS undertaken to ensure that the metrics in the	Yes Department of Health: - Work with partners such as Cancer Research UK to support basic research into how cancer starts and develops; clinical and translational research so that discoveries can move quickly from bench to bedside; research into prevention, screening and epidemiology; health services research; and research to support those living with cancer and those nearing the end of life. - Provision of funding by DH's Policy Research Programme from January 2011 for five years for a policy research unit on Cancer Awareness, Screening and Early Diagnosis. In addition, over the next 18 months, provision of insights by the International Cancer Benchmarking Partnership (led by DH) that will help us	Yes Department of Health: - Reducing inequalities: - Gathering of evidence on the nature, extent and causes of cancer inequalities; advising other parts of the National Cancer Programme on action; and identification and spreading of good practice - Exploration of inequalities in access to clinical trials and whether steps are need to improve access in any patient group - Ongoing work to support clinicians by making sure they have accurate information about an older person's ability to benefit from cancer treatment rather than making assumptions on the basis of age - Support to Macmillan Cancer Support in undertaking a project to apply a human rights approach to the delivery of

COUNTRY	Quality of care	Cancer research	Others
	National Radiotherapy Advisory Group (NRAG) report remain meaningful and current Additional investment in radiotherapy capacity over the next four years. - Exploration of options for developing PBT facilities in England to treat up to 1,700 patients per year – with provision in the meantime of additional funding over the next four years to treat patients (predominantly children) abroad Chemotherapy - Use by NHS commissioners of financial incentives and contractual arrangements to improve quality and choice, to encourage reductions in emergency admissions and to reward improvements in patient experience - Improvement of the collection and publication of data on chemotherapy activity, outcomes and costs; introduction of chemotherapy dataset in April 2012 should provide commissioners, providers and others with invaluable information - Enhancement of the information available to patients on the benefits and toxicities of treatment Access to medicine - Work towards a new system of pricing for medicines, where the price of the drug will be linked to its assessed value Targeted medicine - Development and commissioning of a funding structure to enable the efficient delivery of high quality molecular diagnostic testing through centres of excellence	understand survival differences between countries and thus to take steps to address them.	cancer treatment and care and work with Macmillan Cancer Support to ensure that outputs are applied to promoting equality in cancer services - Provision of information to consortia on the equality and inequality characteristics of their cancer populations, as well as how their performance compares with other areas Autonomy, accountability and democratic legitimacy: commissioning and levers - Publication of advice to commissioners and providers on photodynamic therapy, stereotactic body radiotherapy and robotic surgery for prostate cancer in 2011 - Development and focusing of the Cancer Commissioning Toolkit and the Cancer Commissioning Guidance on what works best in supporting pathfinder GP consortia - Development, in 2011, of a cancer commissioning support pack to enable commissioners to access in one place the key information they will need to discharge their functions effectively - Investigation of the potential development of a range of tariffs to incentivise high quality, cost-effective services - Development of links between the National Cancer Equalities Initiative (NCEI) and HealthWatch

COUNTRY	Quality of care	Cancer research	Others
	Inpatient stays and emergency admissions - Development of tariffs to incentivise quality and productivity in terms of inpatient care and avoidance of emergency admissions - Lessons learned from the Transforming Inpatient Care Programme to be disseminated to providers and commissioners - Collation and publication of information on admissions, lengths of stay and bed days by commissioner and by provider Trust - Implementation of the end of life care strategy to encourage the development of community-based services for people in the final phase of life		

N/A= not available

* These countries don't have formal Cancer Plans but they carry out related activities

Table 13: CANCER PLANS: Budget and Capacity

COUNTRY	Additional financial resources available?	Specific activities to receive additional funding	Comments
Belgium	Yes	Screening porgrammes Cáncer care: personnel, innovation, pediatric oncology, reimbursement of medicines, rehabilitation, and research and innovation	A global budget was allocated for implementation of the Plan
Cyp	Yes We intend to have an independent budget, after the preparation of our action plan. Meanwhile, all the activities are funded by the Ministry of Health and charities (Bank of Cyprus).		In our National Plan, we describe the ideal. The Action plan includes prioritization of goals, because there are economic restrictions. We set immediate –Mid term – Long-term applicable goals.
Czech Rep	Yes	Screening programme, and partly National Cancer Registry	
Denmark	Yes	More or less all initiatives in the plan are followed by additional funding to cover development and implementation of the initiative.	
Estonia	Yes		Funded from government budget, Health Insurance Fund, ESF. Prevention activities are financed partially by voluntary contribution.
Finland	No		There are no additional funds available unless the University Hospital Districts decide to add some new elements in their budgets
France	Yes	All 30 measures were allocated specific additional financial resources for their implementation	

COUNTRY	Additional financial resources available?	Specific activities to receive additional funding	Comments
Germany	Yes	-Organisation/administration - Research	There is a separate budget for administrative and organisational tasks/issues within the Cancer Plan (e.g. organisation of steering committee meetings or working group meetings). There is also a separate budget for research activities in connection with the Plan. As a Cooperation and Organisation Programme the overarching aim of the National Cancer Plan is to coordinate more effectively the activities of all those who are involved in combating cancer, to promote a more focused approach and to use more efficiently resources that are already dedicated to the prevention and control of cancer. Budgetary issues are being addressed in the objectives of the German National Cancer Plan. Thus, the relevant stakeholders will provide funding for the implementation of specific objectives depending on their responsibility and accountability, within their budgetary constraints. Therefore, the Cancer Plan has not got an overall budget as such.
Greece	Yes		Priorities included: Data and information Education and prevention Quality of care
Hungary	Yes	- population-wide screenings (colorectal, cervix, breast) - improving healthy lifestyle - Implementation of a Modern Regional Oncological Network - improving technical infrastructure and human resources.	The Social Infrastructure Operational Programme (SIOP) will support programmes in NCCP. New tender for the SIOP 2.2.5 (2011-2013) could give the opportunity to continue the initiated programme of the Implementation of a Modern Regional Oncological Network.
Ireland	Yes	acute cancer services, including radiation oncology, and screening	
Italy	No		Budgeting procedures do not allow ear-marking of NHS funds for specific diseases or actions

COUNTRY	Additional financial resources available?	Specific activities to receive additional funding	Comments
Latvia	No	Organized cancer screening program, oncologic patient treatment, home health care for oncologic patients and palliative care according to the medical indications.	The Oncologic Program will be implemented through allocated financial resources and the issue of additional funding for next years has to be considered at the Cabinet of Ministers with the medium-term budget priorities of all ministries and other central government institutions for the current year state budget bill preparation and review process.
Lithuania	Yes	Screening programmes, Diagnostic and treatment facilities	Diagnostic and treatment facilities are financed by EU Structural Funds resources. Screening programmes are reimbursed from Compulsory Health Insurance Fund.
Malta	Yes	All measures in the National Cancer Plan have been allocated with a specific budget, timeline and leading accountable entity for their implementation	There are also other improvements to the cancer care in Malta that are being funded through other means and these have not been included in the financial package for the NCP. These include the building of a new cancer hospital and the purchase and installation of new equipment including a PET/CT scanner and new linear accelerators.
Netherlands	No	100 000€ annually for coordination and monitoring of the plan	The actions/activities formed a part of the strategic plans of the different partners and in consequence the different partners incorporate the actions out of the plan into their own strategy and annual budget.
Norway	Yes	Equipment to the hospitals, education/personnel and expanding radiation therapy.	The plan envisages use of the normal funding for cancer care. But for the first 5 years there was allocated 625€ mill. for investments in Equipment to the hospitals, education/personnel and expanding radiation therapy.
Poland	Yes Moreover, it has to be added that funds are transferred from other multi-annual programs to the National Program for Combating cancer and help with the tasks associated with the purchase of specialized equipment.	Equipment replacement	The budget for the CCP is included every year at the general budget

COUNTRY	Additional financial resources available?	Specific activities to receive additional funding	Comments
Portugal	No	N/A	The NCS is implemented through the financial resources for this matter included in the MoH general's budget.
Romania	Yes	Prevention, cancer registry and research.	
Slovenia	No	N/A	
Spain	Yes		A total budget for specific health strategies is proportionality distributed by population into all Autonomous regions for implementing them at regional level. One of these strategies is Cancer strategy.
Sweden	Yes	Building regional cancer centers, pilot projects to improve processes in cancer care and reduce waiting times, antismoking activities, improved information to patients and public, developing specific target levels for quality indicators, promoting concentration of parts of cancer care and several other activities	
England	Yes	-Increased radiotherapy capacity via a small increase in machines, access to specialised treatment overseas and improved utilization of existing machines - Improvements to the current screening programmes and the induction of flexible sigmodoscopy - Improved primary care access to key diagnostics and a publicity campaign to improve public awareness of symptoms - Data collection changes to provide an early indication of improved outcomes	£750 million over four years.

N/A = not available

Table 14: CANCER PLANS: Budget and Capacity

COUNTRY	Sufficient level of funding?	Influence of budgetary restrictions on plan	Comments
Belgium	Yes	N/A, as sufficuent funding were allocated before the launch of the cancer plan	
Cyprus	N/A	N/A	
Czech Rep	No	Yes, across all topics	Insufficient funding might endanger the whole program.
Denmark	Yes	None	None
Estonia	-	Yes	Most affected were prevention activities.
Finland	No	N/A	Additional funding will be needed in new personnel in care and rehabilitation
France	Yes	Yes, budget was negotiated with the ministers cabinets	
Germany	Under discussion	(Due to the complexity of the issues involved see comment on the right)	There is a separate budget for administrative and organisational tasks/issues within the Cancer Plan (e.g. organisation of steering committee meetings or working group meetings). There is also a separate budget for research activities in connection with the Plan. As a Cooperation and Organisation Programme the overarching aim of the National Cancer Plan is to coordinate more effectively the activities of all those who are involved in

COUNTRY	Sufficient level of funding?	Influence of budgetary restrictions on plan	Comments
			combating cancer, to promote a more focused approach and to use more efficiently resources that are already dedicated to the prevention and control of cancer. Budgetary issues are being addressed in the objectives of the German National Cancer Plan. Thus, the relevant stakeholders will provide funding for the implementation of specific objectives depending on their responsibility and accountability, within their budgetary constraints. Therefore, the Cancer Plan has not got an overall budget as such.
Greece	N/A	N/A	
Hungary	No	No	No programmes apart from screening can be fully carried out with current funds.
Ireland	Yes	No	The allocation of additional funding year-on-year is carried out as part of a Government-wide annual estimates process. To date priorities for implementation have been determined mainly by clinical and quality standards.
Italy	N/A	N/A	
Latvia	No	Some activities related to distribution of informative booklets and realizing informative campaigns will be postponed.	
Lithuania	No	Yes	Due to lack of finances, colorectal cancer screening is not national programme yet, now is pilot programme only in two regions (Vilnius and Kaunas). No funding from Compulsory Health Insurance Fund for the cancer research.

COUNTRY	Sufficient level of funding?	Influence of budgetary restrictions on plan	Comments
			Cancer research of Universities
Malta	Yes	Yes	
Netherlands	Yes	No	The idea was to re-allocate the budget (avoiding overlaps, being more efficient etc) instead of new budget.
Norway	Yes	No	The plan envisages use of the normal funding for cancer care. But in the first five years of implementation there was additional funding to compensate for the investment in equipment, personnel/education and expanding radiation therapy.
Poland	Yes	Yes	Undoubtedly increase of the budget will not improve the situation. At present, the resources for promotional and educational activities are sufficient. However, there is lack of funds for the purchase of specialized equipment.
Portugal	N/A	No	
Romania	No	The strategies adopted were according to the level of funding.	Insufficient funding for implementation at a population level.
Slovenia	N/A	N/A	
Spain	No	Yes	
Sweden	N/A	No	
England	Yes	Yes	The activities outlined in Improving Outcomes had to be clearly evidence-based and cost-effective.

N/A = not available

Table 15: CANCER PLANS: Budget and Capacity

COUNTRY	Specific budget allocated to implementation of different measures within plan?		Specific alliances made with other relevant stakeholders	Comments
	Yes / No	Sufficient?		
Belgium	Yes	Yes	Yes Interministerial Conference for Health	The Belgian Cancer Center guarantees a strong collaboration with all stakeholders in the field as well as patients
Cyprus	N/A	N/A	Yes There is an alliance with anticancer society, with Europa Donna and- huomo and Society of Cancer Patients and friends in order to disseminate the information and support the patients	
Czech Rep	Yes	No	No	
Denmark	Yes	Yes	Yes With all relevant stakeholders	Organisation of Danish Regions is specifically important
Estonia	Yes	No	Yes Foundation of Support Treatment of Cancer Patients, OÜ Mammograaf, Association of Radiologic Technologist of Estonia	
Finland	No	No	No	

COUNTRY	Specific budget allocated to implementation of different measures within plan?		Specific alliances made with other relevant stakeholders	Comments
	Yes / No	Sufficient?		
France	Yes	Yes	Yes	Each measure has a specific pilot according to required competences
Germany	Yes	Under discussion	Involvement of relevant stakeholders	There is a separate budget for administrative and organisational tasks/issues within the Cancer Plan (e.g. organisation of steering committee meetings or working group meetings). There is also a separate budget for research activities in connection with the Plan. As a Cooperation and Organisation Programme the overarching aim of the National Cancer Plan is to coordinate more effectively the activities of all those who are involved in combating cancer, to promote a more focused approach and to use more efficiently resources that are already dedicated to the prevention and control of cancer. Budgetary issues are being addressed in the objectives of the German National Cancer Plan. Thus, the relevant stakeholders will provide funding for the implementation of specific objectives

COUNTRY	Specific budget allocated to implementation of different measures within plan?		Specific alliances made with other relevant stakeholders	Comments
	Yes / No	Sufficient?		
				depending on their responsibility and accountability, within their budgetary constraints. Therefore, the Cancer Plan has not got an overall budget as such.
Greece	Yes	No	Yes Universities and Institutions, the Church, NGOs.	
Hungary	In part	No	Yes With social services, local organisations, EU Partnership	Only screening programmes have sufficient funding.
Ireland	No	N/A	Yes	The allocation of additional funding is carried out as part of a Government-wide annual estimates process. An Annual Service Plan from the Health Service Executive sets out the services it will provide for the coming years across health and personal social services. The Service Plan incorporates the specific priorities of the National Cancer Control Programme for the coming year, which flow from the priorities set out in the Strategy.
Italy	No		Yes With patients' associations	

COUNTRY	Specific budget allocated to implementation of different measures within plan?		Specific alliances made with other relevant stakeholders	Comments
	Yes / No	Sufficient?		
Latvia	Yes	No	Yes With professional societies, patients' organisations	Budget is decided by Cabinet on a yearly basis; activities without funding will be postponed, but not abandoned.
Lithuania	Yes	Yes	Yes	For the preparation of the programme specialists of Universities, scientists, physicians, NGO, patients organization and others were invited.
Malta	Yes	Yes	No	
Netherlands	No		Yes	Partners committed a total of €100,000 to coordination of the plan; further funds to carry out activities will be allocated by partners on an individual basis*
Norway	No		No	
Poland	Yes	Yes	Yes	The National Consultants in oncology matters had a contribution in the phase of establishing the national cancer control program.
Portugal	Yes	No	Yes With Regional Health Administrations	Lack of funding constitutes threat to implementation of NCS

COUNTRY	Specific budget allocated to implementation of different measures within plan?		Specific alliances made with other relevant stakeholders	Comments
	Yes / No	Sufficient?		
Romania	Yes	No	Yes With patient organisations, professional societies, NGOs for psychology, palliation, etc	
Slovenia	No		N/A	
Spain	Yes	No	Yes With patients' organizations, scientific societies and NGOs.	
Sweden	Yes	No	Yes Close collaboration with the Swedish Cancer Fund, 14 patient organisations, and professional organisations	
England	Yes	Yes	Yes With the NHS and the charity sector	

N/A = not available

*Netherlands: They did not put extra money for actions and activities out of the plan, the only commitment the 5 partners had was to put a small amount of money into coordination and monitoring of the plan (€100 000.- in total per year-). The actions/activities formed a part of the strategic plans of the different partners and in consequence the different partners incorporate the actions out of the plan in to their own strategy and their own annual budget.

Table 16: CANCER PLANS: Budget and Capacity

COUNTRY	Timeframe for plan implementation (years)	Specific objectives for every measure taken in cancer plan?	Comments
Belgium	3	Yes	No goals specified for specific actions
Cyprus	5	N.A.	
Czech Rep	-	No	
Denmark	2, 3 and 10	Yes	
Estonia	8	Yes	
Finland	10	Yes	
France	5	Yes	
Germany	Gradual roll-out	Yes	
Greece	5	Yes	
Hungary	7	Yes	The operational phase of the Hungarian National Cancer Plan is different in case of each objective, some of them are continuously ongoing, while the others have definite timeframe
Ireland	Ongoing	Yes	The Strategy includes 55 recommendations and 19 policy indicators.
Italy	3	Yes	
Latvia	7	Yes	
Lithuania	10	Yes	

Malta	5	Yes	
Netherlands	5	Yes	
Norway	Ongoing	No	Some indicators: a) reduce the number of new cancer cases; b) increasing the chances for cure by early diagnoses; c) increasing capacity for treatment, including palliative care
Poland	10	We have adopted specific targets for each issue but they are not always measurable	
Portugal	4	Yes	
Romania	10	Yes	
Slovenia	2	N/A	
Spain	4	Yes	
Sweden	6	Yes	
England	4	No	

Table 17: CANCER PLANS: Budget and Capacity

Country	Implementation structure included in plan?	Responsibility	Currently functional?	Additional human resources	Comments
Belgium	N/A; not necessary through existing structures	Ministry of Health (Federal Public Service of Public Health, Food Chain Safety and Environment) - National Institute of Health and Disability Insurance - Regional and Community authorities	Yes	Yes	The Belgian Cancer Center advises the already existing strcutures when necessary and relevant
Cyprus	Yes	The National Cancer Committee is an established body with terms of reference to develop an action plan and implement the strategy within five years	It is made functional, since October 2010.	Information not available yet.	
Czech Rep	No	MoH	N/A	N/A	
Denmark	A detailed implementation structure has been formulated following the completion of the plan	The National Board of Health and "Task Force on the implementation of cancer policies"	Yes	N/A	
Estonia	Yes	National Institute for Health Development; with Health Insurance Fund, and NGOs	No	No	
Finland	Mostly.	University Hospital Districts	Mostly	No	New structures will be needed for the evaluation of new drugs and palliative care.
France	Yes	The National Cancer Institute	Yes	Staff of 160 people. Two extra people are employed at the department of health	
Germany	Yes	In 2010 and 2011 recommendations for most but not all objectives of the German National Cancer Plan were adopted. At	--	Undecided	

Country	Implementation structure included in plan?	Responsibility	Currently functional?	Additional human resources	Comments
		the beginning of 2012 the Federal Ministry of Health and the stakeholders concluded the development of an implementation strategy. There is no single organisation responsible for its implementation. However, the Federal Ministry of Health has got the overall responsibility in coordinating the activities of the Cancer Plan.			
Greece	N/A	Ministry of Health and Social Solidarity in collaboration with various bodies, governmental and non-governmental.	N/A	No	
Hungary	No	The Ministry of National Resources - State Secretariat for Healthcare National Institute of Oncology National Public Health and Medical Officers' Service	N/A	No	The annual budget of the Hungarian National Programme for the Decade of Health financially supports the 'Reducing morbidity and mortality due to neoplasm' sub-programme. Especially organising and publishing population-wide screenings and appropriate screening methods. Moreover the currently ongoing EU projects (SIOP 2.2.5) has its own financial structure.
Ireland	No	Health Service Executive; National Cancer Registry of Ireland; Health Information and Quality Authority.	Yes	Yes	The Strategy does not detail how its implementation should be structured, although it does identify the agencies responsible for the implementation of many of its recommendations.
Italy	No	regional local governments	Yes	No	No specific devoted structure; but regional services are now in charge to implement it according to local scenarios and other regional planning activities

Country	Implementation structure included in plan?	Responsibility	Currently functional?	Additional human resources	Comments
Latvia	Detailed information on activities, predictive results and funding are shown by years.	Line ministries, municipalities, social partners and non-governmental institutions; MoH	Yes	No	
Lithuania	No	Ministry of Health, Universities, Hospitals, GP, Health Education and Diseases Prevention Centre under the Ministry of Health, National Health Insurance Fund	No	N/A	
Malta	Yes	Steering committee in the Office of the Chief Medical Officer	Yes	No	
Netherlands	Yes	All partners	Yes	No	
Norway	No	Each responsible provider of health care is responsible for his part in the implementation.	Yes	No	Additional human resources was made available in connection with investments in equipment through the first five years of implementation
Poland	Yes	MoH and Cancer Control Council	Yes	N/A	
Portugal	Yes	NCOD and Regional Health Administrations	Yes	No	
Romania	Yes	Cancer Commission at de MoH	Yes	Working groups of experts	
Slovenia	Yes	MoH. It nominated the special board to monitor the implementation and assess the indicators and reports	Yes	N/A	The special board was established in 2010
Spain	Yes	Ministry of Health, Social Policy and Equality, Regional Health Authorities, Scientific Societies and Patient Associations	Yes	No	(In Spain the MoH, the regional health authorities, the scientific societies and patients associations are responsible of the

Country	Implementation structure included in plan?	Responsibility	Currently functional?	Additional human resources	Comments
					implementation)
Sweden	Yes	Ministry of Health, National Board of Health and Welfare, regional and local healthcare providers	Yes	Yes	
England	Yes	Department of Health, the NHS Commissioning Board and the Public Health Service. An Implementation Advisory Group (IAG)	Not yet	No, but it was taken into account	

N/A = not available

Table 18: CANCER PLANS: Budget and Capacity

COUNTRY	Presence of a national/regional cancer centre to coordinate action	Comments
Belgium	Yes	Belgian Cancer Center Scientific Institute of Public Health J. Wytsmanstraat 14 1050 Brussels Belgium 00 32 2 642 57 04
Cyprus	No MoH and National cancer committee are responsible for Cancer in Cyprus	National Cancer Commitee Prodromou 1, 1449 Nicosia-Cyprus
Czech Rep	No	
Denmark	National Board of Health and "The Task Force on implementation of cancer policies"	
Estonia	No	
Finland	No	
France	Yes	Institute National du Cancer 52 rue André Morizet 92513 Boulogne Billancourt France Tel : 33 1 41 10 50 00
Germany	Yes The Federal Ministry of Health is coordinating the German National Cancer Plan. The German Aerospace Center is providing administrative and organisational support	
Greece	No	
Hungary	Yes	National Institute of Oncology
Ireland	No	As outlined above, a number of agencies are responsible for the implementation of the Strategy. The Department of Health and Children has an oversight role of all actions.
Italy	No	The role of MoH includes a broader but less specific task dedicated to coordination of activities
Latvia	Yes	"Riga East Clinical University Hospital" Latvian Oncology

		Center, Health Payment Center
Lithuania	No	
Malta	No	
Netherlands	Yes	
Norway	No	
Poland	Yes	Poland has Regional Coordination Centers, Central Coordination Centers, Registries at central and regional level
Portugal	Yes	NCOD
Romania	Yes	The Oncology Institute in Cluj-napoca, cancer control and prevention centre
Slovenia	No	Different bodies are dedicated to particular parts of the Plan
Spain	No	
Sweden	Yes	Six regional cancer centres established (with national coordination)
England	No	

N/A = not available

Table 19: CANCER PLANS: Dissemination of plan to public

COUNTRY	Dissemination of plan to public						Regular communication to public on plan implementation
	Gov't website	MoH website	Regional website	Nat'l cancer center	Nat' Inst. of PH	Other	
Belgium	✓	✓	✓			✓	Annual progress report, through NGOs, issue-specific press releases, professional conferences, specific website under construction
Cyprus		✓			✓	✓	Through the NGOs who represent the advisory body of the National Cancer Committee.
Czech Rep	✓			✓		✓	No
Denmark		✓	✓	✓	✓		National Board of Health website
Estonia	✓				✓	✓	Annual communication plan, coordinated by National Institute for Health Development
Finland		✓			✓	✓	No
France	✓	✓		✓			Websites and issue-specific press releases
Germany		✓				✓	Yes, the MoH website is being up date regularly
Greece		✓				✓	No
Hungary	✓	✓	✓	✓			No
Ireland		✓					No
Italy	✓	✓				✓	Not yet, but it is scheduled for 2012
Latvia	✓						No
Lithuania	✓	✓		✓			Yes, information about cancer prevention and screening programmes
Malta		✓					Not yet on a formal basis, but there have been a series of radio and television programmes aimed at a general audience.
Netherlands						✓	Newspapers, professional conferences, individual communication plans of each of the five partners and a separate site for the cancerplan.
Norway	✓	✓				✓	No
Poland		✓					Yes, annual reports (from the realization of National Cancer Program till 31 of May every year and send it to the Parliament for

							acceptation. Moreover, this document is available on Polish Parliament website)
Portugal		✓		✓			No
Romania		✓					Yes, Media and NGOs
Slovenia		✓					Yes, the board is going to prepare the yearly report on the implementation, which will be available publically
Spain	✓	✓	✓				Yes, through patients' associations
Sweden	✓	✓	✓				Focus groups, regional seminars, websites of regional cancer centres, etc.
England	✓	✓					Yes, cancer bulletins

Table 20: CANCER PLANS: Evaluation

COUNTRY	Final evaluation envisaged?	How will the evaluation be carried out?			Indicators be used for the evaluation
		structure	process	outcome	
Belgium	Yes	✓	✓	✓	identification of pragmatic indicators for specific action as well as population based indicators in preparation by the Belgian Cancer Center
Cyprus	Yes			✓	Information not available yet
Czech Rep	Yes	✓	✓	✓	N/A
Denmark	Yes		✓	✓	Have not been formulated; Estimates on patient flow/times and survival rates for specific cancer forms are being evaluated and followed up on by The National Board of Health/Task force on implementation of cancer policies on an ongoing basis
Estonia	Yes		✓	✓	1. Incidence 2. Survival (FRS – five-years relative survival) 3. Quality of life 4. Mortality
Finland	Yes	✓	✓	✓	Included in plan
France	Yes	other			Responsibility for evaluation of the Cancer Plan 2009 2013 falls to the Haut Conseil de la Santé Publique (HCSP) and the AERES, for measures in the Research axis. They may also call on external service providers selected on the basis of an invitation to tender. Two evaluations have been scheduled: an interim evaluation at the end of 2011 and another at the end of the plan in 2013. The summary reports from the evaluation will be sent to the French President and the Ministries concerned.

COUNTRY	Final evaluation envisaged?	How will the evaluation be carried out?			Indicators be used for the evaluation
		structure	process	outcome	
Germany	Under discussion	Under discussion			The Plan is envisaged to span several years. Its progress is being monitored continuously with interim evaluations carried out periodically.
Greece	Yes		✓	✓	not yet specified
Hungary	Yes			✓	Health status - Demographic and socio-economic factors Life expectancy; Standardised death rates; Cancer incidence; Prevalence of cancer; Incidence of cancers related to the sex; Healthy Life Years (HLY) o at birth, by gender and healthy life expectancy at age 65, by gender. Determinants of health: smoking, total alcohol consumption etc. Health interventions: health services - Breast cancer screening coverage; Cervical cancer screening coverage; Hospital beds; Physicians employed; Medical technologies (CT/MRI); Hospital in-patient discharges, limited diagnoses; General practitioner (GP) utilization; Expenditures on health; Survival rates breast, cervical cancer.
Ireland	No (interim)		✓	✓	19 policy indicators are listed in the Strategy (as set out above) for evaluation of outcomes at a later stage. Monitoring and review of implementation (process) is ongoing focusing on the 55 recommendations in the Strategy and on the specific actions identified each year in the Service Plan
Italy	Yes		✓	✓	the structure and methodology are left to a subsequent Ministerial decision
Latvia	Yes	✓	✓	✓	There are 20 indicators following from programme goals. programme goals. Ministry of Health prepare program`s implementation progress report in 2013 and 2016.
Lithuania	Yes			✓	• decline in patients with lung cancer as a result of the primary prevention of cancer.

COUNTRY	Final evaluation envisaged?	How will the evaluation be carried out?			Indicators be used for the evaluation
		structure	process	outcome	
					• increase the number of cancer cases diagnosed early. • 30-percent reduction in patients with cervical cancer. • deaths from breast cancer reduced by about 15%.
Malta	Yes	✓	✓	✓	Trends in incidence, mortality and survival for all cancers and for specific cancer sites and types (quantitative) and patients' and carers' satisfaction and assessment of services (qualitative).
Netherlands	Yes	✓	✓	✓	See the website: www.npknet.nl
Norway	No (periodic)				(There is a planned interim report)
Poland	Yes			✓	The main indicators are: - population screening tests; - geographical allocation of medical equipment, infrastructure, personnel; - number of trainings.
Portugal	Yes			✓	
Romania	Yes	✓	✓	✓	Indicators for all activities: cancer registry, prevention and treatment
Slovenia	Yes		✓	✓	Indicators are prepared in action plans, which is preparing for each year. Indicators will be used for final evaluation, but the indicator are not defined in the plan

COUNTRY	Final evaluation envisaged?	How will the evaluation be carried out?			Indicators be used for the evaluation
		structure	process	outcome	
Spain	Yes	✓	✓	✓	Incidence and mortality. Process indicators related to screening program, resources devoted to cancer care and audit of clinical practice with indicators for breast and colorectal cancer.
Sweden	Under discussion	Under discussion			
England	Yes			✓	Not yet determined

N/A = not available

Table 21: CANCER PLANS: Strengths

COUNTRY	Strengths in drafting of plan	Strengths in implementation
Belgium	- extensive consultation of stakeholders in development of the Plan - specific actions with specific objectives have been identified - diversity of the identified actions	- budget specifically allocated to the Cancer Plan, and budget specifically allocated to each action made implementation possible - most of the actions have been implemented - clear responsibilities
Bulgaria*	Concentrate on specific target groups. Hospitals may be supplied with Linear Accelerator for radiation therapy.	
Cyprus	The cooperation of all stakeholders was valuable.	N/A
Czech Rep	Not yet evaluated	Not yet evaluated
Denmark	A both relatively broad and deep involvement of relevant stakeholders in the process of developing the cancer plan has given the plan legitimacy, relevant content and a good basis for implementation.	We are still in the initial process of implementation.
Estonia	It is based on the WHO recommendations.	Early detection and screening
Finland	N/A	N/A
France	Each measure has an objective, a pilot, financing and indicators. The drafting was based on PR. Grünfeld's report which was based on wide range consultation of experts, professionals and NGO's.	Monitoring of the implementation of the plan is carried out by the interministerial monitoring committee chaired by the Director General for Health or his representative, who must be in a position to mobilise central administrative departments, decentralised services and the agencies involved in implementing the measures set out in the plan, with the National Cancer Institute (INCa) at the forefront. The monitoring committee meets once a quarter. Its main mission is to monitor the implementation of the measures set out in the plan. It may suggest changes to the implementation of the plan in line with changing circumstances or in light of the planned interim evaluation report. Twice a year, the committee produces a progress report, which is sent to the French President and the Ministries concerned. The report is based on the monitoring work carried out on the implementation of the measures of the plan, which have been developed as part of a public health approach with targets, interventions or actions and performance indicators, including budget implementation indicators produced by the National Cancer Institute, whose role is to coordinate the various stakeholders involved in fighting cancer.

COUNTRY	Strengths in drafting of plan	Strengths in implementation
Germany	The German National Cancer Plan takes a stepwise approach in defining priorities, developing recommendations, their implementation and the evaluation of the activities. The consultation phase and the ensueing extensive discussions involved representatives of all major stakeholders including patient representatives. During its first stage four areas for action were identified as priorities and 13 specific objectives including over 40 subobjectives/targets were put forward. In 2010 and 2011 a set of concrete recommendations was developed for most objectives. At the start of 2012 the Federal Ministry of Health and the stakeholders concluded the development of an implementation strategy. For the next phase of the National Cancer Plan it must be determined whether there is a need to take action in additional areas in order to combat cancer (particularly in relation to primary prevention, cancer research, environmental, occupational and consumer-oriented cancer protection). Subsequently, a decision will be made as to which additional fields of activity are to be included in the Cancer Plan. The strength of this approach is that resources are utilized very efficiently. However as a consequence the Cancer Plan is, at this stage, not comprehensive in terms of the definition proposed by the investigators of this study as for example primary prevention is not explicitly part of the current priorities. However, there is already a wealth of initiatives outside the National Cancer Plan that aim at improving health promotion and primary prevention by focusing on common non-disease specific risk factors such as smoking, alcohol, poor diet and lack of physical activity.	
Greece	Strong presence of the NGOs.	Sufficient legislation framework Insurance coverage for diagnostic tests and treatment Strong presence of the NGOs Examples of good practice of medical units and laboratories
Hungary	- The National Cancer Control Programme was creating with a complex, comprehensive and coordinated society-wide cooperation that includes all affected disciplines and addresses all involved groups of people. - Following the guidelines and recommendations of the World Health Organization's National Cancer Control Programmes we are initiating our own Hungarian National Cancer Control Programme.	- The aim is to transform current practices to achieve a complex oncological outlook, to shape and operate an effective treatment system that offers balanced efficient patient care.
Ireland	Representative membership and national perspective: the Strategy was developed by the National Cancer Forum, a group established by the Minister for Health and Children which included nominees representing clinical professional bodies, the Minister, the Health Service Executive and the Irish Cancer Society. Wide consultation informed the development of the Strategy; the Forum carried out a public consultation process, received detailed submissions from professional and voluntary organisations and received presentations from health professionals and cancer patients.	Establishment of the National Cancer Control Programme within the Health Service Executive to implement the Strategy; political support; strong leadership. The strengths outlined in response to 10.1 above also have assisted the implementation, as the Strategy has had wide acceptance among the clinical community in particular but also other stakeholders.

COUNTRY	Strengths in drafting of plan	Strengths in implementation
Italy	- A comprehensive approach to reducing the burden of cancer - The inter-professional approach - To take care of patients' associations involvement - To have based the drafting the contents on the scientific evidence, the aim of continuous quality improvement and the need of innovation. - To stress the role of national networks - To take care of patients with comorbidity - To take care of a global approach for long-term survivors	N/A, The implementation is just starting.
Latvia	The collaboration of highly specialized experts.	Awareness that oncologic diseases have a high negative impact on human health and that joint action should improve the situation on oncology in Latvia.
Lithuania	Evaluation of the epidemiological situation, main tasks in cancer programme. Coverage all basic aspects of cancer control at institutional and national level. Population based cancer registration.	Main strength in the health promotion area is existence of the coordinated system, directed by the Government or by the Ministry of Health and network of the institutions working at the national and the local level. Cancer prevention programmes started in Lithuania, education of population and professionals, research.
Malta	Health promotion and prevention and cancer services in Malta are already well developed. The Plan could assess these services and design measures for the gaps identified and where improvements such as the updating of services to include emerging methodologies and treatments were needed. Awareness of budgetary availability during drafting process	Implementation started straight after the Launch in February 2011.
Netherlands	Collaboration between the partners, collaborative responsibilities, reallocation of available budget, priority setting	Given the responsibilities of implementation and evaluation among the partners, each of the partners felt responsible and keep on going on. In addition the VIKC /IKNL is organized so that it covers the whole of the Netherlands through a network of regions keeping track and supporting quality improvement oncological activities in that region for all the hospitals and professionals.
Norway	A very resourceful and skilled health care service at population disposal.	The Norwegian organization of the health care services: The organization is based on the principle of responsibility. The principle of responsibility contributes to avoid fragmentation of responsibility in implementation.

COUNTRY	Strengths in drafting of plan	Strengths in implementation
Poland	Stable budget for the National cancer control programme implementation.	Current information about implementation of the programs. There are multi-dimensional and multi-threaded actions related to health education, promotion and purchase of equipment etc.
Portugal	Burden of cancer, with great social impact as a disease with high incidence and mortality rates; one of the major priorities in the national and international health agenda. Inequalities in cancer care that require reorganization and improvement in the provision of health care. A need to establish a national cancer strategy with a coordinating body (NCOD). Need to increase the efficacy and efficiency of the national health system and reduce costs.	Establishment of the requirements for integrated treatment of cancer since primary care to palliative care, including psychosocial care. Leadership of NCOD. Highly motivated and collaborative partners: Regional Health Administrations, Cancer Centers and hospitals, Cancer Patients' organizations. Development of the Regional Oncological Committees responsible for the regional implementation cancer strategy.
Romania	Existent strategy in implementation with consensus of actors involved.	Pilot in cervical cancer screening and regional cancer registry excellence of cancer centres.
Slovenia	The main strength is the intention to structure the cancer diagnostic and care, to concentrate some current split activities and having special body to yearly monitor the situation on cancer field	N/A
Spain	Multidisciplinary care perspectives Palliative care in patients with cancer. Public network for research.	Patients' involvement thought formal associations. (a strength in Spain is the participation of different stakeholders during the plan formulation, implementation and evaluation of this implementation)
Sweden	Strong engagement by decision-makers and patient and professional organisations	Strong engagement by decision-makers at all levels and patient and professional organisations National cancer coordinators at both the Ministry of Health and the Swedish Association of Local Authorities and Regions. Many well-functional elements of the cancer strategy already in place (e.g. national guidelines, registers for follow-up, screenings, mostly high quality of medical interventions.
England	Strong stakeholder and political engagement.	It´s too early to say.

N/A= not available

*This country doesn't have formal Cancer Plans but they carry out related activities

Table 22: CANCER PLANS: Weaknesses

COUNTRY	Weaknesses in drafting of plan	Weaknesses in implementation	How were weaknesses dealt with?
Belgium	- short deadline for the first Plan, which has led to insufficient time for developing evaluation tools and indicators	- lack of cost-effectiveness analysis - insufficient consultation of stakeholders on implementation	Development of monitoring and evaluation were done after the drafting stage. Implementation of a Belgian Cancer Centre
Bulgaria*	Lack of financial resources and risk management.		
Cyprus	Special groups did not agree with some targets that would change some structures and practices. The MOH, as the coordinator, insisted on the European guidelines.	N/A	N/A
Czech Rep	Not yet evaluated	Not yet evaluated	
Denmark	The plan was drafted under the constraints of a politically set deadline, which gave a bit of time pressure. However the time pressure is not suspected to have influenced the content of the plan and stakeholders have been positive about the process.	We are still in the initial process of implementation.	The process was made very efficient and a lot of work was put into drafting the plan within the set period of time.
Estonia	The palliative and nursery care of oncological patients is still a problematic issue in Estonian medicine as there is not enough staff members or resources and finances.	Our weakness is that we have no still a screening register	We are working at the screening register. Hopefully we´ll have it in a couple of years.
Finland	N/A	N/A	
France	A very short time frame between receiving the Grünfeld report and the writing of the plan. In fact working groups for the drafting of the plan	Measures regarding social and occupational areas were new and the pilots have a global approach to all diseases and do not deal specifically on cancer.	More time for drafting of plan. For implementation: Needs better implication of the leaders who have many other important fields to deal with.

COUNTRY	Weaknesses in drafting of plan	Weaknesses in implementation	How were weaknesses dealt with?
	started before reception of the Grünfeld report.		
Germany	See general comments in table 21.		
Greece	- Absence of reliable cancer data due to the non full operation of the National Cancer Registry - Absence of coordination among bodies related to cancer - Lack of evaluation of the quality of services and care provided in the Public and Private Sector - Insufficient facilities for hospital at home care and terminal cancer patients care (hospices)	N/A	N/A
Hungary	N/A	- The overall aim of the National Cancer Control Programme is to halt the growth trend of tumour mortality, the attainment of which requires action and progress on 16 objectives, but there is no budget assigned to all of them. - Other difficulties during the implementation: human resources deficiency; population behaviour attitude.	For implementation: - The National Cancer Control Programme was launched in 2006, it should be review. - Planning a mid-term evaluation structure. - Need a long-time monitoring (least a decade) to have valid data about the outcome of a Cancer Plan.

COUNTRY	Weaknesses in drafting of plan	Weaknesses in implementation	How were weaknesses dealt with?
Ireland	None significant	There have been challenges, as expected, around the reorganisation of acute cancer services in particular.	For implementation: The strengths above, in particular strong leadership, political support and wide acceptance of the Strategy, have assisted in meeting these challenges
Italy	We've not experienced a real weakness in drafting the Plan but we had to face the scenario of a new model of governance related to the ongoing devolution process in NHS		N/A
Latvia	Drawing a general conclusion and summarizing the data on the situation in oncology in Latvia. Various views of medical experts that are occupied in oncology area.	1. The implementation of the cancer plan has just started so it is too early to identify the weaknesses of its implementation. The challenges in the implementation of the cancer plan could be the following: - how to introduce health promotion and prevention more efficiency, in accordance with lifestyle factors - obesity, lack of exercise, alcohol consumption and smoking. - how to raise awareness regarding cancer prevention, especially among target groups, such as women and children, by engaging young people in their communities (e.g. the Ministry of Education, regional governments, schools) and via media, the Web, among cancer society etc. 2. We also need to reduce high proportion of malignant tumors diagnosed at advanced stages. In order to accomplish that it would be necessary to - develop rapid access to diagnostic services and multidisciplinary treatment, by increasing patient involvement and; - develop the coordination of the cancer pathway. 3. Another important factor is the implementation and development of screening programme. To do that we have to: - improve attendance and coverage (systematic communication and activities targeted screening, motivation of patients, education among medical groups etc.) At this stage: 21,1% coverage rate in breast cancer screening, 19,4% coverage rate in cervical cancer screening. - ensure efficiency requirements of screening programme - coordination and cooperation between all included structures and levels of care, development and	For drafting of plan: All points of view were discussed and the most appropriate solution was chosen. For a implementation: Problems have been acknowledged and monitored.

COUNTRY	Weaknesses in drafting of plan	Weaknesses in implementation	How were weaknesses dealt with?
		implementation of quality criteria for health tests. 4. The essential part of the plan is devoted to the cancer care. The most important tasks in this field are: to - create, develop, review and harmonize the existing clinical guidelines, which were adapted to the local context and the resources available; - develop standardization of multidisciplinary care, coordination and collaboration among all levels of care and specialists involved, - develop standards for care of children with cancer, the palliative and psychosocial care, taking into account available financial resources and necessity to use them more efficiency. To ensure the effective implementation of the plan the cancer surveillance is needed. The tasks of the surveillance include providing accurate and comparable data on cancer incidence, prevalence, morbidity, cure, survival and mortality.	
Lithuania	Not enough attention to the evidence based treatment, to the evaluation of cancer treatment results and to the evaluation of the screening programmes results.	No final evaluation of cancer control 2003-2010 programme yet, but that is for seen. Lack of promotion of screening programmes. Lack of activity in primary prevention & early detection services due to lack of funding.	For implementation: For the new plan should be given to the program coordinating authority and the responsible person to ensure the implementation of the program and its evaluation at the end of the program.
Malta	The length of time that was needed to conclude it and eventually launch it. The experts who were working on the plan did not have protected time for this task and therefore work on the plan had to constantly compete with other priorities. This resulted in a long time period between the actual consultation for the plan and its publication such that some of the consultees continue to claim that they were not adequately involved.	Implementation has just started (after Launch in February 2011)	

COUNTRY	Weaknesses in drafting of plan	Weaknesses in implementation	How were weaknesses dealt with?
Netherlands	The medical professionals did not get enough time to think about the priorities and the consequences. It has to do with the actual structure that the associations are per discipline not per tumour, and that all these associations have to get their feedback from the members and that take a lot of time.	The medical professionals did not get enough time to think about the priorities and the consequences. It has to do with the actual structure that the associations are per discipline not per tumour, and that all these associations have to get their feedback from the members and that take a lot of time.	For drafting of plan: the national multidisciplinary tumor groups started to make their own planning in order to improve their strategies. On national level a federation was set up between the radiotherapists, the oncological surgeons and medical oncologists to set up joint priorities (SONCOS)
Norway	Bridging the discrepancies between ideal goals and the budgetary and resource constraints.	Cancer care divided between to many hospitals. Fragmented organization of the hospitals.	For implementation: Centralizing cancer care and organizing the hospitals in health trusts owned by The Ministry of Health and Care Services
Poland	Only some areas are possible to measure and define We didn't define a legible measures at the cancer control program were not defined and it was difficult to obtain to get a list of results relevant to every task of the National cancer control program from coordinators of every task.	Every year the NCC program has to be accepted by cancer control council and Ministry of Health executive Board, council of ministers. It´s too long and complicated way of implementing the program every year. There is an excessive length of proceedings because every year the National Cancer Program has to be accepted by Cancer Control Council, Ministry of Health Executive Board, Councils of Ministers and send to the government who is accepts this document.	
Portugal	At the beginning there wasn't a predefined structure at regional level (responsible for the cancer strategy). There was no template available and a great variability of plans among EU countries.	NCOD lack of autonomy. Lobbies from Medical College, scientific associations, and pharmaceutical industry, which created implementation difficulties. Misinformation by the media.	Having a National Cancer Director with autonomy and specific budget
Romania	Political lobby (no more explanation)	Political lobby (not more explanation)	For drafting of plan and for implementation: Limited resources
Slovenia	N/A	N/A	N/A
Spain	Not to have all the cancer information	N/A	For drafting of plan: Not possible at the moment. Possible solutions for the future: To extend the regional registries and the information regarding stage at diagnosis.

COUNTRY	Weaknesses in drafting of plan	Weaknesses in implementation	How were weaknesses dealt with?
Sweden	Financial constraints. Few innovative proposals in prevention, early detection and patient empowerment.	Some areas (psychosocial support, rehabilitation and palliative care, in particular) fragmented and of highly varying quality. Limited financial resources. Unequal distribution of manpower across the country.	N/A
England	A challenge during the drafting process was that the emerging structure of the new NHS was the subject of a consultation and so had not yet been finalized.	For implementation: It´s too early to say.	For drafting of plan: By engaging closely with the relevant policy leads.

N/A= not available

* This country doesn't have formal Cancer Plans but it carries out related activities

Table 23: CANCER PLANS: Results

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
Belgium	Since the first Plan was only adopted in 2008, it is too early to report any results regarding incidence or mortality. There is some doubt about the feasibility of measuring these results and attributing them to the launch of a Cancer Plan, as there is a substantial amount of confounding factors, which could also be held responsible for decreased incidence and mortality.	Yes, it has at least put cancer on the political agenda and created an increased awareness. Because a specific budget was allocated, we were able to implement most of the Plan. The actions were formulated in a specific way and with specific objectives, which led to implementation of actions with immediate impact on the working field (eg, funding of multidisciplinary teams in hospitals)
Cyprus	The cervical cancer campaign was so effective that we did have a decrease of the mortality from 11 (2005) to 6 (2009). An increase of Breast carcinomas in situ, due to our screening Programme is also an indicator of our success.	Firstly, it did bring all the stakeholders together and secondly it organised all actions that are already offered. It is the first organized action of the government in order to reduce the burden of cancer.
Czech Rep	Only in Breast Cancer screening program - included in Czech Cancer Care in numbers 2008-2009 – the last edition. See also www.svod.cz, web portal of cancer epidemiology.	Improvements observed to some extent in Breast cancer. Improvements: Quantitative results included in Czech Cancer Care in numbers 2008-2009 – the last edition. See also www.svod.cz, web portal of cancer epidemiology.
Denmark	The standardised cancer mortality rate has dropped 9 pct from 2000 to 2009. The standardised cancer incidence rate has risen 17 pct from 2000 to 2009. The drop in mortality rate cannot be specifically connected to initiatives in the cancer plans, but the cancer plans are definitely expected to have contributed to the fall in cancer mortality.	Efficient initiatives seems to have been put in place with the cancer plans. Examples of specific improvements include: - Introduction of fast track pathways. On going monitoring of the patients diagnosis and treatment times shows generally falling system delay. A status report from the Danish Regions from September 2010 states that the introduction of fast track pathways has been a success leading to among other a quicker and better coordinated diagnosis and treatment process for Danish cancer patients. - Introduction of a national screening programme for colorectal cancer with Cancer plan III – expected to save 150 lives a year - Introduction of smoking ban (national legislation) and non-smoking campaigns. There has been a drop in Danish every day smokers from 23 pct. to 20 pct. from December 2008 to December 2010.
Estonia	None available	The plan has been helpful in order to plan prevention actions incl. screenings systematically Improvements: Over the past 4 years, number of people participating in the screening has risen by 10%

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
Finland	None available yet	None available yet
France	The cancer plans are too new to have an impact on mortality.	Yes: permanent financing for screening, more tobacco control … But there is an improvement of the follow up of the plan and of its monitoring.
Germany	At this stage it is too early to see improvements in terms of the incidence, mortality of cancer etc. as a consequence of the current National Cancer Plan. However, German health policy has given the battle against cancer high priority for many years now. In recent years and decades, fundamental improvements and considerable progress have been made for the population in Germany: - in the area of primary prevention, through campaigns addressing known risk factors for cancer such as tobacco, alcohol, ultraviolet radiation, poor diet and lack of physical activity in the area of secondary prevention, through the ongoing development of early detection programmes by the health insurance funds - in providing better protection against environmental and occupational carcinogens, - with regard to the treatment of cancer, by continuing to develop better structures of oncological care (Model Programme by the Federal Government to improve the care of cancer patients: between 1981–-1990 the establishment of 24 tumour centres at universities and 34 departments of oncological specialisation at larger hospitals in the old Laender along with an additional 10 tumour centres and 12 departments of oncological specialisation in the new Federal Laender between 1991 and 1996), - in the area of oncological rehabilitation - in palliative medicine, where the Federal Government funds the establishment of palliative units to ensure comprehensive medical and psychosocial care of cancer patients, - in the field of cancer information for those affected by cancer, for example, through the Cancer Information Service (Krebsinformationsdienst Ger. abbr. = KID) at the German Cancer Research Centre (Deutsches Krebsforschungszentrum) in Heidelberg - in the establishment and/or expansion of cancer registries and, not least of all, - in the area of cancer research. With the introduction of disease management programmes (DMP), women with breast cancer	The rationale in initiating the National Cancer Plan was to coordinate more effectively the activities of all of those who are involved in combating cancer and to promote a more focussed approach. It has succeeded in convincing dedicated partners from the Laender, health insurance funds, and pension funds, as well as service providers, researchers and patient organizations to work together in a joint effort. At this stage it is too early to see improvements in terms of the incidence, mortality of cancer etc.

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
	now have access to evidence-based and quality assured breast cancer treatment and follow up care. DMPs have been well received by the insured parties. In addition, numerous measures were adopted during the process of reforming the statutory health insurance system, which now benefit cancer patients. Examples of these included - strengthening primary health care provided by General Practitioners, - introducing integrated care, - opening up hospitals for outpatient care, - improving access to off label drug use for out-patients covered by statutory insurance - strengthening outpatient palliative care - introducing quality assurance measures in outpatient and inpatient care - strengthening the area of health care research. These measures are complemented by a variety of initiatives and activities of scientific societies, self-help and patients' organisations — e.g. the current projects by the German Cancer Society and German Cancer Aid to further develop the oncological care structures and to promote the development of oncology guidelines. Due to the above activities in the areas of early detection, diagnosis and therapy, the survival rates and quality of life of cancer patients have improved considerably since the 1970s. According to the most recent report published by the Robert Koch Institute (for the reporting period 2005/ 2006) the relative 5-year survival rates (all registered cancer patients) are between 61 and 62 percent for women and between 54 and 57 percent for men. This represents a significant improvement compared to data from the 1980s with 5-year survival rates of 50 to 53 percent (women) and 38 to 40 percent (men), respectively. In line with this trend age-standardised cancer mortality rates have improved, too. Furthermore the survival rates of children suffering from cancer have increased considerably in recent years, too. While the 5-year survival rate of children suffering from cancer in the early 1980s was 67 percent, it is now 83 percent.	
Greece	None, as the national cancer plan has just been implemented.	N/A
Hungary	SDR, malignant neoplasms, 0,64, per 100000, male:	Given the extremely unfavourable conditions in Hungary compared to other countries, the launch of the Hungarian

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
	2006 2007 2008 2009 174.36 172.28 172.13 173.48 SDR, cancer of the cervix, 0,64, per 100000, male: 2006 2007 2008 2009 5.17 5.31 5.75 4.84 Cervix uteri cancer incidence per 100000: 2006 2007 2008 2009 21.46 21.40 20.77 19.76 Female breast cancer incidence per 100000: 2006 2007 2008 2009 139.33 128.88 135.30 138.26 (Source HFA Database)	National Cancer Control Plan the main was to halt the growth trend of tumour mortality. The programme is expected to establish a healthier environment in which the incidence of cancer will decline, a more humane, better-equipped care system that operates up to contemporary standards will evolve, and up-to-date diagnostics will promote quick and effective complex treatment. As a result an improvement in patient care, better quality of life for patients and their families, easier readjustment to family and society, a drop in mortality, and better care, support, and qualify of life for the terminally ill are certainly succeeded. In 2009 the model programme of colorectal screening started. For now 175 GP is involved who nearly done 20 000 screening on vulnerable-aged people. Health visitors could take a more active role in public health organization for cervical screening. They were involved in a cervical screening programme in 2009. The target population was the women between the ages of 25-65 from villages. In 2009, 110 volunteer health visitors were involved. The number of the target group was 30,717, the visitors could contact with 13,823 (45%) of them. But only 4,764 women's (34.5%) cervical smear tests were carried out.
Ireland	Estimates of Irish five-year relative survival rates show improvements in survival for almost all types of cancer diagnosed in the period 2002-2006, compared with people diagnosed in 1998-2001. While this is welcome, Irish survival rates for major cancers are currently below the OECD average.	As a result of the implementation of recommendations in the current cancer plan , A Strategy for Cancer Control in Ireland 2006, improvements have been brought about in a number of areas. These are listed below. It should be noted that the implementation of the current plan is not limited to these areas but they are set out as defined items. Screening Breast screening is now nationwide and is organised on a call/recall system. A woman can attend her GP for free cervical smear testing within an organised programme and have early cell changes detected and treated to prevent cancer developing. Likewise, when colorectal screening is introduced next year, it will prevent cancer developing in a significant number of those screened. Primary care The National Cancer Control Programmes's Community Oncology Programme aims to create capacity and knowledge within health professionals in the community to promote best practice in cancer control. GPs now use standardised

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
		referral forms for the common cancers, making the referral process more seamless, safer and more efficient. Education for primary care nurses to enhance their skills and knowledge in relation to both cancer treatment and prevention is underway. Acute cancer care The Strategy identified an evidence-based requirement for eight cancer centres in Ireland, each serving a population of around half a million. The Health Service Executive designated eight hospitals as these centres in 2007, two in each HSE Region. The Health Service Executive also designated one satellite centre. Breast cancer In June 2007, 33 hospitals were providing breast cancer services. Today, 100% of breast diagnosis and surgery in the public hospital system takes place in one of the eight cancer centres (or at one satellite centre). Women who are referred for investigation of possible breast cancer are seen within defined timelines. A high volume throughput, multidisciplinary care and enhanced and improved services at each centre are in place to ensure the best possible outcomes. Rectal cancer An audit of rectal cancer surgery showed that in 2007, 577 patients had rectal cancer surgery performed by a total of 86 surgeons in 41 hospitals. The number of hospitals providing this service is down to 13 and will reduce further over the coming year. The reduction in the number of surgeons and hospitals providing it ensures that the necessary volumes are maintained, to support best outcomes for patients. Pancreatic cancer Up until 2009 almost all pancreatic cancer surgery was being performed in six hospitals nationally. Hospitals on average were performing fewer than 20 surgical procedures each. By contrast, in 2010 more than 220 patients were seen at the new National Surgical Centre for Pancreatic Cancer. Ocular cancer Brachytherapy for the treatment of ocular cancer began in September 2010. Previously, patients could access this service only under the Treatment Abroad Scheme. Rapid access clinics for lung and prostate cancers Lung and prostate cancers are two of the most common cancers in Ireland. In order to improve access to early diagnosis and multidisciplinary decision-making for these cancers, Rapid Access Diagnostic Clinics for each have been established in most cancer centres. Rapid Access Prostate Clinics are established in six of the eight cancer centres, and Rapid Access Lung Clinics in seven. Patients who meet agreed criteria are fast-tracked to these clinics, ensuring they have better access to early diagnosis and multidisciplinary decision-making to improve outcomes. Radiation oncology New radiotherapy units have been completed, leading to an increase of 50% capacity in the Eastern Region, allowing more patients to access the service on a more rapid basis. The new units reflect the latest advances, equipment and expertise available internationally. They are daycase facilities, reflecting the fact that the majority of radiotherapy patients can access treatment on a daily basis rather than as inpatients.

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
Italy	We can report a trend in decreasing mortality for all cancer as well as reduction of incidence for several cancers. These good results are due to different factors and past cancer plans are part of them	No evaluation available yet.
Latvia	Please see on the most important figures of oncology in Latvian from 2001 until 2009, in the original documents	The implementation of the cancer plan has just started so it is too early to identify whether Oncologic Program has improved cancer prevention and control in Latvia. Provisional data illustrate that organized cancer screening helps to involve more people than opportunistic screening (that was before 2009 in Latvia).
Lithuania	Not enough data	Up to 70% breast cancer patients now are diagnosed in stage I –II disease, cancer in situ, increased number of early favourable prognosis prostate cancer patients, new treatment methods for the early diagnosed cancer (radiotherapeutic, chemotherapy, availability of targeted therapies).
Malta	No. The plan has just been launched.	Putting cancer on the national agenda
Netherlands	N/A	Yes (see the plan) Lessons learned: that the stage of many tumours at diagnoses became lower, but that the differences between regions. It should give other possible best practices more focussed on organisation of care than expertise. The main improvements we have are: implementation of psychosocial care and better translational research.
Norway	Mortality is down and survival (both short and long term) is up.	- More radiation capacity has been added - The number of hospitals operating cancer patients is reduced and now each of those hospitals are getting more experience - More diagnostic capacity has been added (CTs, MRIs, PET/CT-scanners) - The hospitals are now organized independent of the organization of counties and resources are better organized
Poland	Not yet	40.35 % coverage rate in breast cancer screening; 27% coverage rate in cervical cancer screening; 36,562 the number of colonoscopy tests; 4,841 the number of trained people
Portugal	No, the NCS is under evaluation	The say that they have improved their screening programs from opportunistic to monitorized/evaluated population-based programs; improved the cancer data and information (improved cancer registries and epidemiological surveillance); improved integrated treatment and care through multidisciplinary teams and guidelines for some pathologies. Established legislation for tobacco control. The impact of these measures cannot be assessed in such a short-term..

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
Romania	Partly.	40% Coverage with active cancer registries 20% Coverage screening for cervical cancer in north western region of Romania Due not sufficient coverage, piloting didn't have impact on incidence and mortality, but improved a lot the prevention by saving lives and by multiplying resources.
Slovenia	It is not yet possible as it was adopted in 2010	Significant achievements in tobacco control; All three screening programmes have been introduced; Cervical cancer screening programme has high coverage and good results regarding cancer incidence and mortality; Colorectal cancer screening programme after first cycle has more than 60% coverage.
Spain	Yes. See Volume 21 Supplement 3 Annals of Oncology	100% breast cancer screening 25% colorectal cancer screening 60% access to genetic counselling.
Sweden	Six regional cancer centres established. National cancer information website (interactive) established. First open comparisions (benchmarking) of the quality of cancer care in regions and hospitals published in 2011. No results in terms of burden of cancer yet available (implementation phase started in 2010).	Baseline data available on incidence, survival, patient-reported outcomes and quality of cancer care.
England	Yes, from previous Cancer Plans.	Survival The first results of the International Cancer Benchmarking Partnership published in December 2010, showed (for the latest available data up to 2007) that: - Since the introduction of the Cancer Plan in 2000, there has been a steady improvement in cancer survival in the four cancers (breast, bowel, lung and ovarian) in England. - However, survival in England remains lower than many of the other countries in the partnership. These differences - "the survival gap" – are greatest in the first year after diagnosis and for patients aged 65 and older. The patterns are consistent with late diagnosis and/or treatment, particularly in England (and Denmark), and among older patients. - In terms of breast cancer, five-year survival in England (and Denmark) has improved more than in the other four countries, rising in England from 74.8% in 1995-99 to 81.6% in 2005-7. The 5 year survival gap between England and

COUNTRY	Available results	Overall evaluation of effectiveness/improvements of cancer control
		the best performing countries (Australia, Canada and Sweden) has narrowed from around 10% for patients diagnosed in 1995-99 to 5% for those diagnosed in 2005-07. - Although survival in England has improved in colorectal and lung cancer, the gap in survival between ourselves and the best performing countries has remained consistent, with a slight narrowing of the survival gap in ovarian cancer. Mortality - Significant reductions in cancer mortality have been achieved among the under 75s, with the three-year average mortality rates for cancer reducing by 15.1% between 1998 and 2009 (October 2010 Mortality Monitoring Bulletin). - Cancer mortality in the under 65s has fallen in England in both males and females faster than the European average. The cancer mortality rate for males in this age group in England has fallen particularly fast, and is now amongst the lowest rates in the EU. Incidence - Latest figures show incidence rates per 100,000 population of 402.6 in males and 352.0 in females in England (Health Profile of England 2009, data from 2007). Since 2000, incidence in both males and females has been relatively stable.

N/A= not available