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CANCER SURVIVAL IN EUROPE CONTINUES TO IMPROVE, BUT UK STILL LAGGING BEHIND

Cancer survival in Europe is improving and wide variations in between-country survival differences might be on the verge of decreasing according to findings in two **Articles** from the EUROCARE group published **Online** this week, and in the September edition of *The Lancet Oncology*. However, cancer survival in the UK is still below the European average and similar to some eastern European countries that spend less than one third of the UK's per capita healthcare budget.

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At face value, these findings suggest that the NHS cancer plan is not working, and the UK faces challenging questions about the provision of oncology services if it is to close this gap, says an accompanying **Editorial**.

The EUROCARE collaborations are the largest international population-based analyses of survival of patients with cancer with data from 83 registries in 23 countries. According to previous EUROCARE studies reported in 1995, 1999, and 2003, survival varies greatly across Europe for both common and rare malignancies*.

In the first *Lancet Oncology* **Article**, Franco Berrino (Fondazione Istituto Nazionale dei Tumori, Milan, Italy) and colleagues report survival data for 2.7 million adult cancer patients for eight selected cancer sites**. Patients diagnosed in 1995–99 were compared with those diagnosed in 1990–94. The authors also analysed 5-year relative survival for all cancers combined, and compared findings according to countries' total national expenditure on health (TNEH).

The authors say that survival for the four most common cancers (colorectal, lung, breast, and prostate), and for ovarian cancer, was highest in Nordic countries (except Denmark) and central Europe, intermediate in southern Europe, lower in the UK and Ireland, and lowest in Eastern Europe. As expected, countries with higher TNEH generally had better all-cancer survival. However, the UK and Denmark had lower all-cancer survival than countries with

similar TNEH. By contrast, Finland had high all-cancer survival but only moderate health expenditure.

Importantly, all-cancer survival increased in countries where all-cancer survival was low in the previous time period, resulting in a narrowing of between-country survival differences. The findings suggest a substantial improvement in cancer care in countries with poor survival. However, the authors conclude that despite these improvements, differences in survival for individual cancers between countries and regions in Europe remain: “If all countries attained the mean survival (57%) of Norway, Sweden, and Finland (countries with high survival and medium-to-high TNEH), about 12% fewer cancer deaths (about 150 000) would occur in the five years after diagnosis”.

In the second **Article**, Arduino Verdecchia (Istituto Superiore di Santità, Rome, Italy) and colleagues estimate survival of patients diagnosed more recently in 2000–02 by country and cancer site, assess survival changes in Europe, and compare findings with data on cancer survival in the USA for patients diagnosed in the same time period^{***}. The authors noted that overall survival has improved for all cancers and for the major cancer sites. Survival for patients diagnosed in 2000–02 was generally highest in northern Europe (especially in Sweden) and lowest in eastern Europe (the Czech Republic and Poland)—although patients in eastern Europe had the largest improvement in survival, and, as a consequence, the gap between eastern European survival and other European areas is decreasing. For all cancers, 5-year period survival improved for patients diagnosed in 2000–02.

For patients diagnosed in 2000–02, survival for patients with solid tumours was lower in Europe than that reported for patients from the USA. 5-year survival in the USA for all cancers combined was 66·3% in men and 62·9% in women; both these percentages were significantly higher than those for Europe—47·3% for men and 55·8% for women. The authors claim that the differences in survival are due to a variety of reasons including factors relating to cancer services (eg, organisation, training and skills of health-care professionals, application of evidence-based guidelines), and clinical factors (eg, tumour stage and biology).

The authors conclude: “Currently, in the EU, the organisation of cancer services is the sole responsibility of member states. Sharing the dividends of successful national cancer plans between European policymakers, and in the long-term, developing a pan-European cancer plan could assist in the adoption of modern diagnostic and treatment facilities and the establishment of evidence-based clinical practice in all European countries”.

In an accompanying **Comment**, the UK cancer Tsar Mike Richards, welcomes the EUROCARE-4 studies and news of improvements in cancer survival, but emphasises that “the findings also show that many more lives could be saved if the outcomes in all countries were brought up to the standards of the best countries”. According to Richards, of particular importance is

the conclusion that poor results from the UK reported in the previous EURO CARE studies are attributable mainly to patients having more advanced disease at diagnosis, and that this “indicates that particular emphasis should be put on achieving earlier diagnosis”.

The accompanying [Editorial](#) poses a number of questions and challenges to the UK government in light of the EURO CARE study results and concludes: “the answers are likely to lead to a fundamental reassessment of the ways in which the NHS operates...such as divorcing the NHS from political control and short-term political gains”.

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Note to Editors

*These variations can be explained by differences in the quality of cancer-treatment facilities, in screening programmes, in evidence-based best-practice guidelines, and in access to new anticancer drugs.

** The eight sites—breast, colorectal, lung, melanoma, ovary, prostate, testis, and Hodgkin’s disease were selected because they are common or are major and potentially curable diseases.

***From the US SEER (Surveillance, Epidemiology, and End Results) programme.