

## Possible Impact of a European Agency for the Strategic Management Against Cancer (EASMAC) on Treatment, Diagnosis and EU Politics

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### 1. Abstract

Each European Union (EU) country has its own therapeutic and diagnostic protocols for cancer treatment, contrary to the USA. In order to achieve a therapeutic and follow-up harmonization, the existence of a central EU agency can be of paramount importance. The aim of the current paper is to present the (still in paper) European Agency for the Strategic Management Against Cancer (EASMAC) and its possible impact on cancer patient treatment and diagnosis and EU politics in general.

### 2. Introduction

Each year 13% of deaths have cancer as their cause [1], making it the leading cause of mortality in the western world [2]. Actually, in 2012 this translated in 1.270.000 deaths among the 28 European Union (EU) member states [3]. Besides the high cancer-related mortality, other identified factors contributing to this high rate are, among others: differences amongst the countries in the way that cancer is treated [4], social [5-7] and economic [8] patient conditions, cancer research fragmentation [9], etc...

Five-year survival for all cancer types ranges from 55% in Europe to 68% in the United States of America (US), with approximately the same chances of all cancer types occurring in the two areas [3, 10]. Thus, given that about 2,600,000 people are diagnosed with cancer each year in Europe [2], about 1,430,000 of them will survive for at least five years [3], while if they were treated in the US 388,000 more would make it [10].

This article will try to explain the reasons behind this big difference between the EU and US and propose a possible solution, but not

without long-term societal and political consequences.

### 3. Differences Among us and EU

African Americans and Hispanics in US are known to have higher cancer mortality than Caucasians [11]. According to the relevant official authorities, the percentage of Caucasians in the two regions is different, being clearly higher in Europe [12]. Thus, if the race of the local population was responsible for the above difference, it should be reversed and "in favor" of the Europeans.

In terms of lifestyle, red meat consumption in the US is about 50% higher than in Europe [13], percentage of smokers is about the same [14], as is "adequate" daily exercise [15], while the number of overweight people is about 13% higher in the US [16]. So, if way of life was to be blamed for this difference, it should again be inverted and "in favor" of the Europeans.

There is no doubt that there are great socio-economic differences between residents of different US states and there also exist large differences within the states themselves. In fact, US tops the list of countries with the most socio-economic inequalities. This is, however, also partly true for Europe, where not only the member countries are significantly different [17], but there are also very large socio-economic differences by region within the countries themselves, with the more classic example being between Southern and Northern Italy (difference greater than 50% - [18]). So socioeconomic data do not seem responsible for the difference in five-year survival between US and Europe.

On a political level, although the US health care system is considered liberal and generally lacks significant state influence (lack of a

“real” NHS) [19], the National Cancer Institute (NCI) was created in 1937 and is still under the roof of the Federal National Institute of Health [20]. In 1906 the Federal Food and Drug Administration (FDA) was created [21] and “War on Cancer” was “declared” by President Nixon in 1971 [22], a political “bet” that was renewed several times, most recently by President Obama. Thus, there is a clear US Cancer Health Policy, led by the NCI and the FDA [23], which shapes various forms of cancer treatment through:

- the approval of new anticancer drugs and treatments at a federal level; and
- information, through centrally conducted research by the NCI's National Clinical Trials Network (NCTN), on the most appropriate and up-to-date treatments ([24] as an example). On the contrary, one could in general argue that neither a harmonized evidence based treatment [25-29] nor ways of following-up “survivors” [30] exist within the EU, where the Health System in all countries is national [31] and the Lisbon Treaty of 2007 leaves Health management to the member countries [32]. This means that there is no Pan-European Cancer Health Policy in the same sense as in the US, but rather a nationally [33], regionally [34], in-hospital [35] or doctor [36] decided treatment, depending on the country. This treatment choice freedom (a paradox for state-controlled health systems – contrary to the relative lack of freedom in US, despite the liberality of the system) allows health practitioners to maybe choose treatments schemes that are not necessarily based on well-documented, published scientific knowledge, as they are usually based on treating physician personal experience, alleged expertise and/or old practices. It is characteristic that the word “doctor” in German and Dutch is “artz” and “arts” respectively, implying that practicing medicine is (also) an art, greatly increasing the social position of doctors, but also the distance between “good” and “bad” doctors, something not common in US society [37]. So, the lack of a central, Pan-European control mechanism seems to be of paramount importance and could (partially) explain the observed five-year survival difference between US and EU.

Last but not least, according to the European Agency for Nuclear Medicine, although there are large differences in the number of Positron Emission Tomographies in Europe per million inhabitants [38], the average is close to the US one [39]. Respectively, the number of other cancer diagnostic methods is comparable [40]. What really differs between EU and US is the number of therapeutic devices, such as linear accelerators used in Radiotherapy: although the number of linear accelerators in Germany and US was comparable in 1987 (3.13 and 3.97 respectively, excluding East Germany), this ceased to be valid in just 5-6 years (4.6 in Germany, always excluding ex-East Germany, and 10.3 in the

US in 1993). Similar differences are observed in the number of oncology clinics and beds, which is clearly “in favor” of US [41]. Thus, the large number of therapeutic (but not diagnostic) devices, even with a partially “erroneous” geographical distribution (non-ideal accessibility – [42;43]), may also partly justify the difference in five-year survival between US and the EU.

#### 4. Proposal and Possible Future Implications

In order to achieve harmonization in cancer prevention, diagnosis, treatment and follow-up, a central authority, such as a new EU Agency, with recognized and unquestionable executive and legislative power, can be of paramount importance. This new Agency should also be based on Strategic Management [44], a way of managerial thinking that has already been implemented successfully many times in Health in general [45-49] and cancer management in particular [50-53].

This future European Agency for the Strategic Management Against Cancer (EASMAC) should have the following missions:

- a) Enhance cancer prevention,
- b) Harmonize cancer diagnosis, treatment and follow-up methods, based on evidence based medicine,
- c) Ensure the viability of social security systems and health insurances, by providing adequate reimbursement for cancer related medical acts described under (b),
- d) Manage EU's financial support for cancer research and reduction of access inequalities,
- e) Improve the (social, professional and economic) living conditions of “survivors” and
- f) Promote international collaboration.

EU creation in itself is based on the feeling maintained even today by the “average” citizen of its member states, who “wants to live in harmony with all other Europeans in a wider and common political-economic-social context”, as various studies of the European Commission have already proven via the “Eurobarometer” [54]. Of course, this unification has not yet taken place, as each Member State still retains full control on most sectors. Nevertheless, the voices in favor of full unification are beginning to grow and, in fact, expand to “significant” figures for the EU, such as the leader of the Liberal MEPs [55], the French Ex-President François Hollande [56] and many others [57]. Last but not least, the European Atomic Energy Community (Euratom [www.euratom.org/]) is already an EU body that enjoys full legislative power and acts like a Pan-European “Supra-ministry”.

Seemingly in contrast with the Lisbon treaty, the EU created in 2007 the European Partnership for Action Against Cancer (EPAAC) [http://www.epaac.eu] and some Members of the European Parliament (MEPs) created a “team” named Members of the

European Parliament Against Cancer – MAC [58]. EPAAC ceased its operation, as predicted, in February 2014 with "Comprehensive Cancer Control Joint Action – (CanCon)" being its successor [59], which in its turn was completed in 2017. EASMAC, although in apparent contradiction with the Lisbon Treaty, would just be the natural continuation of CanCon and would additionally lead the way not only for improving cancer treatment, but also for unifying EU.

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