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REPORT

on breast cancer in the European Union
(2002/2279(INI))

Committee on Women's Rights and Equal Opportunities

Rapporteur: Karin Jöns

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PROCEDURAL PAGE

At the sitting of 13 February 2003 the President of Parliament announced that the Committee on Women's Rights and Equal Opportunities had been authorised to draw up an own-initiative report, pursuant to Rule 163 of the Rules of Procedure, on breast cancer.

The Committee on Women's Rights and Equal Opportunities had appointed Karin Jöns rapporteur at its meeting of 26 November 2002.

The committee considered the draft report at its meetings of 19 February, 18 March and 24 April 2003.

At the last meeting it adopted the motion for a resolution by 16 votes to 0, with 2 abstentions.

The following were present for the vote: Helena Torres Marques, acting chairman; Karin Jöns, rapporteur; Ulla Maija Aaltonen, María Antonia Avilés Perea, Regina Bastos, Armonia Bordes, Lone Dybkjær, Fiorella Ghilardotti, Koldo Gorostiaga Atxalandabaso, Lissy Gröner, María Izquierdo Rojo (for María Rodríguez Ramos), Hans Karlsson, Rodi Kratsa-Tsagaropoulou, Maria Martens, Ria G.H.C. Oomen-Ruijten (for Miet Smet), Christa Prets, Olle Schmidt (for Marieke Sanders-ten Holte) and María Sornosa Martínez (for Elena Valenciano Martínez-Orozco).

The report was tabled on 7 May 2003.

EUROPEAN PARLIAMENT MOTION FOR A RESOLUTION

on breast cancer in the European Union (2002/2279(INI))

The European Parliament,

- having regard to Article 152 of the EC Treaty in the version as amended by the Treaty of Nice,
- having regard to Article 35 of the Charter of Fundamental Rights of the European Union¹,
- having regard to its resolution of 9 March 1999 on the Commission communication on the state of women's health in the European Community²,
- having regard to its resolution of 13 February 2003 on the Commission communication on Community and national measures in relation to breast implants³,
- having regard to its resolution of 4 October 2001 on the patenting of BRCA1 and BRCA2 breast cancer genes⁴,
- having regard to its resolution of 15 January 2003 on the Commission communication on the future of health care and care for the elderly⁵,
- having regard to the Community action plan to combat cancer adopted by Decision No 646/96/EC of the European Parliament and of the Council ('Europe against Cancer')⁶ which was extended by Decision No 521/2001 of the European Parliament and of the Council⁷,
- having regard to Decision No 1786/2002/EC of the European Parliament and of the Council on a programme of Community action in the field of public health (2003-2008)⁸,
- having regard to Decision No 1513/2002/EC of the European Parliament and of the Council concerning the sixth framework programme of the European Community for research, technological development and demonstration activities contributing to the creation of the European Research Area and to innovation (2002-2006)⁹,
- having regard to Directive 2001/20/EC of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical

¹ OJ C 364, 18.12.2000, p.1.

² OJ C 175, 21.6.1999, p. 68.

³ P5-TAPROV(2003)0063.

⁴ OJ C 87 E, 11.4.2002, p. 263.

⁵ P5-TAPROV(2003)0015.

⁶ OJ L 95, 16.4.1996, p. 9.

⁷ OJ L 79, 17.03.2001, p. 1.

⁸ OJ L 271, 9.10.2002, p. 1.

⁹ OJ L 232, 29.8.2002, p. 1.

trials on medicinal products for human use¹,

- having regard to Charter of Paris Against Cancer, adopted on 4 February 2000 at the first World Summit Against Cancer,
 - having regard to the ‘European Guidelines for Quality Assurance in Mammography Screening’²,
 - having regard to the recommendations of the European Society of Mastology (EUSOMA) set out in ‘The requirements of a specialist breast unit’³,
 - having regard to the ‘Recommendations on cancer screening in the European Union’ of the Advisory Committee on Cancer Prevention⁴,
 - having regard to Rule 163 of its Rules of Procedure,
 - having regard to the report of the Committee on Women's Rights and Equal Opportunities (A5-0159/2003),
- A. whereas Article 152 of the EC Treaty lays down that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities and that Community action, which shall complement national policies, shall be directed towards preventing major health scourges, such as cancer, by promoting research into their causes and their prevention, as well as health information and education,
- B. whereas, in 2000, the World Health Organisation reported more than 216 000 newly diagnosed cases of breast cancer and 79 000 deaths from breast cancer in women, whereas breast cancer is the most frequent cancer affecting women, with one woman in nine suffering from the disease, and whereas breast cancer is the most frequent cause of death in women between the ages of 35 and 55 in the European Union,
- C. whereas the Charter of Fundamental Rights of the European Union recognises that everyone has the right of access to preventive health care and the right to benefit from medical treatment,
- D. whereas every woman, irrespective of place of residence, social status, occupation and education, should have access to high-quality screening for, treatment of and aftercare in the event of cancer, but whereas huge disparities exist in the quality of breast cancer services and, hence, in the chances of survival of women in the various Member States, the regions and even between individual hospitals in a given city,
- E. whereas the 1999 Eurocare Study demonstrated in the various Member States unacceptable disparities by up to 16% in the survival rates of breast cancer patients which

¹ OJ L 121, 1.5.2001, p. 34.

² In 2001, the European Commission published the third edition of this European Breast Cancer Network publication.

³ Published in the European Journal of Cancer 36 (2000) 2288-2293.

⁴ Published in the European Journal of Cancer, 36 (2000) 1473-1478.

were attributed, inter alia, to disparities in access to screening, diagnosis and treatment¹,

- F. whereas research has not yet developed effective measures for the prevention of breast cancer or for curing the disease irrespective of the diagnosis stage, and whereas up to 90% of breast cancer patients may be cured if diagnosed and correctly treated at an early stage,
- G. whereas the Community programme entitled 'Europe Against Cancer' has given a significant boost to the fight against breast cancer, with the 'European Guidelines for Quality Assurance in Mammography Screening', which were originally drawn up in 1992, setting a good example for quality standards and best practice in European health policy,
- H. whereas, according to the World Health Organisation, high-quality mammography screening, i.e. regular invitations to women to undergo free, voluntary mammographies and follow-up diagnoses as part of an organised population-based regional or national programme, can reduce breast-cancer mortality in women aged between 50 and 69 by up to 35% and whereas, according to scientific studies, breast-cancer mortality in women aged between 40 and 49 can also be reduced by up to 20%,
- I. whereas women with breast implants must be offered ultrasound screening, since they are more difficult to screen,
- J. whereas breast self-examination is a valuable tool for increasing women's self-awareness of health, although it may never constitute an alternative to early diagnosis based on screening, and whereas the WHO has also concluded that there is still insufficient evidence that clinical breast examination or self-examination reduces mortality from breast cancer,
- K. whereas clinical examination of the breast constitutes an important tool for the early detection of carcinomas in the interval between two screenings and in the case of women who, because of their age, are not entitled to take part in organised screening programmes,
- L. whereas early detection, diagnosis, treatment and aftercare of breast cancer should be performed only by a multidisciplinary team of fully trained physicians, since that may significantly increase the survival rates of the women involved,
- M. whereas high-quality breast cancer services may lead to savings for health care systems in the medium and long term, with unnecessary examinations and treatment being avoided and mammary cancer detected at an earlier stage and, therefore, requiring less expensive operations and aftercare,
- N. whereas the highest possible quality of life must be achieved for patients, since the treatment of breast cancer involves substantial physical and psychological burdens,
- O. whereas breast cancer patients should be adequately informed by the attending physician about their diagnosis and treatment and should be involved in decisions about therapy options, while also being made aware of any possible side-effects,

¹ Survival of adult cancer patients in Europe diagnosed from 1978-1989: The Eurocare II study, European Journal of Cancer, Vol. 34, No 14.

- P. whereas not all Member States have yet adopted a specific regulation on patients' rights, which means that the relevant rights are currently far from transparent for patients,
1. Calls on the Member States and on the European Commission to make the fight against breast cancer a health policy priority and to develop and implement effective strategies for improved preventive health care: screening, diagnosis, treatment and aftercare in order to achieve the highest quality breast-cancer treatment throughout Europe;
 2. Calls on the Member States to set themselves the target of creating, by 2008, the conditions required for a 25% reduction in the average breast-cancer mortality rate in the EU and of reducing to 5% the disparity between the Member States in the five-year survival rate;
 3. Is dismayed to note that, to date, only eight of the 15 Member States have taken measures based on the 'European Guidelines for Quality Assurance in Mammography Screening' to introduce nation-wide screening programmes; calls, therefore, on the Member States to offer, at the earliest possible opportunity, mammographies at two-year intervals to all women between the ages of 50 and at least 69, with the following quality criteria being observed in a population-based programme where voluntary participation in the programme achieves a participation rate of over 70%:
 - screening shall take place in dedicated and certified units, or in fixed or mobile units under the authority of such centres, with the assessment of cases with suspicious results also being carried out by a multidisciplinary team in dedicated units,
 - each mammogram shall be read independently and double-blind by two radiologists, each of whom reads the screening mammograms of a minimum of 5 000 women per year,
 - the image quality and radiation dose of the screening equipment shall be monitored regularly; the development process should also be checked,
 - physicians and paramedical staff shall regularly attend further training courses;
 4. Calls for the presence in screening programmes of equipment for ultrasound screening for women with breast implants which inhibit the penetration of x-rays;
 5. Calls for all women suffering from breast cancer to be entitled to be treated by an multidisciplinary team and calls on the Member States, therefore, to establish a network of certified multidisciplinary breast centres which cover the entire population and fulfil the following criteria:
 - each breast centre shall perform a minimum of 150 primary breast cancer operations per year,
 - each breast centre shall operate under the direction of a highly qualified physician who specialises in breast disease, while the multidisciplinary team shall consist of physicians experienced in and performing only breast surgery, together with radiologists, oncologists, pathologists, nurses and radiographers who also specialise in breast disease, as well as a data manager,
 - multidisciplinary pre-operative and post-operative case conferences shall be held at least once a week,
 - the quality of the results shall be guaranteed by means of clinical research,

- physicians and paramedical staff shall regularly attend further training courses,
 - physicians and paramedical staff shall be required to pass a test at regular intervals to show that they have sufficient up-to-date knowledge and skills,
 - follow-up and aftercare examinations shall be carried out in close cooperation with the relevant multidisciplinary breast centre,
 - patients shall receive onco-psychological counselling, psychotherapeutic support and physiotherapy services, as well as social services;
6. Welcomes the allocation of EUR 400 million for cancer research in the sixth framework programme of research and calls on the Commission and the Member States to:
- (a) ensure more effective coordination between national and European research,
 - (b) ensure that evidence-based medicine also constitutes the basis for breast cancer treatment in Europe,
 - (c) incorporate the positive findings of fundamental research into treatment as soon as possible and further strengthen clinical research, in particular the clinical trials coordinated by the European Organisation for Research and Treatment of Cancer (EORTC) and conducted in cancer centres and clinics across the European Union,
 - (d) provide more funding than in the past for breast cancer research in order to:
 - step up the search for the causes of the disease and for forms of therapy,
 - improve prediction of the effect of treatment and certainty of outcomes,
 - further investigate the relationship between breast cancer and potential risk factors such as tobacco, diet, hormones and life-style (body weight, physical activity),
 - increase research into in-patient and out-patient treatment protocols, with a view to reducing the unnecessary burden on patients of clinical and medical treatment services,
 - develop a method for the standardised risk assessment of women potentially in danger of developing a hereditary breast disease;

7. Calls on the Member States, within the limits of their powers and responsibilities, to:
- (a) comply with the WHO recommendation and, with the involvement of all the major actors concerned, draw up national action plans against cancer,
 - (b) develop and continuously update further evidence-based guidelines on breast-cancer screening, diagnosis, treatment and aftercare, establish a national breast-cancer coordination office and ensure the implementation of the guidelines by means of a transparent auditing process,
 - (c) protect the psychological well-being and physical integrity of women by ensuring that:
 - every woman is informed of the results of a clinical examination and of a screening examination within five working days and that no woman who has been diagnosed as suffering from breast cancer needs to wait more than four weeks before treatment begins,
 - in order to reduce the number of breast amputations, breast-conserving surgery is available to every woman in every instance where it is medically justified and that, wherever possible, breast reconstruction operations are performed using the patient's own tissue and within the shortest possible time,
 - every woman receives a reliable pre-operation diagnosis (in particular through minimal invasive biopsy),
 - women who have received breast implants are issued with a patient's pass which includes an indication of the specific features and requisite post-operative aftercare measures,
 - (d) ensure that the cost of any supplementary aids, such as wigs and bra prostheses and lymphatic drains in follow-up care, is reimbursed,
 - (e) expand medical specialisation schemes leading to qualifications, for example, as breast surgeon, breast cancer nurse or onco-psychologist which have already proved their worth in some Member States, by setting up appropriate training and further training facilities,
 - (f) set up establishments for the medical and psychological counselling of women with a presumed risk of hereditary breast cancer and offer an intensified screening programme for women whose test results are positive,
 - (g) adopt a specific regulation on individual patients' rights, giving patients the following rights:
 - the right to appropriate and qualified medical care provided by qualified medical staff in suitably equipped and organised practices and hospitals,
 - the right to easily understandable, expert and appropriate information and advice from the physician, before, during and after treatment,
 - the right to self-determination based on full information,
 - the right to treatment records and to inspection thereof,
 - the right to confidentiality and data protection,
 - the right to lodge a complaint,

- the right to a second medical opinion in the case of cancer,
 - (h) involve patients' organisations in health-policy decisions more heavily than in the past and support their activities in an appropriate manner,
 - (i) improve data compilation and, at the earliest possible opportunity, set up national cancer registers which meet the standards set by the European Network of Cancer Registries, so that the EU may finally have available informative and comparable European data about the development of cancer and breast cancer;
8. Calls on the European Commission to:
- (a) promote in an appropriate manner, in the future as well, the innovative projects, such as the European Breast Cancer Network, the European Network of Cancer Registries and the European Prospective Investigation into Cancer and Nutrition (EPIC) network, set up on the basis of the earlier Europe Against Cancer programme which formed part of the programme of Community action in the field of public health (2003-2008),
 - (b) combine the current activities of the Directorates-General for Health, Research and the Information Society and create a common EU website on cancer on which individual citizens and lay persons, as well as medical experts and research workers, may find information about cancer variously compiled by European and national research workers, medical societies and patients' organisations, etc., written in easily comprehensible terms and in various languages,
 - (c) come forward at short notice with a proposal for a Council recommendation on cancer screening based on the 'Recommendations on cancer screening in the European Union' of the Advisory Committee on Cancer Prevention which emphasises an organised and consistent approach to cancer screening (breast cancer, cervical cancer, colorectal cancer and prostate cancer); considers that a Europe-wide coordinated approach is essential in order to prevent inefficient, low-quality and opportunistic screening; urges the European Parliament to be involved in this process;
9. Emphasises the importance of clinical studies for medical progress; welcomes the adoption of Directive 2001/20/EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use; believes that the requirements of research bodies should be taken into account when the relevant implementing provisions are being drafted, that the objective of the harmonisation of the legal and regulatory arrangements for clinical research will not be attained and that the current obstacles to clinical studies involving several Member States will not be eliminated;
10. Calls on the Member States with Objective 1 regions to allocate more Structural Fund resources to financing investment in the healthcare system in view of the significant regional disparities in access to early detection, diagnosis and treatment of breast cancer;

11. Reiterates its concern at the possible consequences of the granting by the European Patent Office of patents on BRC AC 1 and BRC A2 ('breast cancer') genes; calls on the EPO to reconsider the patenting of these genes and calls on the Council, the Commission and the Member States to ensure that the human genetic code is freely available for research throughout the world and that medical applications of certain human genes are not impeded by monopolies based on patents;
12. Calls on the Commission to organise a conference, jointly with the Italian Presidency in late 2003, when the final projects are coming to an end, in order to draw up a final summary of the successes and failures of the 'Europe Against Cancer' programme, partly with a view to the new action programme in the field of public health (2003-2008);
13. Is concerned at the comparatively poor survival rates for women suffering from breast cancer in the accession countries, calls on the accession countries to step up their efforts to fight breast cancer and calls on the Commission to arrange a structured exchange of experience with the future Member States;
14. Calls on the Commission, jointly with the Member States, to draw up, in time for the spring 2006 summit, a report on the measures taken by the Member States and, in the light of the progress achieved, to take a decision on further steps in the fight against breast cancer;
15. Instructs its President to forward this resolution to the Council and Commission and to the parliaments of the Member States.

EXPLANATORY STATEMENT

1. General information about breast cancer

1.1. Breast cancer in the European Union

Since the end of the Second World War, the number of new cases of breast cancer in women (breast-cancer incidence) has been increasing world wide. Today, breast cancer is the most common disease affecting women in the European Union. According to statistics from the World Health Organisation's International Agency for Research on Cancer (IARC), more than 216 000 women were suffering from breast cancer in the EU in 2000, and more than 79 000 women died from the disease¹. Breast cancer is the most common cause of death in women between the ages of 35 and 55.

World wide, every industrialised nation, except Japan, has a high incidence rate, but there are large disparities in such rates among the individual countries. In Europe, the regions in western and northern Europe have the highest incidence rates, while countries in southern and eastern Europe have lower incidence rates. The risk of developing breast cancer is 60% higher in western Europe than in eastern Europe. In 2000, the Member States with the highest incidence rates² (morbidity per 100 000 women) were the Netherlands (91.6), Denmark (86.2), France (83.2), Belgium (82.2) and Sweden (81), while other Member States such as Greece (47.6) and Spain (47.9) and applicant countries such as Lithuania (39.8) and Latvia (42.2) had much lower rates. In most of the Member States and applicant countries, the number of new cases of breast cancer is increasing annually by about 1.5 %.

To some extent, the disparities in the current EU, whereby women in the countries of western and northern Europe are almost twice as likely to develop breast cancer as those in southern Europe, may be ascribed to certain risk factors connected with the respective socio-economic development of the country involved. Experts therefore designate breast cancer as an 'affluence disease'. Disparities resulting from socio-economic factors may also be found within individual countries: women living in urban regions suffer more frequently from breast cancer than women from rural areas. What is more, breast cancer is found more frequently among women of high social status.

1.2. Stage reached in research: Origins of breast cancer and risk factors

Breast cancer is a very complex disease, the causes of which have, to date, been inadequately clarified. As a rule, women in whose family cases of breast cancer have occurred have a genetically-related higher risk of developing breast cancer. However, more than 80% of women diagnosed as suffering from breast cancer are the first in their family to do so. It is currently assumed that about 5% of breast cancer cases are caused by inherited conditions. To date, two defective genes (BRCA 1 and BRCA 2) have been identified as causing breast cancer.

¹ For figures and risk factors, see: Tyczynski J E, Bray F, Parkin D M: 'Breast Cancer in Europe', ENCR fact sheets of the International Agency for Research on Cancer, Vol. 2, December 2002.

² GLOBOCAN 2000: Cancer Incidence, Mortality and Prevalence Worldwide, Version 1.0. Internet: <http://www-dep.iarc.fr/globocan/globocan.html>.

Scientifically proven risk factors for breast cancer, apart from increasing age, are reproductive and hormonal factors. Women who began menstruating very early, who gave birth to their first child late in life or remained childless are at greater risk. That also applies to women who entered the menopause comparatively late. Experts suspect a connection between breast cancer and oestrogen, i.e. the longer the exposure to oestrogen, the higher the risk. There may well be a slightly higher risk caused by hormones introduced into the body from outside (contraceptive pill/Hormone Replacement Therapy), especially if this occurs over a fairly lengthy period of time.

Life-styles also influence the risk of developing breast cancer. Women who become overweight in the post-menopausal period run a significantly higher risk. It has also been proved that a lack of physical activity and regular consumption of alcohol increases the risk. On the other hand, no connection has been proved between breast cancer and diet. The same applies to the consumption of tobacco. There is still no scientific evidence to prove the belief that has been going the rounds for decades that breastfeeding reduces the risk of cancer.

1.3. Trends in probable survival rates

In the EU, the 1950s and 1960s were marked by an increase in the number of deaths from breast cancer. In the 1970s and 1980s, some western European countries in the EU (e.g. DK, NL, S and UK) recorded stationary or falling mortality rates, although the number of deaths from breast cancer rose in the countries of southern and eastern Europe.

The stability of the mortality rate despite the increase in new cases of the disease may be explained by the higher probable survival rates of women suffering from breast cancer. From the late 1970s to the late 1980s, according to the WHO, the five-year survival rate in Europe as a whole increased from 65.8 % (1978-1980) to 74.3 % (1987-1989). It is, however, very difficult to quantify survival rates with any accuracy, since not all countries have established national cancer registers. Furthermore, the quality of those that have been established is very variable. The most comprehensive study on survival rates in the cancer patients is the Eurocare II Study published in 1999¹, which investigated more than 3.5 million male and female patients from 17 countries between 1985 and 1989. The five-year survival rate of women suffering from breast cancer varied between 81% (S and F) and 58% (PL and Slovakia). The authors of the study ascribed this disparity primarily to differences in access to and quality of breast-cancer treatment.

In recent years, studies in Italy, the Netherlands, Sweden and the United Kingdom have proved that, as a result of improved screening and treatment of young and middle-aged women, mortality rates could be reduced by more than a quarter. According to the studies, permanent improvements could be made to probable survival rates in other European countries as well through better screening, specialised training of surgeons in diseases of the breast, and the introduction of the latest scientifically recognised pharmaceutical forms of therapy (chemotherapy, hormone treatment).

¹ Survival of adult cancer patients in Europe diagnosed from 1978-1989: The Eurocare II Study. EJC Vol. 34, No 14.

2. Europe Against Cancer

In 1987, the European Community introduced the first action plan 'Europe Against Cancer' (1987-89). That was followed by two further action programmes (1990-94, 1996-2002). The aim was a 15% reduction in mortality rates from cancer compared to 1987. The programme's priorities were: improved quality control with regard to screening, exchanges of experience with regard to best practice, and the standardisation and compilation of comparable health data, as well as progress in health education and studies into prevention.

2.1. Drawing up of the 'European Guidelines for Quality Assurance in Mammography Screening' by the European Breast Cancer Network

As a result of the first 'Europe Against Cancer' action plan, the Breast Cancer Screening Network was set up in 1990 in order to extend mammography screening throughout Europe, with common recommendations being drawn up on the basis of exchanges of experience among national experts. In 1992, the network submitted the 'European Guidelines for Quality Assurance in Mammography Screening', which resulted in technically improved mammography equipment and progress in quality control. At the same time, a European Association of Reference Centres for Mammography Screening was set up. Subsequently, the network concentrated on further developing the European Guidelines and assisted with their transposition in some of the Member States. In addition to screening as such, it has recently been investigating how multidisciplinary breast centres may guarantee an optimum follow-up diagnosis of suspicious cases discovered during screening examinations, as well as high-quality treatment for women actually suffering from breast cancer. This extension of its activities is reflected in the network's new name: since 2000, it has been known as the European Breast Cancer Network (EBCN).

The 'European Guidelines for Quality Assurance in Mammography Screening' are among the most successful projects in the action programme on health policy. They serve as a model for the drawing up of European quality standards and best practice. Their success is also demonstrated by the fact that the third edition of the 2001 Guidelines is among the ten best selling EU publications. By now, the Guidelines have become the foremost reference document, inside and outside the EU, for ensuring the quality of screening programmes. Given this success, the Commission is planning to submit, in the first half of 2003, a proposal for a Council recommendation on other screening procedures relating to cancer.

In October 2000, a vigorous scientific dispute broke out in the wake of a study by Gøtzsche and Olsen¹ on the reliability of previous studies on mammography screening. That dispute has been deemed to be settled since a WHO (IARC) Conference held in March 2002. It is now scientifically proved that mammography screening carried out in compliance with quality standards like the European Guidelines contributes to a reduction in breast cancer mortality rates of up to 33% in women aged between 50 and 69.

¹ Gøtzsche PC and Olsen O.: Is screening for breast cancer with mammography justifiable?, Lancet 2000, 355, 129-134.

2.2. Transposition of the Guidelines by the Member States

Since the European Guidelines for Mammography Screening constitute simply recommendations and are not binding, it is for the Member States to transpose them into national legislation. That process has shown that their introduction was easier in countries which had uniformly organised health systems at national level than in those where the system was more decentralised. The availability of a high-quality cancer register was also useful, since such registers not only include up-to-date data on the incidence of breast cancer and mortality but also provide an initial opportunity for the monitoring and assessment of the screening programmes.

At present, the national mammography screening programmes are very different as regards the way in which they are organised, transposed and implemented. Currently, just eight of the 15 Member States (B, FIN, F, UK, IRL, LUX, NL and S) have a national mammography screening programme, and, even then, the European guidelines are not always respected. On the other hand, Italy, Austria and Spain currently have no more than regional programmes; although national programmes have been introduced in Denmark and Portugal, they are not yet operating throughout those countries. Pilot projects designed to lead to the introduction of national programmes have been launched in Germany and Greece.

In most countries, women aged between 50 and 69 are invited to undergo screening as part of the national programme. In Sweden, Portugal and Greece, women are invited for such tests when they reach 40. The percentage of women actually screened in the corresponding age group varies from between just 2 per cent in Germany to close to 100 per cent in Finland, the United Kingdom, Luxembourg, the Netherlands and Sweden. The participation rate, which constitutes an indicator for the acceptance of the screening programmes, ranges from between less than 30 per cent in Belgium to 89 per cent in Finland¹. The higher the participation rate in mass examinations, the more women's lives may be saved. The interval between examinations ranges from one and half to three years.

The introduction of mammography screening programmes in accordance with EU guidelines has highlighted the need for multidisciplinary cooperation in the fight against breast cancer. Follow-up diagnosis to clear up any suspect cases is carried out by multidisciplinary teams in screening centres.

3. Treatment of breast cancer in the Member States

3.1. Breast centres

In 2000, the European Society for Mastology (EUSOMA) published a document entitled 'The Requirements of a Specialist Breast Unit'², according to which one breast centre should be provided for every 330 000 inhabitants. That would imply the provision of 1 250 centres throughout the EU in order to guarantee quality throughout the treatment chain relating to breast cancer. According to estimates, there are currently in the EU no more than about 250 such breast centres, and in only four Member States (DK, UK, P and S) do they cover the

¹ IARC Handbooks on Cancer Prevention (Vol. 7): Breast Cancer Screening, IARC, Lyon 2002.

² European Journal of Cancer 2000, 36, 2288-2293.

entire country. Studies show that women treated in breast centres enjoy a better quality of life and receive better treatment. Their chances of survival are higher than those of women not treated in such centres. The decisive factor is that the medical team in a breast centre should work on an multidisciplinary basis and specialise solely in diseases of the breast. Since breast centres are currently springing up like mushrooms, without meeting the requisite quality criteria, it is a matter of urgency that European criteria for breast centres should be developed.

3.2. Cancer register

In order to acquire reliable data concerning the screening and treatment of breast cancer, country-wide cancer registers should be compiled on the basis of uniform criteria, and the data contained therein should be forwarded to the European Network for Cancer Registries (ENCR), set up in 1989 and supported by the European Commission, so that EU-wide comparable data become available. Currently, no more than 47% of the population of the EU is covered by cancer registers. Only eight Member States (DK, FIN, UK, IRL, NL, A, P and S) have national cancer registers. Five Member States (B, D, F, I and ES) have regional cancer registers.

3.3. Aftercare

EUSOMA also proposes that aftercare should be available in specialised breast centres so that the combined expertise acquired may be used for the benefit of the patients. In addition, patients should also be offered psychological support and physiotherapy services, such support and services to be paid for by the health insurance scheme. That also applies to supplementary medical aids such as wigs and bra prostheses. Such aids are not reimbursed, for example, in Italy and Spain. In the United Kingdom and in Italy, the entire cost of even a medically required lymphatic drain must be borne by the patient; in Denmark, the patient must bear part of the cost thereof.

4. Future prospects – current challenges

If we are to achieve optimum quality in the entire treatment chain relating to breast cancer, since, in that way, even today, 50 per cent of all deaths could be prevented, we require as a matter of urgency:

- coordination of national policies and a demonstration of best practice in the treatment of breast cancer;
- further development of the EU guidelines on mammography screening;
- guidelines to be drawn up by the EBCN for multidisciplinary breast centres;
- more intensive research into the prevention of breast cancer;
- the compilation of further national cancer registers in accordance with uniform ENCR criteria.