COMMISSION OF THE EUROPEAN COMMUNITIES

COM(85) 628 final

Brussels, 14 November 1985

Proposal for a

COUNCIL RESOLUTION

on a programme of action of the European Communities on cancer prevention

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(submitted to the Council by the Commission)

COM(85) 628 final

EXPLANATORY MEMORANDUM

In September 1984, the Commission submitted a Communication to the Council on Co-operation at Community Level on Health Related Problems*). This identified, inter alia, the public health problem of diseases due to smoking and observed that a total of more than one million deaths from lung cancer will occur in the Community before the year 2000. Co-operation to agree on common objectives and to support the actions of Member States was advocated.

The European Council in Milan, June 1985, approved the proposals of the ad-hoc Committee on a People's Europe which invite the Ministers of Health to give appropriate follow-up to this Communication.

The European Council also accepted the suggestions along the same lines contained in the French Memorandum on a People's Europe, emphasizing the section on health and the value of launching a European action programme against cancer. The memorandum identified the areas of basic research, prevention and therapy and observed that by focussing on the five most lethal forms of cancer, deaths from the disease could be reduced by 10-15%. In the area of prevention specific reference was made to smoking and the early detection of cancer in women.

This proposal has been formulated in the light of these conclusions. It is concerned with the area of cancer prevention. Complementary actions in areas research and development will be contained in the proposal for a Council Decision adopting the fourth medical and public health research programme (1987-89) to be submitted in early 1986.

A description of the nature and extent of the problem of cancer, together with a statement of the aims and objectives of the programme are given in the Annex. It is proposed that actions should be directed towards dietary factors, smoking, screening and early detection, health education and improved epidemiological monitoring and information. Collaboration with international and national organizations in the field should be fostered.

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*) COM(84) 502 final

PROPOSAL FOR A COUNCIL RESOLUTION ON A PROGRAMME OF ACTION OF THE EUROPEAN COMMUNITIES ON CANCER PREVENTION

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II

(Preparatory Acts)

COMMISSION

Proposal for a Council Resolution on a programme of action of the European Communities on cancer prevention

COM(85) 628 final

(Submitted by the Commission to the Council on 18 November 1985)

(85/C 336/09)

ß THE COUNCIL OF THE EUROPEAN COMMUNITIES

Having regard to the Treaties establishing the European Communities,

Having regard to the draft submitted by the Commission,

Having regard to the opinion of the European Parliament,

Having regard to the opinion of the Economic and Social Committee,

Whereas, under Article 2 of the Treaty establishing the European Economic Community, the Community shall have in particular as its task, by establishing a common market and progressively approximating the economic policies of Member States, to promote throughout the Community a harmonious developing of economic activities, a continuous and balanced expansion and an accelerated raising of the standard of living;

Whereas the European Council in Milan on 28-29 June 1985 emphasized the value of launching a European action programme against cancer;

Whereas this European Council approved the proposals of the *ad hoc* Committee on a Peoples' Europe calling for appropriate follow-up to the Commission's communication on cooperation at Community level on health problems;

Whereas various Community actions to prevent cancers arising from exposure to ionizing radiation or exposure to chemical carcinogens are already being carried out under the Euratom Treaty and the Treaty establishing the European Economic Community;

Whereas actions to reduce the risk of cancer from exposure to carcinogenic substances are included in a number of existing Community programmes on the environment, worker protection, consumer protection, nutrition, agriculture and the internal market;

Whereas the present programme should increase knowledge about the causes of the cancer and the possible means of preventing and treating it;

Whereas by ensuring a wider dissimination of knowledge about the causes, prevention and treatment of cancer, and an improvement in the comparability of information about those matters, in particular concerning the nature and degree of risk of cancer arising from exposure to given substances or processes, the programme will contribute to the achievement of Community objectives, in particular the removal on non-tariff barriers to trade, while contributing to the overall reduction of risk of cancer;

Whereas research into cancer and the carcinogenic effects of physical and chemical agents is undertaken in a number of Community research programmes;

Whereas the coordination of national research activities relating to the early detection and treatment of cancer will form part of the proposal for a Council Decision adopting the fourth medical and public health research programme of the European Economic Community (1987-1989) to be submitted in early 1986,

Whereas cooperation with international and national organizations carrying out work in this field will ensure a wider dissemination of knowledge about cancer and assist in avoiding duplication of effort;

HEREBY ADOPTS THIS RESOLUTION:

1. *The Council hereby identifies the following objectives:*

   i) to halt the increase of cancer in the Community leading to a downward trend in both incidence and mortality from the disease,

ii) to decrease the potential years of life lost from cancer.

2. *The Council, approving the Action programme of the European Communities on Cancer Prevention as proposed by the Commission and annexed to the present resolution, adopts the following priority actions:*

i) Development of a nutritional strategy, including alcohol, to complement existing actions at Community level in the fields of food production and consumer protection.

ii) Development of a strategy against cigarette smoking with coordination and support of national programmes and actions.

iii) Development of guidelines for the allocation of resources to preventive and therapeutic services.

iv) Improvement in the availability and comparability of epidemiological data on cancer.

v) Development of programmes of health education for cancer prevention and treatment.

vi) Collaboration with international and national organizations in the field covered by these actions.

3. *The Council, noting those actions relating to cancer prevention already undertaken at Community level, expresses the necessity for them to be strengthened and coordinated with the actions established by the present programme.*

4. *The Council hereby invites the Commission to submit a proposal or the setting up of a Committee to assist the Commission in the preparation and implementation of this programme.*

ANNEX

ACTION PROGRAMME OF THE EUROPEAN COMMUNITIES ON CANCER PREVENTION

1. **Introduction**

1.1. Cancer may appear either as local solid tumours or as systemic diseases such as the various types of leukaemia. The characteristic feature of all cancers is that some cells of the human body are altered in such a way that they divide and proliferate independently of the normal controlled growth. They are further characterized by the fact that the cancer cells may spread throughout the body. The spread of the tumour locally or to other parts of the body will inevitably lead to death if left untreated.

1.2. Most cancers take several years to develop and some cancers are easily curable whereas others are almost always incurable by the time they are clinically diagnosed, depending largely on the organ of the body (lung, intestine, etc.) in which the first altered cells originate. The low rate of success in the treatment of certain cancers, for example lung cancer, underlines the importance of a strategy of prevention.

1.3. Cancer is second to cardiovascular diseases in causing most deaths annually in the Community. In approximate terms, one million people develop cancer each year and 500 000 die from it. All forms of cancer account for some 25 % of deaths.

1.4. Another way of quantifying the impact of cancer on the health of the population is to calculate the potential years of life lost due to premature deaths from the disease. This indicator is essentially designed to give a broad view of the relative importance of the various major causes of premature mortality. The figures show that death from all forms of cancer before age 70 contributes up to 20 % of the total.

1.5. In the past 40 years the total incidence of cancer has been increasing. Concealed within this rising trend, the incidence of some cancers has increased markedly (lung, bladder, kidney) and some have decreased (stomach, oesophagus).

1.6. It is now recognized that the common fatal cancers occur in large part as a result of personal, social and environmental factors. These include exposure to natural and man-made carcinogens, nutritional deficiencies or excesses, infections, reproductive activities and a variety of other factors determined wholly or partly by personal behaviour. In principle, therefore, these cancers are largely preventable.

1.7. The variations noted in the incidence of various cancers in recent years serve to underline the fact that the agents or habits which greatly increase or decrease the likelihood of developing one particular type of cancer may have little effect on other types of cancer, so that the prevention of each type must be considered separately.

1.8. The objective of definitive treatment is to destroy the altered cells by surgical removal, chemotherapy or radiotherapy. The main parameter for measuring the success of treatment is the proportion of patients surviving for 5 years after treatment. For some cancers this proportion is small, i.e. approximately 5 % for lung cancer; for other cancers the figure is greater, i.e. approximately 50 % for bladder cancer. There is considerable variability in the figures for 5 year survival both between and within Member States.

1.9. In general the earlier a cancer is diagnosed, the more successful treatment is likely to prove. However, as commented previously many cancers are beyond the scope of definitive treatment by the time they have caused signs or symptoms of their presence leading to diagnosis.

1.10. These reasons have led to much effort in recent years to develop and evaluate screening and diagnostic methods for the early detection of cancers. For two cancers in particular (cervix, breast) there is evidence that population screening is effective in reducing mortality. For cancer of the large intestine the evidence suggests that there might be a similar benefit; by contrast, for cancer of the lung there is evidence that population screening by mass X-ray examinations does not reduce mortality.

1.11. The increasing number of cancer patients, the development of new diagnostic techniques and treatment regimes, and the development of programmes of population screening have all contributed to greater demands on available health care resources. It is not unreasonable to predict that these demands will continue to escalate.

1.12. The nature of the disease, the results of treatment and the increasing load on treatment services support the case for a strategy of prevention or avoidance. In determining this strategy due consideration must be given to recent published analyses which show that of the various classes of factors involved, approximately one third of all cancer deaths can be attributed to diet, including alcohol, one third can be attributed to cigarette smoking, and the remaining third to a variety of factors amongst which the most notable are infection, reproductive and sexual behaviour, and occupation.

2. Recent Community Actions and Activities Related to Cancer Prevention

2.1. Activities at Community level have been undertaken to identify carcinogenic agents (both chemical and physical) and to prevent exposure of the public and workers to such agents. These have been contained in a number of different Community programmes, for example, elimination of technical barriers to trade, environment, occupational safety and health, consumer protection, and agriculture.

2.2. Community research programmes have provided support for these activities. Close cooperation has been maintained with the World Health Organization and the International Agency for Research on Cancer.

2.3. Protection of the population and workers against the long-term effects (cancer) of ionizing radiation is embodied in the Euratom Treaty. Since 1959, Directives have been adopted to limit exposure of the population and the workers. Recently a Directive was adopted to reduce the possible carcinogenic risk of medical X-rays.

2.4. Community legislation on chemical carcinogens under Article 100 EEC covers labelling, prohibition of use, prohibition or limitation of discharge and limitation of exposure. The principle of labelling carcinogenic compounds was established by a Directive in 1979 and practical guidelines defined in 1983. Simultaneously the obligation to test new chemicals for their carcinogenic potential was also introduced.

2.5. The possibility exists of prohibiting or limiting the use of specific compounds and preparations. For example, the placing on the market and use of crocidolite, blue asbestos, was proscribed by a Directive of 1983. Similarly, in the field of cosmetic products and food additives, lists have been established prohibiting the use of carcinogens as food additives or their introduction into cosmetic preparations. Lists have been established of toxic chemicals, including carcinogens, the discharge of which in the aquatic environment is prohibited or strictly limited.

2.6. For worker protection Directives limit exposure to vinyl chloride and asbestos and a proposal has been made for a Directive proscribing certain dangerous (carcinogenic) substances. In a broader sense, the Directive of 1982 under Article 100 EEC on major accident hazards of certain industrial activities aimed at protecting the workers and the population contains a list of 178 substances and classes of substances, including carcinogens.

2.7. This outline of actions at Community level in various sectors might suggest that chemical carcinogens are easily identified. This is not correct and it is important that at Community level the same scientific evidence and conclusions are used as a basis for all actions. The Scientific Advisory Committee to examine the toxicity and ecotoxicity of chemical compounds, set up by the Commission in 1978, has undertaken at the request of the Commission to provide such scientific opinions. In the framework of the Action Programme on Toxicology for Health Protection, submitted to the Council in 1984, it is proposed to enhance and accelerate the work of the Committee in this field. To avoid duplication of work and to ensure that all information on carcinogenicity is available to the Commission, close contacts are maintained with international and national institutes and agencies.

3. **Aims and objectives of the present programme**

3.1. The first aim of the programme is to contribute to an improvement of the health and quality of life of the citizens within the Community by the prevention of cancers.

3.2. The objectives of the programme are:

(i) to halt the increase of cancer in the Community leading to a downard trend in both incidence and mortality from the disease,

(ii) to decrease the potential years of life lost from cancer,

(iii) to establish health strategies for those factors to which cancer is attributed,

(iv) to improve the data available on cancer incidence and mortality and the data for epidemiological studies for monitoring the health of specific groups of the population and for identifying new or unforeseen risk factors for cancer,

(v) to facilitate cooperation at Community level and exchange of information relating to programmes for population screening and treatment in order to improve their performance,

(vi) to collaborate with international and national organizations in the field of cancer prevention to the attainment of these objectives and the application of the results of cancer research.

3.3. A second aim of this programme is to provide a setting in which existing actions and future initiatives in the field of prevention can be made more coherent.

4. **Initiatives to be taken at Community level**

4.1. Attainment of these objectives requires many initiatives involving the health care professions, educators and administrators. Such initiatives presuppose the effective participation of individuals in managing their own health. In broad terms the prevention or avoidance of cancer can only be brought about by means that are socially and personally acceptable.

4.2. It has, therefore, to be appreciated that the timescale for many of the actions has to be long. The nature of the problems and the actions to be taken mitigate against any short-term impact on the morbidity and mortality experience of the population.

4.3. The following areas will be addressed:

(i) Development of a nutritional strategy, including alcohol, to complement existing actions at Community level in the fields of food production and consumer protection,

(ii) Development of a strategy against cigarette-smoking with coordination and support of national programmes and actions,

(iii) Development of guidelines for the allocation of resources to preventive and therapeutic services,

(iv) Development of the date base for the evaluation of preventive services and the identification of new or unforeseen risk factors for cancer,

(v) Development of programmes of health education for cancer prevention and treatment,

(vi) Collaboration with international organizations active in the field.

5. **Nutrition**

5.1. There is strong but indirect evidence that many of the common cancers could be made less so by suitable modification of national dietary habits. Diet is implicated in cancer of the stomach and large intestine as well as of the body, of the uterus and gallbladder. Diet may also prove to have a material effect on the incidence of cancers of the breast and pancreas, and, perhaps through the anti-carcinogenic effects of various micronutrients on the incidence of cancers in many other tissues.

5.2. There are many mechanisms by which diet may operate to promote cancer. Carcinogens may be present in foodstuffs as naturally occurring substances or may be introduced by cooking or contamination. The constituents of the diet influence digestion and excretion. Micronutrients may be deficient. And lastly excessive calorie intake and obesity are associated with an increase in cancer risk.

5.3. Alcohol is also implicated in cause of cancers of the mouth, pharynx and oesophagus, and there is evidence that alcohol consumption sufficient to cause liver disease will also increase the incidence of liver cancer. Of particular importance, however, is the potential rôle of alcohol in enhancing the effect of other agents. For example, it would seem that alcohol interacts with tobacco to produce a greater effect than either factor acting independently.

5.4. Nutritional policies in Member States have mainly been concerned with an adequate total intake of calories and essential nutriments. Currently there is a growing concern over the constituents of diet causing or contributing to disease patterns in the population, not only cancer but also cardio-vascular disease, for example.

5.5. It is, therefore, becoming necessary for the Community to identify dietary objectives for, inter alia, cancer prevention. The Commission will review the development of national policies in this area and their impact on dietary consumption and disease. The Commission will make periodic reports and recommendations.

6. **Tobacco**

6.1. No single measure is known that would have as great an impact on the number of deaths attributable to cancer as a reduction in the use of tobacco or a change to less dangerous use. Cigarette-smoking is the principal single factor causing lung cancer and cancers of the mouth, pharynx, oesophagus, pancreas and bladder.

6.2. The contribution of cigarette-smoking to mortality from cancer is now widely acknowledged and all Member States have initiated one or more anti-smoking measures. These various measures lack coherence both within and between Member States.

6.3. It is a matter of urgency to establish a common strategy to reduce the toll of smoking related diseases. To this end the Commission will assess the impact of measures already taken by Member States with a view to proposing harmonization of suitable regulatory provisions and coordination of supporting actions.

7. **Services for screening and early diagnosis**

7.1. Population screening or case-finding for cancers of the cervix and breast are now established activities within Member States, although the stage of development of facilities and the geographical distribution varies. New procedures are under evaluation and there is a continuing and increasing pressure on those responsible to enhance the services available.

7.2. To improve the use of resources within Member States there should be an exchange of information on service development and evaluation.

7.3. The Commission proposes to establish a cleaning-house for this exchange, to undertake a series of studies on the cost-effectiveness of different approaches within national settings, and to prepare periodic reports on the utilization and impact of such preventive services.

8. **Mortality and morbidity data**

8.1. In 1979, a group of scientists and doctors from 8 Member States initiated studies to compare data from death certificates to examine possible hazards related to occupation and the environment, including factors concerned with cancer. It was concluded that the data were not strictly comparable due to systematic differences. These findings only served to underline the difficulties of making cross-national comparisons and the caution necessary in interpreting apparent differences in mortality rates between even neighbouring countries.

8.2. A second inquiry demonstrated that only in a minority of Member States was it possible, even with considerable difficulty, to undertake follow-up studies of groups of workers exposed to particular hazards in order to discover any long-term risks particularly cancer. In practice the large majority of such studies has been undertaken in only two Member States.

8.3. Work in progress is revealing that systems of cancer registration will not, with the present degree of coverage and data comparability, provide the means necessary for monitoring potential cancer hazards, particularly those hazards of a specific or limited nature.

8.4. It is necessary, therefore, to improve systems for the recording of vital statistics and cancer registration and to allow the means for individual records to be accurately and completely collated.

8.5. To this end the Commission will undertake consultations with the responsible agencies in Member States to achieve a better comparability and use of data for identifying factors causing cancer and influencing its treatment.

8.6. The Commission will seek to establish at Community level a common understanding regarding the protection of medical data on individuals.

9. **Health education**

9.1. Health education is the corner-stone of any programme against cancer directed towards the population. Health education is necessary to produce the climate of social acceptability for the measures involved and to influence the behaviour of individuals in modifying habits and lifestyles. It is fundamental to the proper use of health care resources. Health education indirectly influences the political process by helping to determine the needs and demands of the population.

9.2. All Member States have health education programmes with some or all of these aims. However, the extent, nature and content, and penetration of these vary greatly. There is virtually no programme coordination between Member States and as a result confusion may arise. Programme effectiveness has often been questioned, although the bases of many past evaluative studie have been wrong, incomplete or the timing has been inappropriate.

9.3. Increasing spread of media productions will require a greater coherence of actions in the field of health education with the opportunity for saving in cost if material can be jointly developed and shared.

9.4. Health education is a collective activity involving individuals, parents and group leaders with teachers, health care workers and media professionals. As an educational activity its needs are not different from the mainstream of education and the actions implemented in this field, namely exchange, closer relations, information and training with the identification of common understanding.

9.5. The Commission, therefore, will sponsor a series of collaborative ventures, joint projects and workshops to improve the cost-effectiveness of health education resources.

10. **International collaboration**

10.1. Many organizations are active in the field of cancer, the principal ones being the World Health Organization and the International Agency for Research on Cancer. Close collaboration has already been established, for example in the fields of toxicology, protection against dangerous substances and workers' health.

10.2. In 1984, the Regional Committee for Europe endorsed a document on 'Regional Targets in Support of the Regional Strategy for Health for All by the Year 2000'. One target specifically relates to cancer and proposes a reduction in mortality of 15% mainly as a consequenceof a reduction in smoking. Cancer is subsumed under a number of other targets.

10.3. This programme would seek to support WHO and IARC goals by coordinating the efforts of Member States in working towards the stated objectives.

10.4. In a similar manner the Commission has established collaboration with other international organizations, e.g. the International Union for Health Education, European Organization for Cooperation in Cancer Prevention Studies, European School of Oncology and with national organizations.

10.5. The Commission will maintain and develop this collaboration, placing emphasis on joint activities and, thereby, avoiding unnecessary duplication and improving the use of scarce resources.

COMMISSION OF THE EUROPEAN COMMUNITIES

FINANCIAL STATEMENT

APPLIES TO THE EN VERSIONS

COM(85) 628 final/2

Brussels, 29 November 1985

Proposal for a

COUNCIL RESOLUTION

on a programme of action of the European Communities on cancer prevention

(submitted to the Council by the Commission)

COM-628/2

FINANCIAL STATEMENT

1) Budget heading :

Chapter 64 : Programme of action on cancer prevention

2) Legal basis :

Article 2 of the Treaty

3) Proposal for classification under compulsory/non-compulsory expenditure:

Non-compulsory

4) Description and justification of project

The programme is aimed at

a) halting the increase of cancer in the Community leading to a downward trend in both incidence and mortality from the disease

b) decreasing the potential years of life lost from cancer.

With this aim in view in order to seek to avoid duplication of efforts, the following actions are planned initially :

- Development of a nutritional strategy, including alcohol, to complement existing actions at Community level in the fields of food production and consumer protection.

- Development of a strategy against cigarette smoking with co-ordination and support of national programmes and actions.

- Development of guidelines for the allocation of resources to preventive and therapeutic services.

- Improvement of availability and comparability of epidemiological data.

- Development of programmes of health education for cancer prevention and treatment.

At the same time the ongoing activities already undertaken at Community level should be strengthened and collaboration with international organizations active in this field reinforced.

5) Type of expenditure and method of calculation

Expenses for studies, training courses, experts and consultants, related meetings and secretarial expenses, missions and subsidies, informatics, publications and the purchase of scientific works and periodicals are charged against this item.

Method of calculation for the first year :

- travel and other expenses for meetings, conferences, seminars and missions	80 000
- experts', consultants', study fees and pilot projects	400 000
- subsidies, secretarial expenses and informatics	100 000
- publications and purchase of scientific works	70 000
	650 000

The distribution of the expenses will be similar for the following years, with an increase in the percentage devoted to :
- experts', consultants', and study fees and pilot projects.

6) Financial implications for intervention appropriations :

6.1 Initially the programme is to last five years. Following preparatory work in the first year, it should become fully operationa in

the third year. It is foreseen that the first year will be essentially devoted to establishing the basis for the various actions, international cooperation and specific activities regarding cigarette smoking and health education.

In the second year these activities will be continued and activities regarding preventive and therapeutic services as well as the comparability of cancer data will be added. In the third year work on the development of a nutritional policy will be also undertaken and all these activities will continue subsequently. The annual budget will take into account changes due to reorientations of the programme on the basis of research findings, and will be established in accordance with the budgetary procedure to a maximum of:

	CE (ECU)	CP (ECU)
1st year	650 000	650 000
2nd year	1 000 000	1 000 000
3rd year	1 400 000	1 400 000
4th year	1 550 000	1 550 000
5th year	1 700 000	1 700 000
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	6 300 000	6 300 000

6.2 Proportion (%) financed from the Community budget : 100%

7) Remarks : Nil

8) Financial implications for staff and current administrative appropriations :

Staff working exclusively on the project : 3 A, 1 B, 2 C