Priorities for cancer control in Spain

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Spanish cancer strategy is being developed in the context of a decentralised health care system. The advantages and challenges posed by this system are reviewed, particularly vis-à-vis the need to build consensus among regional health services as regards priorities in cancer control. Analysis of the impact of cancer in Spain enables smoking prevention and obesity reduction to be highlighted, especially among adolescents, as targets for primary prevention. Two-yearly colorectal cancer screening using the faecal occult blood test and targeting persons aged 50–69 years is a new goal that should be pursued countrywide, as should population-based breast cancer screening. Insofar as health care is concerned, the focus is on promoting and consolidating multidisciplinary cancer care based on evidence-based clinical guidelines, and on ensuring that cancer patients enjoy prompt access to diagnosis and therapy. Psychosocial support, with experience gained in several health services, should be expanded. Palliative care must be consolidated as a necessary therapy for patients who require it. Finally, the important boost to cancer research witnessed in recent years should be sustained. The approach adopted is based on building a co-operative strategy among all of Spain’s autonomous regions (Comunidades Autónomas), which must then apply the interventions in their respective health services. A shared understanding of the main priorities for cancer control, through a review of the evidence and a consensus embracing all stakeholders, including scientific societies and patients’ associations, is an essential step in the implementation of cancer strategy in Spain.

Introduction

The impact of and recent trends in cancer in Spain analysed in the preceding articles provide the necessary background for setting priorities to cope with the challenge posed by cancer in Spain. The lessons learnt from this analysis should be applied to the objectives of the cancer strategy pursued by the national health system. The goal of the strategy 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 Organisation’s approach to cancer control [1]. Spanish Cancer Strategy has been developed with the aim of encompassing cancer in its entirety, ranging from prevention and screening to diagnosis and treatment, as well as psychosocial aspects and palliative therapy.

This article affords an overview of the main consequences of the results discussed in the previous articles, and the priorities set for the health system. First, however, a brief explanation of the specific organisational features of Spain’s National Health Service is required in order to better understand the part played by the different stakeholders involved in its development.

Building a Co-operative Strategy in a Decentralised Health System

Health care in Spain is organised as a National Health System (NHS) [2], with universal coverage for all Spanish citizens. Provision of health care is free of charge at the point of delivery. Yet, the most relevant feature of the organisation of health care in Spain is the fact that it is highly decentralised with responsibility being delegated to the health authorities in the country’s 17 autonomous regions (ARs) (Comunidades Autónomas). These regional health authorities have the power to plan and organise their health services, with the Ministry of Health retaining a co-ordinating role and responsibility in some key areas, such as basic legislation and the package of benefits covered by the health service across Spain. The NHS Interterritorial Council, which is made up of the heads of the respective regional health authorities and representatives from the Ministry of Health, decides upon governance issues affecting the whole system. This Council resolved to set up a nationwide cancer strategy, taking into account the cancer plans implemented at a regional level, as in Catalonia, Andalusia and Valencia.

The main challenge confronting this cancer strategy is how to go about building a co-operative process across such a decentralised health system. The technical aspect has been addressed by a committee, which included representatives from...
The main features of Spanish cancer data on incidence, survival and mortality trends, changes in risk factors and screening, all of which are relevant for setting priorities in cancer control, provide an insight into the significant changes observed in Spain from the 1970s onwards. The best example is afforded by the changing trends in prevalence of smoking for males and females during these years, with a decrease among males from the 1980s until now accompanied by an increase among females, which was seen to have slowed to a halt in the most recent survey. It should be noted that the prevalence observed for males during these years has not been matched by females [5, 6]. This, coupled with the known fact that young females in Spain began smoking after the 1960s, may account for the increase in lung cancer incidence observed among women in recent years [7]. As a consequence, smoking prevention is a key priority in this country but should be implemented by taking into account the markedly different pattern of behaviour between the genders.

Another clear example of changes in risk factors is the increase in the prevalence of obesity, which has registered a trend that should be considered in preventive strategies. There are also positive data, however, such as the decline in excessive alcohol consumption and physical inactivity. Nevertheless, the higher prevalence of obesity observed in several age groups is a cause for concern, due to the magnitude of the change to be achieved, a goal shared by all non-communicable disease preventive strategies.

Insofar as cancer incidence is concerned, the overall picture shows that this is still rising for several of the cancers analysed. In the case of smoking-related cancers, specifically lung and bladder cancer among males rather than females, the increase observed from 1975 onwards, which subsequently slowed down in the 1990s, was remarkable. Starting from very low rates, there has been a marked increase in lung cancer among females, a finding consistent with the spread of the smoking epidemic in Spain [6].

While stomach cancer has decreased across the sexes [8], there has been a clear and strong increase in colorectal cancer, which has been more moderate among women and in recent years for both sexes [9]. In contrast, this tumour plots a different trend for mortality, which has been declining from 1995. A possible explanation for these divergent trends may lie in improved access to diagnostic endoscopies and, by extension, to early diagnosis. Similarly interesting is the levelling-off seen in non-Hodgkin’s lymphoma after the marked rise registered up to 1995, probably related to the changes observed in the AIDS epidemic in Spain [10].

Prostate cancer is also displaying a dramatic increase, with an annual percentage change of 7.3% from 1990, with mortality remaining stable or declining from the mid-1990s onwards [11]. The impact of opportunistic prostate-specific antigen (PSA) screening is clearly the most reasonable explanation for these combined trends, something that is having strong repercussions on health services, such as radiotherapy, in Spain. Indeed, the recently published results of US and European trials have shown the impact of early detection in terms of overdiagnosis [12], which is a very relevant side-effect. Health policy recommendations in Spain have not supported screening in this cancer, though many primary- and specialised-care physicians routinely perform this on their patients, with the observed consequences. It is obvious that a better understanding among physicians and patients of the advantages and disadvantages of PSA testing is called for.

Whereas population-based screening was progressively implemented for breast cancer in all Spanish regions from the early 1990s, opportunistic screening was the strategy selected to cope with cervical cancer [4]. The results of these two strategies have had a different impact on trends in incidence and mortality. Although the cervical cancer incidence rate has always been among the lowest in Europe, and this has been the ground for deciding against a population-based strategy for this cancer anywhere in Spain (a remarkable consensus in itself), the direct consequence of this is that the change observed is moderate in terms of what could have been achieved if another approach had been selected [13]. Note should be taken of the change observed in breast cancer incidence and mortality trends which could be attributable to the extension of screening to the respective regions [14]. Here is a lesson to be learnt when implementing colorectal cancer screening in the coming years.

Finally, the observed trends in and projections for cancer incidence in the immediate future indicate that the impact of cancer is still growing in this country. The positive messages are that mortality is decreasing both overall and for most of the individual tumour types [15], and that survival has been increasing over the period in all the cancer registries involved in the EUROCAN project [16]. As can be easily inferred from the
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Objectives should be restricted to evidence-based consensus. The technical committee described data quality. The key issue is how to build a sustainable infrastructure to assess is yet another challenge owing to the risk of uneven quality control. However, Spain’s cancer strategy has to be set nationwide in order to cope with the challenge posed by cancer in this country. The priority is to establish a comprehensive approach to cancer regionally and nationally, as the best policy option to cope with the challenge posed by cancer in this country. Spain’s cancer strategy has to overcome the problem of first having to set nationwide priorities, which must then be agreed upon and implemented at a regional health service level. Precisely how this strategy is to be assessed is yet another challenge owing to the risk of uneven data quality. The key issue is how to build a sustainable infrastructure. The technical committee described above is where this process takes place. It was decided that the objectives should be restricted to <20, which could then be individually assessed using purpose-designed indicators based on data collected independently by health surveys or clinical audits of the health records of samples of patients in the respective regions. The framework of the cancer strategy addressed different levels of intervention, i.e. primary prevention, screening, cancer care, psychosocial aspects, palliative care and research, and the priorities for intervention were organised accordingly [3].

Smoking prevention, targeting younger males and females in particular and aimed at avoiding subjects’ initiation into the habit and boosting smoking cessation, is the most relevant action in Spain. To implement this type of intervention, gender should be taken into account. Legislation to prevent passive smokers’ exposure to smoke has not been overly strict in public places, such as restaurants, and consequently its impact has been limited, thereby posing a risk to workers in such places. Furthermore, compliance has been a problem [18].

Strengthening and enforcing these regulations should thus be a priority.

Other goals in primary prevention are to increase physical exercise and reduce obesity, especially among the younger age groups. The promotion of a healthy diet in this cohort is a priority. Despite the fact that recent surveys indicate that dietary habits are not worsening, it should not be forgotten that long-term retrospective data have shown a reduction in the consumption of the classic components of the Mediterranean diet [19]. Other objectives linked to messages contained in the European Code Against Cancer which are pertinent here, are prevention of excessive exposure to the sun [20]. In addition, human papillomavirus vaccination is being administered to girls aged 12–14 years (with the specific age being left to each regional health authority to decide), as part of the public immunisation schedule.

The most relevant change has been the decision to implement colorectal cancer screening in Spain, in large part due to the impact of this cancer. The projected age range of the target population is 50–69 years, with screening being conducted biennially using the faecal occult blood test. Following a pilot scheme using the guaiac test [21], all programmes at regional level are moving to immunoassay as their screening test of choice. It is estimated that by 2015 all Spanish citizens will be covered by such a screening programme. Breast cancer screening is undertaken on women aged 50–69 years at 2-yearly intervals, though some regions have decided to lower the starting age to 45 years. It is implemented nationwide with an annual set of quality indicators analysed by the network. Opportunistic screening for cervical cancer every 3 years is continued as an option, with a suggested age range of 25–64 years.

The main goals in this area are to promote and, where applicable, to support an integrated multidisciplinary approach to cancer care, with prompt access to diagnosis and therapy. The priority is to enhance co-ordination over the course of the patient’s cancer journey. Several initiatives, which have focused on prompt access to diagnosis and therapy for the most common tumours at a regional level, should be extended to the country as a whole. A further key issue is the need to guarantee sustainable multidisciplinary decision-making for all cancer patients, something that has been shown to be capable of improving the quality of cancer care [22]. While a number of complex procedures should be concentrated at a regional level to benefit from higher case loads, a short list of procedures should be referred to national reference centres. Another objective connected with cancer care is to continue the process of ensuring the availability of NHS clinical guidelines that address the full spectrum of diagnosis and treatment of the most frequent tumours.

In Spain, childhood cancer has specific characteristics, beginning with the fact that there is a long tradition of having a cancer registry, supported by the Spanish Society for Paediatric Oncology, which keeps a record of incidence as well as survival [23]. Treatment of these types of cases is highly concentrated in a select number of hospitals spread around the country, something that makes for a high case load and the inclusion of survival outcomes in the registry. In this field, the main goal is twofold, namely, to reinforce the current situation and improve psychosocial support for cancer patients. Long-term side-effects should be a co-operative objective and should include patients’ associations, which are very active in this area.

The psychosocial aspects of cancer care are of growing interest to health-policy makers, clinicians and patients alike. Whereas this kind of support has traditionally been viewed as something that should properly be provided by and within the family, nowadays professional support given by psycho-oncologists and mental health professionals is increasingly in demand. Priority should therefore be allocated to increasing the number of well-trained professionals and seeing that they are available at all stages of the care process, where there is a perceived need on the part of the clinician or this is demanded by the patient. Palliative care is widespread in Spain, with different initiatives having been assessed, rated highly and accepted [24]. Although this approach was first deployed in cancer care and several of the leading figures were originally medical oncologists, it is now the goal of another strategy being pursued by the Ministry of Health, which seeks to expand it to other diseases and reduce heterogeneity across regional health services.
Cancer research is a very active sector and has benefited from the consolidation of the Spanish Network of Cancer Research Groups supported by the Carlos III Institute of Health, the main public funding agency for health research in Spain. Following an international review, >100 research groups received a 4-year grant and were included in the network, which aims to promote co-operative research. Other networks also include research groups working in cancer, as is the case of public health and digestive disease networks. Equally deserving support are co-operative research groups, which cover as many as 20 tumours, are composed of clinical oncologists, radiotherapists and surgeons across Spain, and have many clinical protocols and trials to their credit.

In brief, the challenge posed by cancer in Spain has been met by a comprehensive cancer strategy, which has sought to set a limited number of achievable goals after considering the evidence on the impact of cancer and the organisational structure of the Spanish health system. Our approach has been based on building a co-operative strategy endorsed by all ARs having to implement the interventions in their local health services, and on assigning the necessary priority both to the budget and to the changes in organisation of cancer prevention and care required. A key step has been to establish a shared understanding of the main priorities for cancer control, through a review of the evidence and a consensus encompassing all stakeholders, including scientific societies and patients associations.

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disclosures

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references