Medical oncology recognized at EU level to allow free movement of doctors: progress and challenge

On 3 March 2011, ESMO members were informed by e-mail that the European Commission had announced such that medical oncology would be included among the medical specialties covered by Directive 2005/36/EC for the recognition of professional qualifications. It was underlined that the Directive will improve the mobility of medical oncologists in Europe.

While ‘free movement of medical oncologists can be beneficial to address the growing cancer burden, allowing to cope with potential labor shortages more promptly’, this can only be achieved if the movement does not follow a one-way street. The great challenge of this Directive is to make sure that all European cancer patients benefit equally, irrespective of where they live. Otherwise, the stated aim of ESMO will not be achieved: ‘a more uniform and harmonized European setting’.

The accompanying Table 1 shows some facts on cancer, cancer care and care-providing staff in Europe [1]. Obviously, great differences exist between new members of the EU in the East and old members in the West. This is also evident from the fact that only 187 ESMO members are from Eastern Europe, where 20% of the EU population lives. Their numbers are <50% of ESMO membership in Italy and 4.6% of total ESMO membership. Moreover, only 7% of the ESMO Designated Centers of Integrated Oncology and Palliative Care are located in the Eastern part of the EU.

There are several reasons for these differences. Oncology was adequately organized and, at least in part, very successful in meeting the needs of the population of COMECON countries before 1990. For example, the age-standardized mortality rate for 1980 in the former German Democratic Republic (males 162.3; females 104.4) was much lower than that for the Federal Republic of Germany for 1979–1981 (males 180.5; females 114.8) [2]. However, the abrupt change that occurred in state-guided health care in the ex-COMECON countries after the fall of the Berlin Wall created numerous difficulties [3], as did migration of care-giving staff from East to West. Many western industrialized countries are today suffering from a shortage of human resources in the health field due to a continuing brain drain that threatens to worsen over the next decade. Certainly this was a reason why, at the 2005 World Health Assembly, the World Health Organization (WHO) resolved that their General Programme of Work for 2006–2015 should focus on the complexity of issues involved in international health human resource migration [4].

Looking at all these facts, it becomes clear that the new Directive is both a tribute to the level of medical oncology that exists in Europe but also poses a risk. Existing deficiencies in cancer treatment in the East will become greater without a final solution to the complex problem of shortage of doctors in the West. The challenge is to use the Directive to increase the total number of qualified oncologists and spread them out all over Europe. ESO and other organizations have been working for years toward this end. While not easy to accomplish, it is hoped that these efforts will motivate oncologists from both sides of Europe to use the current EC directive to develop new collaborative approaches. Standard requirements for training in medical oncology will support these approaches [5].

To better understand the situation, we have also analyzed several aspects of cancer care in the Eastern part of the EU. Results show a relatively well-developed network for advanced cancer care in Poland. However, in Romania the number of palliative care beds is only 60% of the number in Germany. Still more significant is the difference concerning the number of palliative care teams (1.3 versus 5.9 per million population). Dignity at the end of life was reported for <50% of the East European patients. The reason for this as our analysis shows is poor financing. Additional reasons for countries like Romania

Table 1. East-West differences in cancer care within EU countries

<table>
<thead>
<tr>
<th>Topic</th>
<th>EU</th>
<th>Germany</th>
<th>UK</th>
<th>Poland</th>
<th>Czech Republic</th>
<th>Hungary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality females/males per 100 000 population</td>
<td>126/212</td>
<td>124/202</td>
<td>146/208</td>
<td>145/280</td>
<td>154/261</td>
<td>161/307</td>
</tr>
<tr>
<td>5-year-survival breast (%)</td>
<td>81.2</td>
<td>78.2</td>
<td>78.5</td>
<td>61.6</td>
<td>75.4</td>
<td>72.5</td>
</tr>
<tr>
<td>5-year survival colon (%)</td>
<td>57.4</td>
<td>62.2</td>
<td>51.6</td>
<td>38.1</td>
<td>46.8</td>
<td>35.0</td>
</tr>
<tr>
<td>5-year-survival melanoma (%)</td>
<td>86.1</td>
<td>89.4</td>
<td>84.8</td>
<td>65.8</td>
<td>75.1</td>
<td>72.5</td>
</tr>
<tr>
<td>Foreign physicians (%)</td>
<td>—</td>
<td>4.6</td>
<td>31.4</td>
<td>—</td>
<td>0.8</td>
<td>—</td>
</tr>
<tr>
<td>Remuneration of specialists ratio to GDP per capita</td>
<td>2.7</td>
<td>4.8</td>
<td>—</td>
<td>1.6</td>
<td>1.7</td>
<td>—</td>
</tr>
</tbody>
</table>

GDP, gross domestic product.
and Hungary are a lack of awareness and ignorance concerning existing needs. To conclude, maybe the European Commission in collaboration with ESMO, EAPC and others should come out with recommendations for member states that define more precisely the minimal requirements for adequate cancer treatment. They should include the number of medical oncologists needed to adequately serve a given population. Bologna University would be willing to offer its support and cooperate with such an endeavor [6].

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disclosure
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