

How to tackle the COVID-19 curveball in cancer care

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After years of funding European initiatives on cancer through a series of Joint Actions, the European Code Against Cancer and other related actions, the European Commission launched a consultation on the Europe's Beating Cancer Plan (EBCP) in late 2019. But just as the consultation started, the COVID-19 pandemic hit Europe. Cancer services – from screening programmes to treatment centres and survivorship programmes – were temporarily stopped or heavily disrupted, creating disastrous effects on the lives of not only people living with cancer but also their carers.

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As national healthcare systems scrambled to cope with the pandemic, the importance of working on health-related issues at the European level finally became evident. The EU's 2020 budget for 2021 to 2027 allocated more funding than ever to healthcare, with €5.1 billion marking a stark difference from the €449 million for 2014 to 2020.

The EBCP was adapted to the new situation. Nonetheless, on closer examination of the issues caused by the pandemic, more clearly needs to be done to better

support patients living with cancer and their families; protect the health workforce by investing in training, remuneration and staff retention; ensure that telemedicine works for everyone; rebuild public trust in healthcare providers; and consolidate a deeper European Health Union (EHU) to ensure sustainable and effective cross-border cooperation for a healthier Europe.

BACKGROUND: CANCER IN EUROPE

Cancer is a leading cause of death worldwide. In 2020, there were 4,398,443 new cases of cancer in the EU. 788,398 new cases of lung and prostate cancers were registered, of which 477,534 were new lung cancer cases among both men and women. The four most prevalent cancers – breast, lung, colorectum and prostate – make up 40% of global cancer incidence.¹ An individual's risk of developing cancer varies across the continent: in Western Europe, the risk is above 25%; in Eastern Europe, it ranges from 19% to 25%. Conversely, the risk of dying from cancer is above 12% in Eastern European and Central Asian countries, and between 9% and 12% in Western Europe.²

To act on Europe's second-largest killer, the von der Leyen Commission proposed on World Cancer Day 2020 to create the EBCP. The plan represents "a political commitment to leave no stone unturned to take action against cancer."³ It covers four key areas of **prevention, early detection, diagnosis and treatment, and the quality of life of cancer patients and survivors** and has a committed budget of €4 billion, making it the largest regional initiative on cancer undertaken by the EU institutions to date. And yet, by 2020, COVID-19 threw a spanner in the implementation of the EBCP.

When the coronavirus SARS-CoV-2 started to spread among the European population, neither the EU member states nor the European Commission was adequately prepared. The first European cases were identified in early 2020. By 11 March, there were 118,000 cases and 4,291 deaths in 114 countries, leading the World Health Organization (WHO) to classify the viral outbreak as a pandemic.⁴ The WHO called on all nations to detect, test, treat, isolate, trace and mobilise their citizens. As increasing numbers of people across the EU needed medical attention and hospital care with this highly infectious disease, the burden on healthcare systems became immense. Intensive care unit (ICU) beds are filled with COVID-19 patients, leaving little room for other urgent needs. People with other medical needs, such as cancer, are also affected, as regular treatment and follow-ups become difficult to obtain.

STATE OF PLAY: THE COVID-19 CURVEBALL

The burden of COVID-19 on healthcare systems is magnified in cancer care.⁵ Cancer patients undergoing active treatment are often immunocompromised, leading to an increased risk of adverse outcomes if infected. Many patients were greatly uncertain about how best to approach the pandemic. The European Cancer Patient Coalition (ECPC) initially issued warnings to their members to stay at home and follow national government guidelines.

The **psychological impacts** of COVID-19 on cancer patients are increasingly well documented. Studies in Ireland and Denmark both found that people with cancer reported distress about feeling safe in hospitals during the pandemic. This anxiety stemmed from a fear of infection and the strain of not being able to bring family members for support.⁶

The WHO has described the impact of COVID-19 on cancer services as a “deadly interplay” of restrictions, disruption, and overburdened healthcare systems. Across the EU, the pandemic will have long-term economic impacts and continue to pressure healthcare services. During the first lockdown of 2020, the joint number of **cancer diagnoses** in the Netherlands and Belgium dropped by 30% to 40%.⁷ More generally, cancer diagnosis across the EU in 2020 also dropped by 40%.⁸ The ECPC subsequently revised their original message, urging cancer patients to get treatment safely. Other organisations like the European Oncology Nursing Society ran campaigns to encourage people to attend cancer screenings and not miss treatment appointments.

Cancer does not simply go away. The drop in diagnosis numbers is due to two reasons: during the first COVID-19 wave, many screening programmes closed their doors until the relevant services worked out how to make them safely accessible, or because staff had been diverted to COVID-19 wards. Second, people with cancer symptoms were often too afraid to enter hospitals or doctors’ surgeries for fear of being infected by COVID-19.

For example, in Slovenia, where screening programmes closed, 45% of people with symptoms did not get them checked as they were simply too afraid to go near healthcare services. Between April 2019 and April 2020, Belgium witnessed a 48% decrease in breast cancer screening examinations.⁹ Consequentially, increased numbers of people with late-stage tumours can be expected in the years to come, increasing cancer mortality and placing further pressure on oncology services.

In addition to the economic and societal costs of treating patients with more advanced diseases, another crucial impact of the pandemic is to shine a light on the dangers of (the pre-existing) **healthcare worker shortages**, especially in cancer nursing. Cancer nurses have specific skills in infection control, which are in high demand in the pandemic. As such, during each wave of the pandemic, all healthcare workers, particularly cancer nurses, are pulled from their regular duties to COVID-19 wards or ICUs – one of the root causes of disruption to hospitals’ cancer services. Combined with the necessary restructuring of care pathways to avoid cross-infection, moving healthcare workers to COVID-19 wards added stress on both hospital managers and cancer patients who lost their regular nursing services. Cancer patients’ vastly increased need for **psychosocial care** has also placed dangerous levels of pressure on healthcare workers, who now tend to more psychological needs from patients than ever before.

There is much talk about protecting the **mental health of healthcare workers**. But what does this mean in reality? While spending on health increased by 18% across the EU between 2012 and 2019,¹⁰ much of Europe’s healthcare debate was dominated by cost containment.¹¹ This has arguably led to cancer nurses and other oncology professionals, such as oncology pharmacists and surgeons, not having their specific skills certified nor remunerated. The public greatly admires healthcare workers during the pandemic. This appreciation must be translated into concrete and long-term worker retention policies and the official certification of healthcare workers’ specialist skills.

The pandemic also thrust Europe’s economic and manufacturing strategies for **essential medicines** and **personal protective equipment (PPE)** into the limelight. Medicine shortages, which were already a problem in some areas of Europe, were exacerbated. During the peaks of the first and second waves, 50% of oncology pharmacists experienced shortages of essential anti-cancer medicines, and in some hospitals and regions, these shortages affected more than 10 drugs.¹² Prior to the pandemic, there were few or no stockpiles of essential PPE since manufacturing had been primarily outsourced to outside the EU in the name of cost optimisation. More specifically, pre-pandemic, most PPE was manufactured in China and Malaysia. In the early stages of the crisis, China was its own largest customer, but as the virus spread to the West, national governments panic bought stock as healthcare workers suffered from a lack of PPE, putting themselves and their loved ones in potential danger.

The lack of PPE was a strong contributing factor to Spain having some of the highest rates of COVID-19 infections among healthcare workers in the world.¹³ To make matters worse, the lack of PPE for cancer wards also put the lives of immunosuppressed patients at risk.

In March 2020, the European Commission created a strategic 'rescEU stockpile' of medical equipment (e.g. ventilators, masks) to help member states support their healthcare systems. In an unprecedented show of **solidarity**, 17 member states created joint stockpiles of PPE and assisted in their distribution. Together with the EBCP, this collaboration set the scene for EU countries realising that perhaps the EU should have a stronger role in making healthcare decisions – an area currently firmly in the hands of member states. Whether this commitment will continue as the world learns to live with COVID-19 remains to be seen.

In the face of adversity, healthcare systems prove themselves to be creative and resilient. One of the most rapid adaptations was the use of **digital health tools** to increase the number of cases managed daily by primary healthcare professionals, thereby helping to ensure the continuity of care.¹⁴

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COVID-19 has upended the prevailing clinical approach in medicine: in-person visits between patients and physicians.¹⁵ In order to flatten the pandemic's curve, thousands of appointments were cancelled, and millions rescheduled as **telehealth** visits. The technology used to effect this digital transformation in healthcare is not new, but COVID-19 has forced the widespread adoption of remote encounters via video applications, patient portals and phone calls. Patients, oncologists, cancer nurses and oncology pharmacists, for example, have rapidly adapted to this new way of communicating. Barriers to remote care previously precluded by entrenched culture and billing hurdles have been surmounted quickly. On the downside, the rapid update of telemedicine has widened **inequalities** between urban and more rural areas where broadband issues exist.

When the EBCP was finally launched in February 2021, the European Commission stated that it "is a key pillar of a stronger European Health Union and a more secure, better-prepared and more resilient EU."¹⁶ The plan includes several measures to defend cancer care against the ravages of the pandemic and draws on lessons learnt, including the importance of additional financial investments and high-performance computing to test

existing molecules and new drug combinations more rapidly. Thanks to technology developed by COVID-19 vaccine manufacturers, we are already seeing wider deployment of messenger RNA (mRNA) vaccines against advanced melanoma and mRNA technology for head and neck cancers, which is currently being investigated in ongoing clinical trials.¹⁷ The plan also outlines measures to strengthen and integrate telemedicine and remote monitoring in health and care systems with EU funds. These investments could also support cancer patients in remote and/or rural areas.

Additional funding for the EUBCP is available under the Next Generation EU and unprecedented Recovery and Resilience Facility budgets. A total of €672.5 billion will support COVID-19 recovery and help overcome its economic and social impact.

As waves of COVID-19 spread across Europe, the effects of increased EU cooperation on PPE and **vaccination programmes** became clear. Europe is currently in its fifth wave, a direct result of relaxed regulations and a lack of homogeneity in vaccine availability and uptake. As long as vaccination programmes are not global, this will be the pattern for the foreseeable future.¹⁸ Already weakened healthcare systems face the severe danger of workforce burnout and dropout. Telemedicine does help fill the gaps, but not all cancer patients enjoy sharing their symptoms over the internet or phone. Many need the psychosocial support of face-to-face contact to help them through the difficult and often traumatic journey of cancer.

PROSPECTS: LEARNING TO LIVE WITH COVID-19

To mitigate the effect of the COVID-19 curveball in cancer care, the EU must implement the EBCP. It should also urgently harness member states' concerns to commit, beyond the newly invested EU4Health programme, to a deeper EHU.¹⁹ This should be empowered through 4 policy options to provide sustainable and effective protection for current and future cancer patients:

1. Invest more in health at the European level by ensuring that all cancer workforce professionals can work freely in any member state by **recognising their specialist qualifications**. The EBCP commits to invest in specialist training for oncology nurses, radiologists and oncology surgeons. This should be matched with member states' (strongly encouraged) commitment to recognise and reward these qualifications.
2. Ensure that member states and the EU continue to **treat health as a long-term investment**. For example, the EBCP proposes creating a Network of Comprehensive Cancer Centres. The EHU could build on this to ensure that all Europeans access high-quality cancer research and care.
3. Both member states and the European Commission need to play their part in **investing in and**

establishing the appropriate infrastructure to ensure that telemedicine is available to everyone in the EU. The Commission has already made funding available across different budget mechanisms to improve telehealth. National and regional governments must ensure that they make the best use of these to address health inequalities in access to cancer care.

4. Health authorities, national governments and the European institutions need to work with people with and without cancer and oncology professionals to **reinstate the public's trust in screening programmes and healthcare services** before cancer becomes the next pandemic no one can afford to treat. The Commission is currently exploring the possibility of expanding screening services beyond breast, cervical and colorectal to others, such as lung, prostate and gastric cancers. It is communicating the rigour with which such evidence-based decisions may also help restore public confidence.

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Through strong investment in both primary prevention and early detection, the EBCP has the potential to reduce the number of people developing cancer in the EU. Improving access to quality cancer care and cancer survivorship will improve treatment outcomes and the quality of life of people living with or who have survived cancer. Despite the COVID-19 tsunami, the early phases of the EBCP are underway, albeit with adaptations to the reality that Europe must learn to live with the coronavirus. Due to the pandemic, there is greater awareness of the need for member states to improve the well-being of healthcare professionals, coordinate the procurement of PPE and pharmaceuticals, and ensure greater public confidence in the capacity of their healthcare systems to protect them.

From grassroots adaptations in healthcare services to collaborations between countries on PEE provision and the EU's coordination of medicines and equipment, COVID-19 has taught us that collaboration is key to the successful management of our healthcare services. Deepening the EHU will help Europe become more

resilient in the face of emergencies. Otherwise, we will fail patients and healthcare workers striving for a healthier Europe.

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