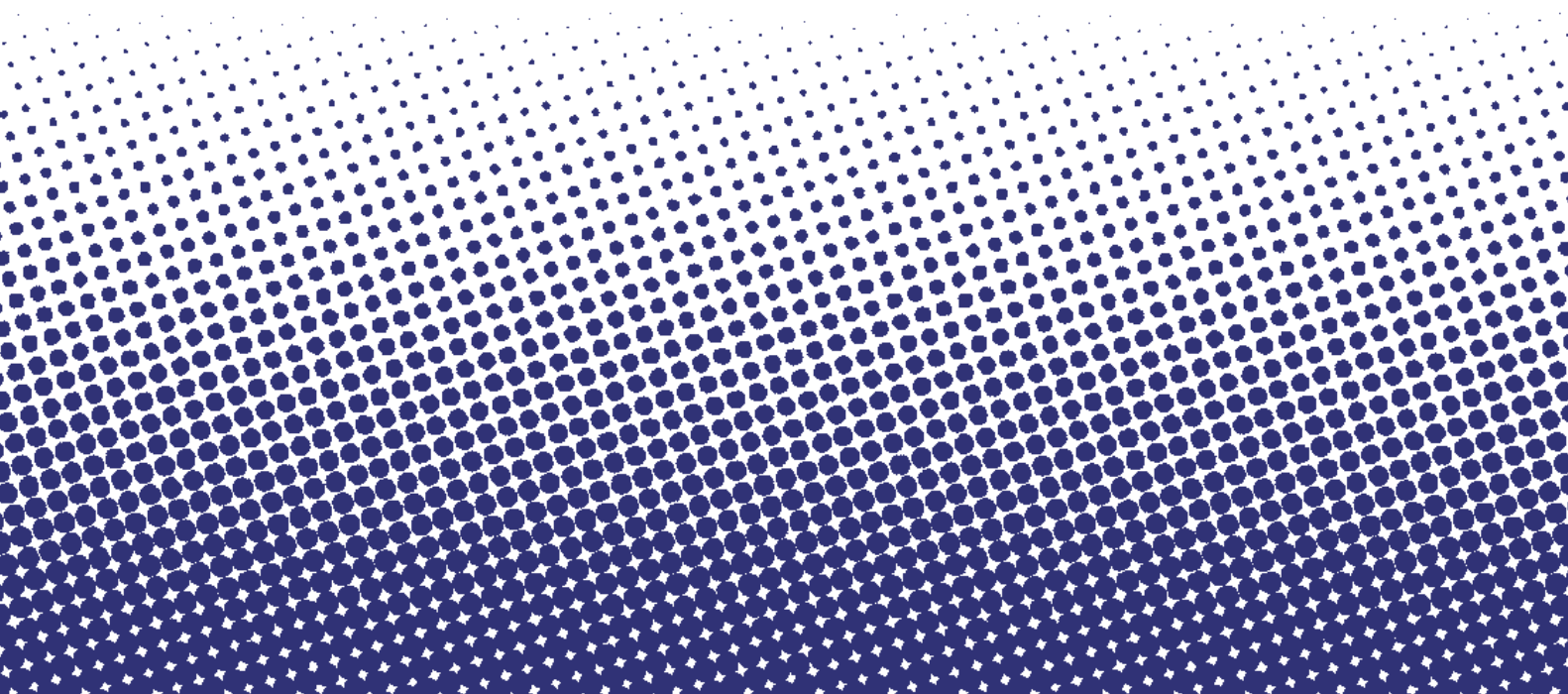




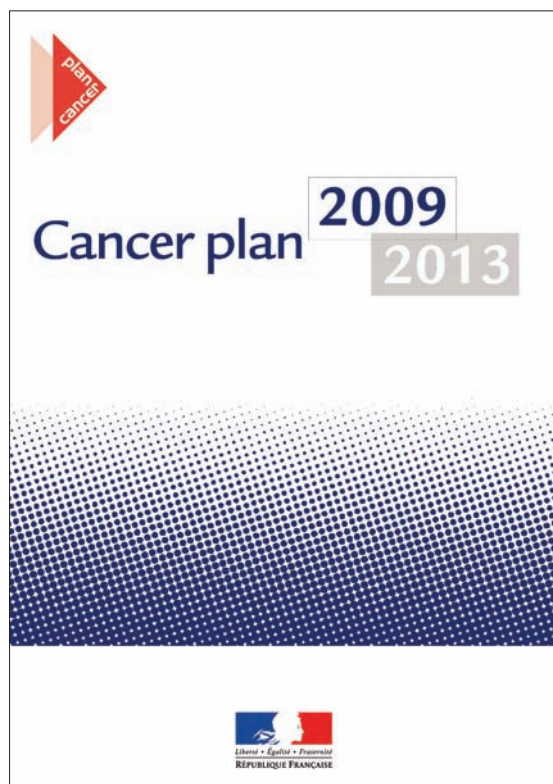
Cancer plan

2009

2013



Liberté • Égalité • Fraternité
RÉPUBLIQUE FRANÇAISE



Launched on 2 November 2009
in Marseille

Introduction



The Cancer Plan 2009-2013 was inspired by the report submitted to the French President by Prof. Jean-Pierre Grünfeld in February 2009: “Recommendations for the Cancer Plan 2009-2013”.

This new plan follows on from the Cancer Plan 2003-2007 and is to some extent based on the measures set out in that earlier document. However, a significant amount of consolidation work will be required, in some cases to ensure the implementation of measures and in others to adapt the way they are implemented.

Based on this starting point, there are new proposals designed to provide new momentum and drive forward new ambitions, with an emphasis on new efforts in research and innovation, including their:

- ▶ “transfer” into the healthcare system;
 - ▶ a more effective consideration of health inequalities in relation to cancer and the implementation of measures designed to correct them;
 - ▶ a better coordination of patient care, including the extension of care beyond the hospital environment by involving referring doctors more effectively;
 - ▶ and new medical and community health initiatives to provide better support for people as part of “life during and after cancer”.
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Methodological note



The Cancer Plan 2009-2013 is the operational version of the report submitted to the French President by Prof. Jean-Pierre Grünfeld in February 2009, “Recommendations for the Cancer Plan 2009-2013”.

It has been developed under the supervision of the French Ministry of Health and Sport and in conjunction with the Ministry of Higher Education and Research and the Ministry of Labour.

The plan was coordinated by the DGS in close cooperation with the DHOS, DGRI, DSS, DGT, DGAS and the National Cancer Institute (INCa).

Professor Jean-Pierre Grünfeld personally monitored the progress of the working groups responsible for drawing up the measures and actions set out in the plan. The members of the commission led by Prof. Grünfeld were brought in halfway through the process and invited to express their views on the measures and actions put forward by the working groups. As a result, the commission was enlarged to include the hospital federations.

The Haut Conseil de la Santé Publique (HCSP) and the Agence d'évaluation de la recherche scientifique (AERES) also contributed their observations and recommendations on the proposed version of the plan.

particular attention was paid to:

- ▶ ensuring that the Cancer Plan was in line with other public health plans that have an impact on it or that relate to it (such as the PNSE2, the PNNS, the Palliative Care Plan, the Occupational Health Plan, and so on);
- ▶ organising the way in which measures are monitored to guarantee that they are implemented and later externally evaluated as effectively as possible (by incorporating the principle of an interim evaluation stage from the outset);
- ▶ ensuring actions are consistent with changes in the structure of the healthcare, research and higher education systems;

Monitoring and evaluation

The monitoring and follow-up system for the plan is in line with the methodology based on the recommendations set out in the Grünfeld report and in the report by the Haut Conseil de la Santé Publique (HCSP).

Monitoring and evaluation of the implementation of the plan are separate from the evaluation of the plan itself.

I. MONITORING IMPLEMENTATION OF THE PLAN

Monitoring of the implementation of the plan is carried out by the inter-ministerial monitoring committee chaired by the Director General for Health or his representative, who must be in a position to mobilise central administrative departments, decentralised services and the agencies involved in implementing the measures set out in the plan, with the National Cancer Institute (INCa) at the forefront.

The monitoring committee is made up of the following members:

- ▶ the Director General for Health or his representative, as chair of the monitoring committee;
- ▶ the Director of Hospitals and Organisation of Patient Care or his representative;
- ▶ the Director General for Research and Innovation or his representative;
- ▶ the Director General for Social Welfare or his representative;
- ▶ the Director General for Employment or his representative;
- ▶ the Director of Social Security or his representative;
- ▶ the President of the National Cancer Institute or his representative;
- ▶ the Director of the Union nationale des caisses d'assurance maladie (social security) or his representative;
- ▶ Jean-Pierre Grünfeld, expert adviser;
- ▶ the President of the Collectif inter associatif de la santé (CISS) or his representative.

The monitoring committee meets once a quarter. Its main mission is to monitor the implementation of the measures set out in the plan. It may suggest changes to the implementation of the plan in line with changing circumstances or in light of the planned interim evaluation report. Twice a year, the committee produces a progress report, which is sent to the French President and the Ministries concerned. The report is based on the monitoring work carried out on the implementation of the measures in the plan, which have been developed as part of a public health approach with targets, interventions or actions and performance indicators, including bud-



get implementation indicators produced by the National Cancer Institute, whose role is to coordinate the various stakeholders involved in fighting cancer.

II. FOLLOWING UP THE ACTIONS SET OUT IN THE PLAN

The National Cancer Institute is responsible for following up the actions set out in the plan through a dedicated team which reports to the monitoring committee for the plan.

Specifically, this team is responsible for:

- ▶ following up the implementation of the actions set out in the plan, in particular by using the indicators defined for each action. As part of this role, it gathers the necessary data to follow up the indicators from each action coordinator;
- ▶ identifying the difficulties encountered by actions coordinators in implementing the actions in the plan and, if necessary, alerting the chairman of the monitoring committee.

It also involves the Directorate General for Health in the follow-up process in order to prepare for meetings of the interministerial monitoring committee.

In addition, and in accordance with the INCa's legal responsibility for coordinating the various players involved in fighting cancer, the Institute presents an annual progress report on the plan to the relevant bodies. As part of this, it organises an annual seminar for its Board of Directors, as well as a joint seminar for its Patients, Friends and Family and Users Committee, and its Healthcare Professionals' Consultative Committee.

The involvement of bodies from within INCa allows to involve key players in the fight against cancer services as well as patients in the progress of the measures set out in the plan. The Coordination with the monitoring committee for the plan is the responsibility of the Chairman of the INCa Board, who is a member of the committee.

III. THE EVALUATION OF THE PLAN

Responsibility for evaluation of the Cancer Plan 2009-2013 falls to the Haut Conseil de la Santé Publique (HCSP) and the AERES, for measures in the Research axis. They may also call on external service providers selected on the basis of an invitation to tender. Two evaluations have been scheduled: an interim evaluation at the end of 2011 and another at the end of the plan in 2013. The summary reports from the evaluation will be sent to the French President and the Ministries concerned.



Cancer plan, 2009-2013

5 areas, 30 measures and 118 actions

5 AREAS

RESEARCH

5 measures – 26 actions

- ▶ Ensuring the swift transfer of research outcomes for the benefit of all patients

Measures 1 to 5

OBSERVATION

4 measures – 12 actions

- ▶ Gain a better understanding of the reality of cancer in France

Measures 6 to 9

PREVENTION – SCREENING

8 measures – 37 actions

- ▶ Take preventive actions to avoid cancers or reduce their seriousness

Measures 10 to 17

PATIENT CARE

7 measures – 27 actions

- ▶ Guarantee each patient individualised and effective care management

Measures 18 to 24

LIFE DURING AND AFTER CANCER

6 measures – 16 actions

- ▶ Improve the quality of life during and after the illness and fight any form of exclusion

Measures 25 to 30

3 CROSS-CUTTING THEMES

The strategy behind the plan is based on three major cross-cutting themes.

These are the primary focus of the plan and are found in every area, expressed as specific measures and actions.

They represent the new challenges faced in the fight against cancer.

They aim to:

- ▶ **take more effective account of health inequalities** to ensure greater fairness and effectiveness in all the measures taken to fight cancer;
 - ▶ **encourage analysis and taking account of individual and environmental factors** to individualise patient care before, during and after their illness;
 - ▶ **and strengthen the role of the referring doctor** at every stage in the patient's treatment, in particular to improve quality of life during and after their illness.
-

6 “flagship” measures

RESEARCH

- Measure 1** Increase resources for multidisciplinary research.
- ▶ **Accredit five multidisciplinary cancer research integrated sites.** These sites will be selected on a competitive basis and should help to transfer scientific research to patient care more quickly.
 - ▶ **Increase patient participation in clinical trials by 50%.** Efforts will focus as a priority on the most vulnerable populations: children, elderly people, rare types of tumour and serious forms of cancer.

- Measure 3** Define environmental and behavioural risks.
- ▶ **Devote more than 15% of the research budget associated with the plan to analysing environmental and behavioural risks.**
 - ▶ **Contribute to the full genome sequencing of the five most common cancers.** This target forms part of the cooperative efforts being made worldwide on tumour genome profiling.

OBSERVATION

- Measure 6** Produce and communicate information on cancer and cancer research and treatment on an annual basis.
- ▶ **Produce an analysis of cancer distribution across the country each year.**
-

PREVENTION – SCREENING

- Measure 14** Tackle inequalities in access and take-up of screening.
- ▶ **Increase participation by the whole of the population in organised screening programmes by 15%.** The level of increase should be 50% in the départements experiencing most difficulties.

PATIENT CARE

- Measure 18** Individualise patient care and expand the role of the referring doctor.
- ▶ **Ensure that 80% of patients benefit from at least one individualised care plan.** This plan should involve the referring doctor on a systematic basis.

LIFE DURING AND AFTER CANCER

- Measure 25** Develop individualised social support during and after cancer.
- ▶ **Ensure that 50% of patients benefit from at least one post-cancer plan.** This plan will take account of individual needs in terms of medical supervision and psychological and social support.



New expenditure over the duration of the plan



	Forecast
RESEARCH	€ 95,287,000
OBSERVATION	€ 12,241,000
PREVENTION - SCREENING	€ 177,359,000
PATIENT CARE	€ 402,772,000
LIFE DURING AND AFTER CANCER	€ 45,000,000
Total	€ 732,659,000

Research

Ensuring the swift transfer of research outcomes for the benefit of all patients.

The aim of the cancer research programme is to reduce cancer-related mortality, reduce the frequency of cancers and improve survival rates and patients' quality of life through the use of more effective and less toxic treatments. Finally, it aims at promoting equity for all citizens in terms of prevention, access to early diagnosis and innovative, effective treatment.

About 5,000 researchers in France work on fighting cancer, in hospitals, universities, Inserm, CNRS, CEA, INRA, INRIA, IRD and the Institut Pasteur, under the umbrella of ITMO (thematic alliance on cancer).

One of the most significant challenges in cancer research at present is the balance between the important support for fundamental research, leading to often unpredictable progress, and applied research, the aim of which is to make rapid progress in developing drugs or techniques that have a direct impact on patient care. The first case means constantly prioritising the imagination and creativity of the researchers. In the second case, project planning and support are essential for targeting diagnostic or therapeutic benefits. In both cases, project excellence and the skills of researchers and teams should be a priority.

Changes are required to meet these objectives, in particular clear support for carefully identified integrated research centres with researchers who are actively involved in fundamental research, research that involves direct interaction with patients (clinical research) and epidemiological research, in public health and human and social sciences, and who have the ability to share ideas, cooperate and make progress together.

These interactions and shared concerns should lead to research that is likely to be able to be transposed to patients quickly in the form of

5 MEASURES

MEASURE 1: STRENGTHEN RESOURCES FOR MULTIDISCIPLINARY RESEARCH.

MEASURE 2: UNDERSTAND THROUGH RESEARCH AND REDUCE INEQUALITIES IN RELATION TO CANCER.

MEASURE 3: CHARACTERISE ENVIRONMENTAL AND BEHAVIOURAL RISKS.

MEASURE 4: STIMULATE CLINICAL RESEARCH.

MEASURE 5: MAKE FRANCE A REFERENCE COUNTRY.

diagnostic tests, drugs and social or public health initiatives (prevention and screening). The development of modern research requires full participation from both patients and healthy volunteers.

The Grünfeld report emphasised the importance of reducing health inequalities in relation to cancer. Research lies at the heart of this issue, by enabling multi-disciplinary cooperation between specialists in biology, genetics, immunology, environmental issues and toxicology, clinicians, sociologists, economists, patients' associations, etc.. Understanding these inequalities should help to provide appropriate and effective responses that are consistent with other actions of the Cancer Plan.



Measure 1.

Strengthen resources for multidisciplinary research.

BACKGROUND

The first Cancer Plan implemented inter-regional organisation and coordination for cancer research, based on seven cancer research clusters. The National Cancer Institute has national responsibility for planning and ensuring competitive financing for research, whilst ITMO ('Alliance multi-organismes pour la recherche sur le cancer') brings together the key stakeholders involved in this research.

- ▶ Bringing together fundamental research and the observations of clinicians, epidemiologists and researchers in social and human sciences and public health is a stimulating and enriching experience for both sides. When such exchanges are organised on a single site, either a hospital and/or university, it accelerates the transfer of results from the laboratory to the patient and helps to explain, through experimental research, the observations made about patients or groups of patients. This type of interactive research is known as translational or transfer research.
- ▶ The early phases of research on drugs and, in particular, targeted therapies, are increasingly critical for later developments and validating their use for patients. The dispersion and reduced critical mass of research centres is disadvantageous given the complexity of the procedures and technical facilities required to carry out an early evaluation of their efficacy and side effects. Industry needs to be able to find committed, competent researchers in the French academic environment who are available and accredited within the context of a national policy.

OBJECTIVES

- ▶ Develop in conjunction with the cancer research clusters a national policy for university hospital-based research integrated sites specialising in cancer with a critical mass of researchers in fundamental and clinical science, public health, epidemiology and health technologies to carry out innovative translational research projects.
 - ▶ Continue to organise sites in which only one or two significant conditions are present.
 - ▶ Reaffirm the importance of fundamental research by focusing on the originality of research and the importance of interactions between different disciplines.
-

- ▶ Accelerate the development and quality of the translational research tools: tissue bank, cell and biological fluids, high-throughput analytical platforms, bioinformatics and biomedical devices.
- ▶ Develop an accreditation and networking process for the centres identified for implementing the early stages of clinical trials.
- ▶ Unify the accreditation process by involving academic and industrial partners.

ACTIONS

1.1 Strengthen translational research through dedicated funding based on calls for proposals and a policy of multidisciplinary accredited and integrated research sites.

The structure of this approach is based:

- ▶ firstly, on competitive, recurrent, targeted calls for proposals that enable teams from hospitals (with access to patients, clinical researchers and clinical and biological resources) and research teams from other organisations (which bring a focus on fundamental sciences and technical facilities) to work together on a single project;
- ▶ and secondly, on a competitive accreditation system for integrated multidisciplinary research centres that combine the various dimensions of research (fundamental, clinical, public health, epidemiology, human and social sciences) and where the required critical mass of doctors, patients and researchers cooperate within the constraints – primarily competitiveness and quality assurance – of translational research. These centres will meet a set of specifications drawn up in accordance with international criteria.

Action texte: Action coordinator INCa, ITMO Cancer.

Co-coordinators: DHOS, DGRI.

In partnership with the relevant stakeholders.



1.2 Support training in translational research for healthcare professionals and researchers through the allocation of grants.

The commitment to this new action will be supported by an active, funded training policy: long-term success will be related to the number of new young doctors, pharmacists and scientists committed to and trained in this approach.

Action coordinator: INCa, ITMO Cancer.

Coordinators: Ministries of Health and Research.

In partnership with the relevant stakeholders.

1.3 Structure and stimulate research in the early phases of new anti-cancer drug trials.

Numerous anti-cancer drugs are currently being developed around the world: the majority of them are aimed at new targets derived from biological research and are radically different from the use of traditional anti-cancer (cytotoxic) chemotherapy.

Prior to their being developed on a large scale, it is more and more essential to carry out “early trials” of these new drugs (phases I-II), to produce essential information on the antitumour target activity of new drugs and help to best “target” the categories of patients who will benefit from them.

France lacks clear, competitive structures to respond to such shared expectations with the pharmaceutical industry. The proposal is therefore to:

- ▶ Accredit and then support research investigation centres specialised in early trials of new drugs.

This approach pre-supposes that sites can be identified where the public research resources necessary for early investigation in partnership with the pharmaceutical industry exist and can be made available.

Action coordinator: INCa, ITMO Cancer.

Co-coordinators: DHOS, DGRI.

In partnership with the relevant stakeholders.

- ▶ Develop and support animal and *invitro* experimental alternatives at the different stages of clinical trials of anti-cancer therapies in humans.

Similarly, our research base must have the resources to avoid, or at least limit, experimentation involving cancer patients: the development of new Pre-clinical models dedicated to these new less or non-cytotoxic therapies is a major challenge in terms of targeting such new therapies more quickly and effectively at the sub-groups of patients who could benefit from them.

Action coordinator: INCa, ITMO Cancer.

Co-coordinators: other multi-organisational specialist institutes,
Ministries of Health, Research and Agriculture.

In partnership with the relevant stakeholders.

1.4 Establish research and development partnerships in cancer research between international laboratories and key research organisations in cancer research under the umbrella of the ITMO Cancer (LIR-G5-LEEM).

The aim is to promote French research in order to make it more attractive and facilitate dialogue with international laboratories. These partnerships will enable patients and researchers in France to benefit from the new molecules developed by these laboratories. A clearer framework and competitiveness gained by identifying and funding research centres should facilitate cooperation with the pharmaceutical industry and the availability of their compounds.

Action coordinators: ITMO Cancer, INCa.

Co-coordinators: LIR, DGRI.

In partnership with the relevant stakeholders.

1.5 Strengthen the interaction between technology transfer offices and economic stakeholders to monitor and support projects with the potential for economic development.

This essential step will be encouraged primarily in terms of project support and facilitated by bringing key stakeholders together.

Action coordinators: ITMO Cancer, INCa.

Co-coordinators: other multi-organisational specialist institutes,
Ministries of Health and Research.

In partnership with the relevant stakeholders.



Measure 2.

Understand through research and reduce inequalities in relation to cancer.

BACKGROUND

Serious inequalities in relation to cancer have been observed and reducing these inequalities lies at the heart of the objectives of the second Cancer Plan. Such inequalities affect both individuals and communities and influence the effectiveness of health policies. Universal social security cover has, in principle, reduced the cost of diagnosis and treatment as a factor of inequality. Nonetheless, inequalities of morbidity and mortality linked to geographical location and professional, socio-economic and cultural background can still be observed. These are associated, amongst other things, with less effective prevention campaigns, lower levels of participation in screening and delays in diagnosis and access to treatment. There are also other inequalities related to the environment in its broadest sense (water, air, radiation, infections, etc.), addiction (alcohol, tobacco, etc.), behaviours (diet, exercise, etc.) and individual genetics, which also plays a role.

OBJECTIVES

- ▶ Mobilise the research community involved in exploring these inequalities to develop multidisciplinary research projects combining biology (genetics, immunology, carcinogenesis, etc.), the environment, epidemiology, public health and economic, social, cultural and psychological aspects.
 - ▶ Carry out field trials to evaluate the impact of public health campaigns designed to reduce inequalities.
 - ▶ Analyse, through research, the impact of these policies on reducing inequalities or the obstacles encountered.
 - ▶ Extend measures with proven impact to the whole of the French population.
-

ACTIONS

2.1 Implement regular calls for research proposals to understand the factors that drive inequalities in relation to cancer and assess the public health actions that help to reduce such inequalities.

Multi-year projects (experimental studies and monitoring and evaluation of actions) will encourage the development of multidisciplinary research projects and should mobilise researchers to study these topics on a regular basis and increase the relevance of their research.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

2.2 Mobilise the cancer research clusters to promote and develop research programmes on the geographical determinants of inequalities with scientists and specialists in public health and healthcare. The results of these programmes should be translated into field actions, validation and roll-out to the target population.

Action coordinator: INCa.

In partnership with the relevant stakeholders.



Measure 3.

Charaterise environmental and behavioural risks.

BACKGROUND

Identifying new risks related to the general and working environment, individual and collective behaviours and technological development is a priority for research into the health of the population. Different disciplines, from descriptive epidemiology to molecular and toxicological epidemiology and social and human sciences will be encouraged to work on reducing the time between the risk identification and its translation into preventive measures.

In the framework of the 2008 road map, large research structures (TGIR) and coordination units have been created, primarily to identify new large-scale biomedical cohorts, as well as research development platforms. These research tools, which are designed to be accessible to the scientific community and require a significant level of investment, are essential for all aspects of medical and epidemiological research and, of course, for research into cancer risk factors.

A considerable effort was made under the first Cancer Plan to set up tumour banks and biological resources (cells, serums, etc.) in accordance with strict quality standards. These measures should be pursued and coordinated with initiatives undertaken in other European countries.

In addition, technological development, from genetics to the analysis of biological fluids, is currently producing a significant amount of data that needs to be analysed on robust bioinformatics platforms and should lead to the development of models of the major physiological and pathological systems.

This measure is coordinated with the research section of the French National Health and Environment Plan 2 and complements the measures and funding for cancerous diseases (cf. actions 48, 49, 50 of the PNSE2).

OBJECTIVES

- ▶ Identify environmental and behavioural risks and the populations exposed to these risks through research to ensure adequate prevention and respond to questions from the public authorities and the general public.
- ▶ Promote interventional research that tests the effects of changes to the environment, individual behaviours (e.g. diet, drugs, vaccinations and sporting activities) and collective behaviours (e.g. work organisation).

- ▶ Develop experimental models to analyse the effects of the environment on the occurrence of tumours.
- ▶ Expand population monitoring in France in the framework of large general cohorts by asking questions about cancer.
- ▶ Combine this with the collection of high-quality, annotated biological samples (tumours and healthy cells and tissues) from sections of these cohorts that will help to answer questions from scientists on cancer in the coming years.
- ▶ Develop bioinformatics and system biology platforms and increase training in these disciplines.



ACTIONS

3.1 Develop research projects in more responsive analytical epidemiology with the help of leading centres.

This action aims at bringing together clinicians and surgical pathologists specialised in certain types of cancer, as a priority those that are thought to be increasing (primarily brain tumours, sarcomas, hepatocarcinomas and lymphomas).

Action coordinators: INCa, ITMO Cancer.
In partnership with the relevant stakeholders.

3.2 Revive competitive research in toxicology, genetics and molecular epidemiology and interventional clinical research through calls for proposals.

Action coordinators: INCa, ITMO Cancer.
Co-coordinator: Afsset.
In partnership with the relevant stakeholders.

3.3 Strengthen the partnership between Afsset, INCa and the ANR on the actions of the French National Health and Environment Programme PNSE2 and organise an international symposium in 2011 to review environmental and behavioural risks.

Action coordinator: Afsset.
Co-coordinators: INCa, ITMO Cancer.
In partnership with the relevant stakeholders.



3.4 Mobilise stakeholders in public health, animal health (veterinary schools and INRA) and the environment (Afsset) to launch calls for proposals and finance research teams on the following thematic programmes:

- ▶ the impact of the environment on certain animal pathologies that could be used as models for human cancers;
- ▶ the development of models to assess the effects of multiple exposures to chemical, biological and/or physical agents, taking into account and/or predicting the interactions between them, as well as multi-channel or prolonged exposures;
- ▶ a study of biomarkers for early prediction of transformation and susceptibility.

Action coordinators: INCa, ITMO Cancer.

Co-coordinators: Afsset, Afssa.

In partnership with the relevant stakeholders.

3.5 Finance large, general national cohorts backed by the collection of biological samples, primarily on the basis of a call for proposals launched by the IReSP with support from the Ministries of Health and Research. Discussions on these projects should be coordinated with other European countries.

Action coordinator: IReSP.

In partnership with the relevant stakeholders.

3.6 Fund with the ANR the development of multidisciplinary approaches to modelling complex biological processes (systems biology).

Action coordinators: INCa, ITMO Cancer.

Co-coordinators: ANR and Inria.

In partnership with the relevant stakeholders.

Measure 4.

STIMULATE CLINICAL RESEARCH.

BACKGROUND

The objectives of clinical research are to make progress in the care and treatment of cancers whilst reducing their secondary effects in the short and long term. Patients and the public are keen to know what progress has been made in cancer research and the most recent therapeutic advances that they may benefit from. Clinical trials, which are governed by strict laws on protecting those who take part, give patients early access to new treatments before they reach the market. The Access to innovation thus contributes to reducing health inequalities.

In recent years, the campaigns launched by the French Ministry of Health, the National Cancer Institute, INPES (French National Institute for Prevention and Health Education) and patients' associations have helped to change French views on cancer. The multiplicity of information sources in the research area, coupled with the complexity of research results and their rapid evolution, makes the potential benefits of current research relatively inaccessible for the population. Access to relevant, validated information is essential for involving patients and the public with research, particularly therapeutic trials. Information tools on the clinical trials currently underway in France have been developed; these should be maintained, further detailed and supplemented by educational documents on advances in all areas of research against cancer.

Full participation of patients and healthy volunteers in the development of modern research should be encouraged and the information provided to people who are willing to take part in clinical trials should take into account all aspects of the trial, including quality of life and the benefits for the community.

The "Hôpital, patients, santé, territoires" law enacted in 2009 confirmed the public service mission in the research activities of healthcare institutions.

OBJECTIVES

- ▶ Increase patient involvement in clinical trials by encouraging participation from the private and public sectors, and general practitioners.
- ▶ Reassert the uniqueness of the Cancer PHRC and support better funding both globally and for each of the studies selected.
- ▶ Produce and disseminate information on the research being carried out against cancer, particularly in the areas of prevention, early diagnosis and treatment for patients and the general public.



- ▶ Work with patient associations as an interface with researchers, provide sound justifications for clinical research and make it understandable to participants, and give patients an insight into what is being achieved.
- ▶ Raise awareness amongst patients and the general public of the value of participating in biomedical research to fight cancer by taking part in clinical research or agreeing to donate a fragment of tumour tissue or a blood sample to research.

ACTIONS

4.1 Support, structure and monitor clinical cancer research through the Cancer PHRC via annual, competitive national calls for proposals.

The previous Cancer Plan provided a mechanism for the best clinical cancer research projects to compete at a national level, thus structuring research by topic on the basis of excellence. In addition to evaluating the projects on a competitive basis, it is apparent that some projects would benefit from closer monitoring in their initial stages to limit certain failures that would otherwise not be identified at a sufficiently early stage. Similarly, inadequate initial funding may limit the expansion and competitiveness of certain projects.

Whilst the policy of national calls for proposals will be maintained, the new objective will be to improve, within the framework of the Cancer PHRC and its circular, the relevance, pragmatism of the questions asked and simplification of academic trials in order to facilitate patients' participation in clinical trials.

This work must be funded at an adequate level in conjunction with the DRCl. Clinical research project monitoring Clinical research project monitoring and support must be organised with the DHOS, the DRCl, University hospitals (CHU), comprehensive cancer centres (CLCC) and cancer clusters to improve success rates.

Action coordinators: INCa, ITMO Cancer.

Co-coordinator: DHOS.

In partnership with the relevant stakeholders.

4.2 Increase inclusion of patients in clinical cancer trials.

The suggested target is a participation rate of 60% in children's cancers, 40% in malign haematology and 10% in metastases of solid tumours. The specific research projects should be carried out in oncogeriatrics, particularly on treatment strategies and the use of new drugs. The suggested target is a participation rate of 5% in elderly subjects (over 75 years) within five years. This would act as a stimulus for combining research with studies on the biological mechanisms common to ageing and cancerogenesis.

Action coordinators: INCa, ITMO Cancer.

Co-coordinator: DHOS.

In partnership with the relevant stakeholders.

4.3 Take advice from patients' committees on clinical research protocols in conjunction with consultations with ethical research committees (CPP).

This action involves mobilising public- and private-sector institutions and hospital federations, comprehensive cancer centres (CLCC), University hospitals (CHU) and the DRCI with the help of patients' associations. It aims to give patients participating in trials a mechanism to express their views before, during and after taking part.

Action coordinators: INCa, ITMO Cancer.

Co-coordinator: DHOS.

In partnership with the relevant stakeholders.

4.4 Organise the collection of information from agencies and clinical research operators and make it publicly available.

A shared knowledge of current clinical trials is not only an obligation in terms of scientific ethics but also necessary so that patients and doctors can plan their participation more effectively. This objective will be facilitated by organising automatic, systematic and validated transmission of information on clinical trials between Afssaps, INCa and international clinical research organisations.

Monitoring trials is equally critical and requires tools to be developed to enable regular reporting of patient inclusion by healthcare institutions "authorised to treat cancer" in conjunction with the DIRCs, University hospitals (CHU), comprehensive cancer centres (CLCC) and cancer clusters. This information must be classified by pathology subtype and age group. (cf. monitoring for action 4.2).



Action coordinator: INCa.
Co-coordinator: Afssaps.
In partnership with the relevant stakeholders.

4.5 Support research on patients' quality of life during and after cancer.

These new research strategies are prioritised in the Cancer PHRC and its circular. Specific programmes targeting the quality of life after cancer will be launched.

Action coordinators: INCa, ITMO Cancer.
Co-coordinator: DHOS.
In partnership with the relevant stakeholders.

4.6 Develop international cooperation in clinical trials.

New momentum needs to be given to international cooperation in order to respond more quickly and in a more relevant manner to the major questions asked in therapeutic trials. In addition to existing cooperation groups, new partnerships will be developed between French programmes and the American, British and German cancer institutes.

Action coordinator: INCa, ITMO Cancer.
Co-coordinators: DHOS, DGRI, MAEE.
In partnership with the relevant stakeholders.

4.7 Disseminate information about progress in research against cancer on a regular basis (cf. measure 6).

Disseminating this information to healthcare institutions authorised to treat cancer is a priority. The development of the INCa website will represent an opportunity to provide validated reference information on this subject matter with patients' associations.

Action coordinator: INCa.

Co-coordinator: Ligue Nationale contre le cancer.

In partnership with the relevant stakeholders.



Measure 5.

Make France a reference country.

BACKGROUND

On 13 November 2008, the “Agence d'évaluation de la recherche et de l'enseignement supérieur” published its evaluation report on the French Institute for Health and Medical Research (Inserm), drafted by an international committee chaired by Mr Zerhouni. The report covered three points: Inserm's organisational structure and operation; its coordination role and interactions with the bodies involved in life sciences and health in France; and the overall structure and function of the French research system in this area.

One of the report's recommendations is to merge the sources of funding for research in life sciences and health. With this in mind, the “Alliance pour la recherche en sciences du vivant et en santé”, an umbrella gathering all research organisations and universities, was recently launched with a dedicated “Institut thématique multi-organismes” (ITMO) for cancer research, led by the director of research at INCa. This change connects those involved in research (teams and staff) more transparently with research project scheduling and funding. The coordination with the “Comité ministériel d'orientation de la recherche” (COMIOR) of the French Ministry of Health includes cancer research as part of the public health and quality of care system and mobilises the research community to respond to health-related challenges in the area of cancer.

France is ranked 4th in terms of worldwide scientific publications in the field of cancer research, behind the United States, Great Britain and Germany. Bibliometric indicators show that there has been progress in this area since 2003, which may reflect the impact of the first Cancer Control Plan. As a result of this new impetus, French cancer research teams have also developed cooperation agreements and are involved in international consortia and major European programmes.

Since 2008, France has been involved in the International Cancer Genome Consortium, the aim of which is to produce an extensive review of mutations in 50 different types of cancer; French participation of 10% in the international programme is significant. Two programmes are already implemented for liver cancer and a sub-type of breast cancer.

OBJECTIVES

- ▶ Clarify the organisation and interactions between agencies, research organisations and INCa, define the coordination process and rules to ensure the sustainability of a unified leadership in cancer.
- ▶ Simplify research funding procedures by developing a single format for application forms and by increasing the project duration.
- ▶ Increase the visibility of French research at the international level, from fundamental to clinical research, and encourage and support the development of international cooperation on cancer.
- ▶ Strengthen the involvement of French teams in European cancer research programmes.
- ▶ Include cancer clusters in the development of European cooperation.
- ▶ Coordinate the participation of French research teams in programmes run by the International Cancer Genome Consortium and include community and industrial partners.
- ▶ Strengthen international cooperation efforts on research and set up coordination of European and American national cancer institutes. Involving industrial partners is essential to promote the cancer control continuum, from research to patients, back and forth.

ACTIONS

5.1 Provide the structural changes required to harmonise scheduling and funding of cancer research programmes and establish an annual consultation process involving the other institutes and the ANR to coordinate scheduling for cross-disciplinary research. Establish this type of consultation on programmes with charities participating in funding for cancer research.

The agreement between the INCa and Inserm to ensure that the cancer thematic research institute and research at the INCa have the same director will be extended to the “Institut thématique multi-organismes for cancer” set up by the Alliance.

Action coordinators: INCa, ITMO Cancer.
In partnership with the relevant stakeholders.



5.2 Support the cancer clusters' regional and inter-regional organisational and leadership efforts: team coordination, mobilisation of new teams in this area, coordination with universities, hospitals and organisations in the selection of equipment within the region, relationship with industry (technology and pharmaceuticals) and the regions. These efforts will be coordinated with the policy on accredited sites for integrated research.

Action coordinators: INCa, ITMO Cancer.
In partnership with the relevant stakeholders.

5.3 Maintain the level of research funding for free investigator-driven projects, for up to 4- to 5-year programmes, at the level of 50% of the INCa's call for research proposals.

Action coordinators: INCa, ITMO Cancer.
In partnership with the relevant stakeholders.

5.4 Support the cancer genome programme within the framework of the International Cancer Genome Consortium (ICGC).

Following the implementation phase of the first French programmes, a scientific evaluation of the initial results will be carried out. Depending on the results and the funding requirements that may emerge with the arrival of new technologies, its development and extension in 2010 and beyond will be assessed. The possible continuation of the programme could be on the basis of public-private partnerships, including charities.

Action coordinators: INCa, ITMO Cancer.
In partnership with the relevant stakeholders.

5.5 Develop international cooperation in research and public health to fight cancer by mobilising the Ministry of Foreign Affairs, INCa, IRD and the ANRS, particularly on training programmes for doctors and paramedics.

Action coordinators: INCa, ITMO Cancer.
Co-coordinators: IRD, MAEE.
In partnership with the relevant stakeholders.

5.6 Build capacity for measuring scientific productivity resulting from research programmes.

This action will be coordinated with research organisations, OST and the cancer clusters. Indicators for scientific production in the area of cancer will be produced and published every year: publications, citations and patent applications.

Action coordinators: INCa, ITMO Cancer.

Co-coordinator: DGRI.

In partnership with the relevant stakeholders.

Observation

Gain a better understanding of the reality of cancer in France

The Cancer Plan 2009-2013 devotes one chapter to the cancer monitoring system, demonstrating the increasing importance that the public authorities are attaching to this issue. Access to recent, reliable and comparable data on the number of cancers and their characteristics, being able to analyse minor signs and broaden our field of understanding beyond the illness itself to patients, the resources required and social representations are essential to the implementation of the Cancer Plan. Three issues are at stake: the cancer monitoring system is an essential tool in deciding on the direction of public policy, monitoring and evaluation of the plan. The cancer monitoring system also determines our ability to detect emerging risks, which is crucial in a context in which new products and technologies are being disseminated. Finally, the organisation of existing data on cancer and cancer research and their widespread dissemination are the natural corollary of taking account of the public's need for information and of the way cancer is perceived.

The Cancer Plan 2009-2013 takes the efforts made in the previous plan one step further in order to develop a national cancer epidemiology system that will be more detailed, more responsive and more forward-looking. It continues the efforts to improve monitoring by the cancer registers and the implementation of a complementary system based on data derived from a range of medical and administrative sources. Harmonisation of the various existing or planned automated information systems at data producers will extend beyond the term of the current plan.

4 MEASURES

MEASURE 6: PRODUCE AND COMMUNICATE INFORMATION ON CANCER AND CANCER RESEARCH AND TREATMENT.

MEASURE 7: OPTIMISE AND DEVELOP THE MONITORING SYSTEM.

MEASURE 8: DEVELOP SOCIAL EPIDEMIOLOGY FOR CANCER.

MEASURE 9: IMPROVE OBSERVATION AND MONITORING OF CANCERS RELATED TO THE WORKING ENVIRONMENT.

Cancer observation and monitoring is by its nature a cross-disciplinary exercise, which takes into account a number of new themes that are prioritised in the Cancer Plan 2009-2013. One example is the support for social epidemiology for cancer, which will provide an opportunity for a better understanding and characterisation of social and regional disparities in terms of incidence, mortality, exposure to risk and access to prevention, screening and treatment. This information is highly valuable for the purpose of implementing policies to reduce these inequalities, the focus of which goes beyond simply looking at the situation of the most vulnerable groups. It also applies to the development of monitoring exposure in the workplace and environmental factors for cancer. In addition to the measures set out in the “Plan national santé environnement 2”, the Cancer Plan 2009-2013 will contribute to the development of an ongoing monitoring system for work-related cancers, primarily based on the COSET cohort. It will increase targeted monitoring of certain cancers, either by implementing a declaration-based system, or by experimentation, in particular in relation to those cancers for which a link to environmental exposure has been proven or is suspected, or the development of which could be a sign of emerging risks.

Pooling, harmonising and disseminating all the data which will be produced in this way is the most visible measure in the “observation” category, both for professionals and the general public, and should begin to be implemented from 2009.



Measure 6.

Produce and communicate information on cancer and cancer research and treatment on an annual basis.

BACKGROUND

The existing data necessary to monitor and evaluate cancers and cancer research and treatment are not homogeneous, given the multiplicity of sources and data producers. In addition, the data producers have a general role and institutional targets specific to their particular function. Monitoring data are of various kinds and derive from a diverse range of information systems, primarily relating to the structure, resources and activities of healthcare institutions or services (e.g. SAE, PMSI, and cancer screening management organisations), coverage by social security (long-term illnesses - ALD), budget information (PLF, PLFSS), epidemiological data (actual incidence and estimates of incidence in the cancer registers, mortality observed at Inserm's Centre for Epidemiology on the medical causes of death (CépiDc), or studies produced by research organisations or learned societies), etc. The institutions in charge of epidemiological monitoring do not necessarily have data relating to cases/incidents and encounter various obstacles in obtaining this kind of information, as well as personal data that would allow monitoring to take place over a period of time. In addition to improving the quality of the information gathered and the rate of data production on the incidence of cancers and survival rates by the registers, the development of the SMSC (cf. measure 7.2) will be used to produce statistics that will be updated on an annual basis. These statistics will be sent to the INCa for dissemination to the general public. A system to improve social monitoring of cancers is provided under measure 8. A summary of this information and its annual publication by the INCa is a means of ensuring transparency in respect of both the general public and decision-makers and will help to monitor the policy for fighting cancer more effectively.

OBJECTIVES

- ▶ Make the main data on cancer and the main indicators for the policy for fighting cancer available to the public and decision-makers on an annual basis, both at a national and regional level.
 - ▶ Ensure ongoing access to existing data by creating a "Cancer" portal on the INCa website.
 - ▶ Carry out regular surveys on understanding, attitudes, behaviours and perceptions of cancers and risk factors.
-

- ▶ Develop a scorecard for cancer research functions and publish a report.
- ▶ Produce and publish an annual estimate of the incidence of cancer and cancer-related deaths in France.

ACTIONS

6.1 Publish an annual updated summary report of cancer-related data and of the principal indicators for the policy for the fight against cancer.

Action coordinator: INCa.
In partnership with the relevant stakeholders.

6.2 Create a portal for cancer data, giving access to a summary of the main relevant data by identified type and source.

- ▶ Create a cancer data portal on the INCa site, summarising the main information. INCa will identify, in conjunction with all the main institutional and community players that produce data, the information to be gathered and published, particularly in relation to descriptive or analytical epidemiology, treatment activities, patients' quality of life, costs of care, the resources mobilised in terms of structures, professionals and funding and any other relevant data.

Action coordinator: INCa.
In partnership with the relevant stakeholders.

6.3 Carry out regular surveys on understanding, attitudes, behaviours and perceptions of cancers and risk factors, in particular a cancer "barometer".

Cancer barometer coordinator: INPES
Coordinator for other surveys: INCa.
In partnership with the relevant stakeholders.



6.4 Produce a report on cancer-related jobs and functions and develop a scorecard in conjunction with groups of experts and healthcare professionals.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

6.5 Monitor patients' living conditions in the years after they have been diagnosed with cancer.

- ▶ Carry out a survey every five years to gather data on patients' living conditions and quality of life two years after their cancer diagnosis using the long-term illness database of the health insurance organisations.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Links with other public health plans.

Quality of life plan for patients with chronic illnesses.

Measure 7.

Optimise and develop the monitoring system.

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BACKGROUND

The monitoring system for cancers in France is primarily based on the specialist and general cancer registers. The registers provide incidence data for the areas they cover, thus making it possible to estimate incidence at a national and regional level and carry out survival studies. Coverage of the general adult population in the “all cancers” registers is 18%. whilst the registers *are the gold standard* for calculating incidence, the system is not particularly responsive and does not include some data that would be useful for environmental studies (precise address) or evaluating screening policies (stage at point of diagnosis) or changes to treatment policies, and only covers part of the country.

There are therefore two aspects to improving the monitoring system:

- ▶ strengthen the existing system of registers, by gathering additional data in a shorter time frame;
- ▶ and continue to develop an automated national registration system for anonymised individual data, the multi-source cancer system (SMSC), based on data derived from anatomico-cytopathology (ACP) reports, the healthcare programme of information systems in healthcare establishments and the long-illness database of the health insurance organisations (ALD 30). The system will adapt to new requirements in respect of the Cancer Communication Record (DCC) and the national health identification number.

OBJECTIVES

- ▶ Maintain and improve the quality of the existing registers.
- ▶ Implement a national information system on the basis of cross-referencing three sources (ACP, PMSI and ALD 30) and publish provisional indicators for incidence at a national level until the SMSC has been fully implemented.



ACTIONS

7.1 Strengthen and rationalise the system for the existing registers.

- ▶ Facilitate access to data sources, if necessary through legislation (ALD 30, DCC, RCP files, CRFS, etc.) and ensure they are sent systematically to registers and cancer screening coordination centres. Include information on individual medical data being sent to registers and cancer screening coordination centres on the various materials sent to patients (welcome booklets, long-term illness booklets, medical expenses reimbursement forms). The legislative and regulatory changes to the registers are targeting individual access to death certificates that refer to cancer held by the CépiDc and free access to the RNIPP to find out whether patients are still alive, information which is essential for monitoring survival rates.
- ▶ Develop a set of specifications by the InVS, INCa and the existing registers in order to increase the amount of information gathered by the registers and define the terms for a regular analysis of survival rates by systematically monitoring cases and defining the terms under which they would be published. These specifications will set out the conditions for improving the methodology for “high resolution” studies to enable regular, detailed analyses of certain cancers. They would include the validation period for data recorded at three years by 2012.
- ▶ Produce annual estimates of incidence and mortality on the basis of a validated methodology; produce updates of prevalence and survival every two years; publish the results on the InVS and INCa websites.

Action coordinator: InVS

In partnership with the relevant stakeholders.

Legislative changes.

PLRPSP 2010.

7.2 Develop a multi-source cancer system (SMSC).

- ▶ Conclude an agreement between the InVS and the Agence des systèmes d'information de santé partagés (ASIP) to draft guidelines on standards and common exchange formats for the ALD and PMSI, on the basis of a unique anonymous identification number (known as a FOIN number) in order to produce provisional indicators for incidence from 2010.

- ▶ Implement the necessary regulations for anatomo-cytopathological data to be sent to the InVS.
- ▶ Define, following agreement between the INCa and representatives of surgical pathologists and in conjunction with the InVS, the minimum enforceable ACP data required to complete the Cancer Communication File (DCC).
- ▶ Continue the work being carried out by the InVS and ASIP on a national health identification number on the basis of semantic (content) and software (exchange standards) compatibility. Authorisation to use the identification number will be requested from the French Data Protection Authority (CNIL).

Action coordinator: InVS

In partnership with the relevant stakeholders.



Measure 8.

Develop social epidemiology for cancer.

BACKGROUND

Health disparities are particularly prevalent in the field of cancer, in terms of risk and quality of life during care and after treatment, as well as in terms of survival. These inequalities are socio-economic as well as geographical and demographic in origin. The risk of dying from cancer between the ages of 30 and 65, for example, is twice as high amongst working-class people as amongst executives and independent professionals; the map of excess mortality shows a crescent in the North/North-East of France and, in recent years, a diagonal line from the North-East to Auvergne.

Reducing these disparities lies at the heart of the Cancer Plan 2009-2013. It is therefore important to produce an inventory of existing data and the data needed to ensure more effective monitoring of changes in disparities. Ways of gathering and analysing data that can quantify these inequalities objectively need to be developed, primarily to gain a better understanding of the factors that underpin these inequalities, adapt policies appropriately and monitor and evaluate the measures implemented.

OBJECTIVES

- ▶ Develop a system for monitoring and measuring changes in inequalities in the field of cancer.
 - ▶ Analyse the socio-economic, geographical and demographic data available for cancer and define relevant monitoring indicators.
 - ▶ Gather information on living conditions and quality of life for cancer patients.
 - ▶ Compile information on intervention strategies using results from research activities.
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ACTIONS

8.1 Improve monitoring of inequalities.

- ▶ Task the Haut conseil de la santé publique (HCSP) with putting forward definitions for relevant indicators, given the existing systems for gathering data, and ensure monitoring of health inequalities in the area of cancer, its risk factors and consequences, particularly in terms of mortality. The HCSP will describe the inequalities around the country in terms of access to cancer prevention and treatment services and monitor changes based on the actions carried out by the regional health authorities. (Measures 2.1 and 2.2 relate to research, whilst measure 8.1 applies to the indicators used in major national surveys such as the health insurance survey (SPSS), the ten-yearly Insee survey and the Cancer Barometer).

Action coordinator: DGS

In partnership with the relevant stakeholders.

Links with other public health plans.

Research contributing to all public health plans.

8.2 Analyse changes in socio-spatial disparities in relation to cancer.

- ▶ Carry out a study every five years on socio-spatial changes in cancer-related deaths at the relevant territorial level depending on the prevalence of each type of cancer.
- ▶ Develop studies either at an aggregate level (including geographical indices for “disadvantage”) or an individual level, cross-referencing changes in mortality with changes in the main demographic, social and economic indicators and in relation to the treatment services available and known exposures.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Legislative or regulatory changes.

Adapt legislation or regulations in light of the obstacles encountered.



Measure 9.

Improve observation and monitoring of cancers related to the working environment.

BACKGROUND

Depending on the sources used, between 2.3 and 5 million employees in France are exposed to carcinogenic agents. The InVS estimates that the proportion of work-related cancers is between 3 and 6%, i.e. between 5,000 and 10,000 new cases each year. Over half of all work-related cancers where the risk factors are known are linked to exposure to asbestos. Mesotheliomas are the subject of a national monitoring programme in 22 of the French départements and detailed recording of all incident mesotheliomas will be a useful addition to the National Multi-centre Pleural Mesothelioma Register (Mesonat). In addition to gaining an understanding of product toxicology, creating a cohort of workers in a range of sectors engaging in a variety of activities and with exposure to a range of nuisances will provide an opportunity for long-term monitoring of the health of populations of exposed workers.

Environmental changes could be partially responsible for the increase in the incidence of cancers. Based on current knowledge, the percentage of cancers that can be attributed to environmental factors cannot be reliably calculated, so research efforts must focus both on measuring different populations' exposure to proven or probable carcinogens and on defining the existence and nature of the causal relationship. In addition to the implementation of a system of biosurveillance through the PNSE2 (National Environmental Health Plan 2), targeted national epidemiological studies are necessary to improve our understanding of the carcinogenic effects of certain pollutants. Finally, it would be useful to carry out further investigations on suspected cancer clusters both in the general population and in the workplace.

OBJECTIVE

- ▶ Strengthen the observation and monitoring systems for cancers related to the general or working environment, gain a better understanding of the delayed effects of exposure and optimise monitoring and alert systems for detecting emerging risks.

ACTIONS

9.1 Make mesothelioma declarations compulsory.

- ▶ Use regulations to make mesothelioma declarations compulsory whatever their anatomical location and test the feasibility of this using a pilot study before moving on to full implementation.

Action coordinator: InVS

In partnership with the relevant stakeholders.

Legislative and regulatory changes.

Decree amending article D.3113-7 of the CSP (French Public Health Code) that sets out the list of illnesses subject to compulsory declaration.

9.2 Develop research on the basis of existing cohorts or those in the course of being created.

- ▶ Continue the development by the InVS of job-exposure matrices applicable to the general population to identify the past workplace exposure of subjects included in the cohort.
- ▶ Examine the feasibility of monitoring biological indicators for exposure in the working population, particularly women.
- ▶ Implement tools for monitoring the health of the working population exposed to new technologies, especially intentionally manufactured nanoparticles.

Action coordinator: InVS

In partnership with the relevant stakeholders.

9.3 Lead and manage the collection of reports and investigations of cancer clusters in the general population and the working environment.

- ▶ Sign an agreement between the InVS and the healthcare professionals (company medical officers, referring doctors, CHSCT, labour inspectorate) to organise a feedback mechanism for the information they are aware of, within the bounds of professional confidentiality.
- ▶ Improve reporting from the various players affected by the implementation of a framework agreement with the InVS, which is in charge of coordinating and updating data.

Action coordinator: InVS

In partnership with the relevant stakeholders.

Prevention - Screening

Take preventive actions to avoid cancers or reduce their seriousness

Action can be taken to lower the incidence of certain cancers by reducing or eliminating exposure to risk factors. It is also possible to reduce their seriousness, lower mortality rates and improve the quality or duration of life for survivors by identifying susceptibility factors, screening or early diagnosis. The “Hôpital, patients, santé, territoires” law has strengthened prevention for the principal risk factors for cancer. Several priority measures have been taken to protect environmental health, women and certain vulnerable categories of population.

Implementing a cancer prevention programme, whether it is targeted at individual or environmental determinants or risk factors, requires the development of a diverse range of individual or collective strategies, based on mobilising professionals from a multiplicity of disciplines and civil society. Front-line healthcare professionals, in particular referring doctors, are in the best position to identify exposure to cancer risks most effectively, recommend ways of reducing risk and offer access to appropriate screening (on an individual basis or as part of an organised screening programme). They have the best understanding of the individual, their environment and the people around them and can introduce these procedures at the appropriate time in their life or treatment regime. The “Hôpital, patients, santé, territoires” law confirmed and strengthened the essential role of the general practitioner at every level of prevention.

Organised screening programmes for some cancers (breast cancer screening for women and colorectal screening for both genders) are automatically offered every two years to people in France aged 50 to 74. These screening programmes must comply with strict requirements

8 MEASURES

PREVENTION

MEASURE 10: CONTINUE TO FIGHT SMOKING.

MEASURE 11: PROMOTE PREVENTIVE ACTIONS ON THE LINKS
BETWEEN DIET, PHYSICAL ACTIVITY AND CANCER.

MEASURE 12: STRENGTHEN PREVENTION PROGRAMMES FOR
CANCERS RELATED TO THE ENVIRONMENT,
PARTICULARLY IN THE WORKPLACE.

MEASURE 13: PREVENT CANCERS OF INFECTIOUS ORIGIN.

SCREENING

MEASURE 14: TACKLE INEQUALITIES IN ACCESS AND TAKE-UP OF
SCREENING.

MEASURE 15: IMPROVE CONFIGURATION OF THE NATIONAL
ORGANISED SCREENING PROGRAMMES.

MEASURE 16: INVOLVE REFERRING DOCTORS IN NATIONAL
SCREENING PROGRAMMES AND GUARANTEE
EQUALITY OF ACCESS TO THE MOST EFFECTIVE
TECHNIQUES THROUGHOUT THE COUNTRY.

MEASURE 17: MONITOR A SCIENTIFIC WATCH AND IMPROVE
KNOWLEDGE ON EARLY CANCER DETECTION.

in terms of quality and safety; their impact depends on the level of participation. In spite of the significant progress made, their benefits are still not sufficiently well understood. New strategies need to be deployed to ensure maximum participation, primarily to limit as far as possible the effects of the social inequalities that tend to hinder participation in screening programmes. Also take account of technological advances whilst maintaining quality and safety standards. Alongside the organised programmes targeting people at medium risk, actions and recommendations need to be developed to take account of higher levels of risk or individual susceptibilities, where screening resources and the expected benefits permit.



Having a positive impact on the determinants for cancer involves imposing constraints on individual behaviours and supply and demand for products whose role in the development of cancer has been established. Verifying compliance with restrictions on the use of carcinogenic, mutagenic or reprotoxic (CMR) products in the workplace needs to be strengthened, as does the development of substitute products. Faced with uncertainties about the links or impact of environmental exposure, which is often diffuse or at a low level, further research needs to be undertaken and precautionary behaviours investigated at a community level.

Measure 10.

CONTINUE TO FIGHT SMOKING.

BACKGROUND

Recent years have seen an aggressive campaign against smoking within the strategic framework of the 2003-2007 Cancer Plan. This policy, which covers all fields of activity in smoking prevention, has to some extent been successful. In particular, it has had lasting effects on young people (minors) and women, who were the two priority target populations for the campaign. Nevertheless, the overall prevalence in France is still too high: with approximately 30% of the population smoking in 2005, our country is still a long way from the prevalence of less than 20% recommended by the WHO. The evaluation of the Cancer Plan carried out by the Haut conseil de la santé publique (HCSP) demonstrated the seriousness of the consequences of increased smoking amongst women in the 70, with higher incidence and mortality as a result of bronchopulmonary cancer in women, contrary to the trend amongst men, whose smoking rates had begun to fall during the same period. At a strategic level, our country needs to comply with the recommendation of the WHO Framework Convention on Tobacco Control, which France ratified in 2004. Just recently, in its report to the DGS, the Académie nationale de médecine (National Academy of Medicine) recommended embarking on a new campaign against tobacco. This invitation echoes the commitments made by health ministers in the European Union, who has taken steps to “reduce the exposure of populations to the main risk factors”, including tobacco use, as emphasised in the conclusions of the Council of Europe “Reducing the burden of cancer”, adopted on 10 June 2008.

OBJECTIVES

- ▶ Reduce the prevalence of smoking in the French population from 30% to 20%.
- ▶ Reduce the multiple incentives to consume tobacco in order to limit demand, while taking account of the necessity of tackling social and regional inequalities in relation to tobacco use.



ACTIONS

10.1 Reduce the attractiveness of tobacco products.

- ▶ Introduce graphic health warnings.

Action coordinator: DGS

In partnership with the relevant stakeholders.

- ▶ Propose the use of legislation to end advertising at the point of sale and during television broadcasts of motor sports.

Action coordinator: DGS

In partnership with the relevant stakeholders.

Legislative changes.

LRPSP 2010.

10.2 Strengthen the policy of help to smoking cessation.

- ▶ Develop access to nicotine substitutes for pregnant women and people entitled to receive full social security cover for medical care.

A funding programme created on 1st February 2007 and financed by the social security is used to reimburse the cost of nicotine substitutes and certain drugs used to stop smoking, up to an amount of € 50 per year per beneficiary. The programme is already open to pregnant women and patients entitled to receive full social security cover for medical care. Given the particular issues involved in stopping smoking during pregnancy, it is proposed to increase the fund to benefit pregnant women and beneficiaries of full social security cover for medical care for their first year of care, for which the French government and social security will increase coverage to € 150, thus covering three months' worth of substitutes.

Action coordinator: DSS.

In partnership with the relevant stakeholders.

- ▶ Improve remote assistance and increase its accessibility and efficiency.

Action coordinator: INPES

In partnership with the relevant stakeholders.

- ▶ Develop information campaigns on the risks of smoking.

Action coordinator: INPES

In partnership with the relevant stakeholders.

- ▶ Improve the quality of help available for stopping smoking on the basis of new professional recommendations.

Action coordinator: HAS.

In partnership with the relevant stakeholders.

10.3 Disseminate more regular data on tobacco consumption.

- ▶ Strengthen the follow-up of measures to fight smoking by developing an annual barometer.

Action coordinator: INPES

In partnership with the relevant stakeholders.

10.4 Implement the measures to protect minors from smoking adopted in the “Hôpital, patients, santé, territoires” law.

- ▶ Ensure that the extension of the prohibition on selling tobacco to minors aged 16 to 18 is actually enforced.
- ▶ Ensure that the prohibition on cigarette sweets is actually enforced.

Action coordinator: DGS

In partnership with the relevant stakeholders.

10.5 Prohibit the sale of tobacco products on the Internet by signing an additional amendment to the Framework Convention on Tobacco Control in 2011.

Action coordinator: DGDDI (customs).

In partnership with the relevant stakeholders.



Measure 11.

Promote preventive actions on the links between diet, physical activity and cancer.

BACKGROUND

The role of nutritional factors as protection or risk factors for cancer is increasingly well understood, as confirmed in the publication of the latest WCRF/AICR report “Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective” in November 2007. The report, which is classed as an international benchmark in this area, re-evaluated the level of evidence for the relationship between nutrition and the risk of cancer. It shows that certain factors, such as physical activity, eating fruit and vegetables and breastfeeding can reduce the risk of cancer. Others, conversely, can increase the risk of cancer, for example being overweight or obese, alcoholic drinks, red meat, cured meat products and salt. Exercise has a preventive effect on colon cancer and a probable preventive effect on post-menopausal breast cancer and cancer of the endometrium. In addition, cancer patients can improve their quality of life and reduce their feelings of fatigue during and after treatment by taking appropriate exercise of low to moderate intensity. Conversely, a sedentary lifestyle has been identified as a risk factor for certain cancers and contributes to around 2,200 cancer-related deaths every year in France. There is deep concern about the lack of physical activity amongst children and adults, particularly in sensitive urban areas, which is closely linked to the inauspiciousness of the immediate environment. Changing the urban environment and examining the question of building design in order to make it easier for people to take part in physical activity in safe conditions is therefore essential.

OBJECTIVE

- ▶ Contribute to creating an environment that helps people to adopt and maintain regular physical activity and a healthy diet for all age groups, particularly those suffering from or at risk of cancer.
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ACTIONS

11.1 Provide information to elected representatives and regional civil servants on the links between nutrition and cancer and the role of physical activity.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.

Links with other public health plans.

PNNS.

PNSE2.

11.2 Provide support for studies on obstacles or difficulties in participating in physical activity, as perceived by both inhabitants and professionals (architects, town planners, sports and sociocultural leaders, etc.).

Action coordinator: DGS

In partnership with the relevant stakeholders.

Links with other public health plans.

PNNS.

PNSE2.

National plan for prevention through physical education (PNAPS) (Report, October 2008).

National “ageing well” plan 2007-2009.

Quality of life plan for patients with chronic illnesses 2007-2011.



11.3 Promote awareness-raising actions on physical activity for future retirees, amongst employers and works committees.

This action will be carried out with the support of complementary social security organisations.

Action coordinator: INPES

In partnership with the relevant stakeholders.

Links with other public health plans.

PNNS.

PNSE2.

National plan for prevention through physical education (PNAPS) (report, October 2008).

National “ageing well” plan 2007-2009.

11.4 Improve understanding of nutritional risks and nutritional care for people with cancer.

- ▶ Launch calls for proposals on nutritional risks and general healthcare (nutritional, physical activity, psychological) for people with cancer, given that obesity in particular is a risk factor for a recurrence of breast cancer.
- ▶ Enhance understanding and information about the link between nutrition/physical activity and cancer within the framework of the PNNS.
- ▶ Finance studies and produce information documents on the current state of knowledge.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Links with other public health plans.

PNNS.

PNSE2.

National plan for prevention through physical education (PNAPS) (report, October 2008).

Quality of life plan for patients with chronic illnesses 2007-2011.

11.5 Specify the alcohol content of alcoholic drinks on the container in order to make it easier to estimate intake.

Action coordinator: DGS

In partnership with the relevant stakeholders.

11.6 Provide more help for people experiencing problems with their level of alcohol consumption.

- ▶ Improve access to care for people experiencing the most problems with their level of alcohol consumption by increasing the resources available to treatment, support and addiction prevention centres.

Action coordinator: DGS

In partnership with the relevant stakeholders.

- ▶ Develop remote support (telephone and Internet) for consumers at risk.

Action coordinator: INPES

In partnership with the relevant stakeholders.

- ▶ Reevaluate strategies for training referring doctors to disseminate early identification and brief intervention information.

Action coordinator: DGS

In partnership with the relevant stakeholders.

Links with other public health plans.

Plan for care and prevention of addiction 2007-2011.

Government plan to fight drugs and drug addiction 2008-2011.

11.7 Implement measures relating to the supply of alcohol adopted in the “Hôpital, patients, santé, territoires” law designed to restrict the supply of alcohol to minors in filling stations, provisions on “happy hours” and display advertising on the Internet.

Action coordinator: DGS

In partnership with the relevant stakeholders.



Measure 12.

Strengthen prevention programmes for cancers related to the environment, particularly in the workplace.

BACKGROUND

Depending on the sources used, between 2.3 and 5 million employees in France are exposed to carcinogenic agents and the proportion of work-related cancers is estimated at between 5,000 and 10,000 new cases each year. In 2006, 1,857 cancers were recognised as being work-related in origin, 1,619 of which were due to asbestos. The difficulty of identifying the proportion attributable to exposure in the workplace is due to the time frame over which cancers appear, the multiple factors that cause them, the lack of awareness concerning exposure and the under-declaration of occupational illnesses, and inadequate research and epidemiological monitoring resources. In addition, there is lack of understanding of the relationship between work and cancer and the difficulty of identifying, in day-to-day medical practice, people with cancer for whom it would be relevant to seek a work-related etiology.

As far as the prevention of carcinogenic risks in professional environments is concerned, France has a comprehensive legal arsenal at its disposal, within the general framework of European Union law and the minimum requirements set out in EU directives. The strategy for protecting workers is based, in the first place, on a particularly stringent obligation to seek substitutes in respect of the chemical risks posed by carcinogenic, mutagenic or reprotoxic products (CMR). Where this is technically impossible, exposure to carcinogenic agents must be reduced to a minimum by implementing appropriate protection.

Cancer is the main source of fear in terms of illnesses related to the environment. According to the InVS, 5 to 10% of cancers are linked to environmental factors. Given the increasing demand for information, doctors deplore the lack of reliable, easily accessible knowledge on this subject. In 2008, European Union health ministers made a commitment to reducing these risks by reducing exposure to carcinogenic agents in the workplace, environment and diet, in the conclusions of the Council of Europe's "Reducing the burden of cancer" report, which echoed the concerns expressed by European Union environment ministers at the "Environment and Health" conference held at the end of 2007. The Exposure to UV radiation is the leading cause of skin cancer. Prevention of this form of cancer is linked to the actions set out in the PNES2, one of the objectives of which is to reduce exposure to pathologies with a serious impact on health.

OBJECTIVES

- ▶ Gain a better understanding of work-related cancers.
- ▶ Guarantee preventive medical monitoring for workers exposed to carcinogenic agents by developing benchmarks for company medical officers.
- ▶ Improve diagnosis of work-related cancer etiologies.
- ▶ Reduce the incidence of skin cancers and exposure to natural or artificial UV radiation.
- ▶ Verify that regulations are enforced.
- ▶ Contribute to developing traceability for environmental exposure, particularly in the workplace, in conjunction with the actions set out in the PNSE2.

ACTIONS

12.1 Improve identification of work-related cancers.

This action will be based on coordinating the existing databases (identification and optimisation of the use of existing databases), improving existing statistical tools and cross-referencing approaches by risk, population and geo-spatial distribution.

Action coordinator: DGT.

In partnership with the relevant stakeholders.

12.2 Carry out more stringent verification campaigns on the application of regulations with all firms, targeting the most commonly used carcinogens and making the necessary changes to regulations.

This involves continuing with existing verification campaigns in order to assess changes and extending them to other CMR (carcinogenic, mutagenic or reprotoxic) chemical products and making changes to existing provisions through pursuing the transposition into law of Directive 2006/25/EC on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation).

Action coordinator: DGT.

In partnership with the relevant stakeholders.



12.3 Develop good practice recommendations for company medical officers and referring doctors to improve medical supervision of workers exposed to CMR.

These recommendations will be drawn up by the Haute autorité de santé and will be applicable to the whole of the working population whatever their status (monitored through the company medical department or after employment) and whatever the health professional.

Action coordinator: DGT.

In partnership with the relevant stakeholders.

Legislative changes.

Bill depending on the results of negotiations between social partners on the reform of occupational health services.

12.4 Test and evaluate the benefits of setting up specific “work-related cancer” consultations to improve the diagnosis of etiologies and declaration of work-related cancers.

This pilot campaign will be based on a call for research/action proposals to test the relevance of the concept of specific “work-related cancer” consultations.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Links with other public health plans.

Plan Santé Travail 2.
PNSE2.

Legislative changes.

PLHPST.
LRPSP 2010.

Other: Bill depending on the results of negotiations between social partners on the reform of occupational health services.

12.5 Increase protection from exposure to UV radiation.

- ▶ Set up an information and prevention scheme on the risks of UV radiation in 2009, in particular the risk from exposure to the sun and from the use of tanning cubicles. The primary target for the scheme will be young children (via their parents), adolescents and young adults, who are the populations with highest exposure to UV radiation.
- ▶ Restrict the sale of sun protection products that only offer protection from UVB, either by prohibiting them – within the bounds of European regulations – or on a voluntary basis, as well as products that offer inadequate protection. Regulatory measures must also be put in place to require the inclusion of information on the risks of natural and artificial UV radiation.
- ▶ Introduce changes to European and national regulations covering artificial tanning services by limiting authorisation to UV3-type devices only and verifying compliance with the regulations, making the completion of an informed consent form by the client compulsory and requiring that information be provided in a written format.
- ▶ Continue efforts to transpose into law Directive 2006/25/EC of the European Parliament and Council of 5 April 2006 on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation).

Action coordinator: DGS

In partnership with the relevant stakeholders.

12.6 Provide better information on the risks of radon in housing.

Although radon, which is a natural radioactive gas, is a proven carcinogen and responsible for 9% of lung cancers and 2% of all cancers in Europe, almost 62% of people questioned in the Inpes-IRSN survey declared that they had never heard of it as a risk and only 12% felt that they were well informed about it.

A management plan included in the second national health and environment plan aims to take account of radon risk in building regulations and strengthen incentives for making it easier to identify and resolve situations of exposure in existing housing. The success of this plan will rely on more effective communication about the risks of exposure to radon.

- ▶ Draw up a three-year communications plan to increase the national recognition index for the dangers of radon in housing. Combine these communications with the dangers of tobacco use as part of a general objective of reducing the incidence of lung cancer.

Action coordinator: DGS

In partnership with the relevant stakeholders.

Links with other public health plans.

PNSE2.

Measure 13.

Prevent cancers of infectious origin.

BACKGROUND

Several infectious illnesses are directly linked to cancers or contribute to their development (cervical, stomach and liver cancers, amongst others). For other cancers (lymphomas, for example) the link with infections, particularly viral infections, is strongly suspected; in HIV infection, it is the resulting immunodepression that seems to be the main factor in the increased occurrence of cancer. Several methods can be used for primary prevention (vaccination: VHB and HPV, reduction in transmission of infection in day-to-day life and during treatment) and secondary or tertiary prevention (screening and treatment of infections).

Chronic infections from the hepatitis B and C viruses affect around 500,000 adults aged 18 to 80 in mainland France. These have the potential to develop into cirrhosis and/or liver cancer (4,000 deaths a year, around a third of which are caused by hepatocellular carcinoma). Epidemiological data show that the most common form of gastric cancer almost always occurs following an inflammation of the gastric mucus caused by chronic bacterial infection.

Cervical cancer is the 10th most common cancer in women in terms of frequency, with over 3,000 estimated cases in 2005 and the 15th most deadly cancer in women, with over 1,000 estimated deaths.

Two vaccinations for VHB and HPV are available. These are the subject of recommendations by the CTV-HCSP, are included in the vaccination schedule and are covered by the social security. Nonetheless, vaccination rates for these two vaccinations are inadequate, in particular for the priority target populations. Screening for chronic VHC and VHB infections and treatment for chronic infections remains inadequate.

OBJECTIVE

- ▶ Prevent cancers of infectious origin, which involves prevention, screening and treatment of the infections themselves.



ACTIONS

13.1 Improve the take-up rate of HPV vaccination in 14-year-old girls.

- ▶ Disseminate appropriate information to the public on the HPV vaccination targeted at girls aged 14 and their parents, whilst emphasising that screening using a cervical smear test is still essential from the age of 25.
- ▶ Examine the conditions for reimbursement from the French social security for the purchase of vaccines in vaccination centres.
- ▶ Examine the conditions for improving access to vaccination for minors whose parents disagree with vaccination.

Action coordinator: DGS

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

13.2 Contribute to the implementation of the measures set out in the plan to fight viral hepatitis B and C 2009-2012, and in particular:

- ▶ Relaunch vaccination for VHB in target populations (infants and people exposed to risk) by providing information to doctors and the population.
- ▶ Encourage screening for chronic carriers of the B and C viruses.
- ▶ Improve access to care and treatment for people with chronic infections.

Action coordinator: DGS

In partnership with the relevant stakeholders.

13.3 Produce information documents for doctors to improve screening for people presenting with a chronic *Helicobacter pylori* infection, which is the cause of some cancers of the digestive system.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

13.4 Promote prevention through early cancer detection and treatment of people living with HIV.

- ▶ Continue epidemiological monitoring and carry out research on risk factors for the occurrence of cancer during.
- ▶ Increase screening for anal lesions for people living with HIV: organise access to specialist consultations at healthcare institutions that are members of COREVIH.
- ▶ Tackle smoking in people living with HIV; improve and support cooperation between specialist HIV teams and teams specialising in addiction and tobacco use; train HIV care teams in identifying and treating tobacco dependence.

Action coordinator: DGS

In partnership with the relevant stakeholders.

Links with other public health plans.

National hepatitis plan 2009-2012.

Government plan to fight drugs and drug addiction 2008-2011.

Treatment and prevention of addiction plan 2007-2011.

National strategy for improving protection through vaccination: under development.

HIV/STI Plan 2009-2012.

Legislative changes.

LRPSP 2010: add a final paragraph to article L.3111-11 of the French Public Health Code (CSP).

Add to the second paragraph of article L.3112-3.

Add to article L.3111-5 of the CSP.

Measure 14.

Tackle inequalities in access and take-up of screening.

BACKGROUND

Two national organised screening programmes for breast cancer and colorectal cancer have been developed and gradually rolled out, and a pilot screening programme for cervical cancer is also being supported.

Referring doctors are at the heart of the screening programme for colorectal cancer, as it is their job to seek consent from the patient, evaluate situations of exclusion and submit the test, explaining the methods used and the consequences of a positive result. They are also in the front line in terms of managing false positives and false negatives produced by screening. Doctors are involved in breast cancer screening through the commitments made in the agreements entered into in 2006 and play an important role in identifying levels of risk. An integrated screening programme for cervical cancer is currently being piloted. Doctors should also be trained so that they are in a position to propose screening by offering appropriate information on its benefits and limitations so that patients are able to make an informed choice.

All populations concerned are sent a personalised letter inviting them to take part in the various screening programmes. Nonetheless, there are a number of disparities in terms of participation across the country and significant inequalities in relation to socio-economic and cultural factors. Further inequalities exist in terms of the level of risk for the population not covered by screening programmes.

In order to make the cancer screening policy more effective it is therefore essential to make it easier for referring doctors to participate in screening, reduce disparity factors and improve the awareness to the existing levels of risk.

OBJECTIVE

- ▶ Facilitate participation by referring doctors in organised screening programmes and make it easier for people to access appropriate screening.

ACTIONS

14.1 Encourage participation in and loyalty to screening programmes and reduce the discrepancies in participation rates.

- ▶ Carry out studies designed to identify obstacles to primary and subsequent participation, particularly in départements with a participation rate of less than 50%, and evaluate the maintenance of dual access to breast cancer screening.
- ▶ Mobilise local players in cancer screening coordination centres, in particular *via* Regional Health Agencies (ARS) to act as a relay for national policy and adapt it to local circumstances.
- ▶ Evaluate compliance with screening rates and good practices in line with specifications and recommendations.
- ▶ Provide information for healthcare professionals and target populations on screening rates and good practices.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.

14.2 Implement actions designed to reduce socio-economic, cultural and regional inequalities in access to and take-up of screening.

This action will be implemented in conjunction with actions 2.1 and 8.1 in this plan on reducing inequalities.

- ▶ Carry out geocoding studies and develop a geographical information system to identify regions where screening rates are low as well as disparity factors.
- ▶ Encourage and finance research/action projects aimed at vulnerable or isolated populations (local actions coordinated by the ARS and calls for specific proposals) and organise seminars to exchange ideas and share experiences.
- ▶ Mobilise health professionals to raise awareness amongst people with problems of access to care in order to ensure they are included in screening programmes for breast, colorectal and cervical cancer.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.



14.3 Support access to testing in line with the level of risk.

- ▶ Develop and disseminate recommendations designed to improve screening conditions for people at high or very high risk and support access to appropriate screening strategies and the participation of the population concerned.
- ▶ Provide information on risk levels and train healthcare professionals to provide more effective guidance for people at high or very high risk, in particular by explaining how to access oncogenetic consultations (breast and colorectal cancer).

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Measure 15.

Improve configuration of the national organised screening programmes.

BACKGROUND

At the national level, screening programmes are organised by the DGS in conjunction with the French social security and the National Cancer Institute. Operational funding for local screening coordination centres (or management bodies) is split equally between the DGS and the French social security with a standardised budget (Apache form) and an annual report. The French social security also funds screening activities and compensates general practitioners as part of the overall screening programme.

Breast and colorectal cancer screening programmes have been successfully rolled out across the country. An epidemiological evaluation is carried out by the Institut national de veille sanitaire (InVS) on a regular basis. Cervical cancer screening trials are currently being rolled out.

At a regional level, the GRSP and the social security are responsible for managing and facilitating programmes linked to the PRSP. The new regional health agencies (ARS) will need to take this over. At a local level, organised screening programmes are run by the departmental or inter-departmental coordination centres (there are 89 centres for 100 départements). An innovation in the field of healthcare, the vast majority of these organisations and centres are associations.

OBJECTIVE

- ▶ Consolidate the system of national organised cancer screening programmes.



ACTIONS

15.1 Improve the efficiency of organised screening programmes by optimising the operation of the cancer screening coordination centres.

- ▶ Pursue and improve participation rates amongst target populations in national organised screening programmes for breast cancer and colorectal cancer. In conjunction with measure 14.1 of this plan, participation in both programmes should increase over the period covered by the Cancer Plan from 52.3% in 2008 to over 65% in 2013 for breast cancer screening and from 43% in 2006 to more than 60% in 2013 for colorectal cancer. Non-reimbursement of individual breast-cancer screening carried out outside the national programme will be examined.
- ▶ Create benchmarks for good practices and good financial management by optimising and professionalising the operation of cancer screening coordination centres.
- ▶ Strengthen management of the national screening programme system by setting up a national conference for key players in screening to obtain feedback on how the programme operates.
- ▶ Carry out analyses of the legal and organisational aspects of the screening system to identify obstacles to effective operation and the tasks assigned to screening coordination centres, as well as practices that could be optimised or shared in conjunction with the French social security and ensure they are firmly anchored in the French prevention system.

Action coordinator: DGS

Co-coordinators: INCa and the French social security.

In partnership with the relevant stakeholders.

15.2 Improve follow-up of screening results.

- ▶ Finalise the implementation of scorecard indicators for managing the organised breast screening programme and set up indicators for other cancers, namely colorectal and cervical cancers.
- ▶ Launch an invitation to tender to create a shared information space to transmit the results communicated by the screening coordination centres to regional and national management bodies automatically and on a regular basis.
- ▶ Continue to develop and upgrade a shared national information system involving various partners by examining methods to optimise the quality and comprehensiveness of data in accordance with security and confidentiality rules.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.



Measure 16.

Involve referring doctors in national screening programmes and guarantee equality of access to the most effective techniques throughout the country.

BACKGROUND

Colorectal cancer is the 3rd common cancer in the French population (37,400 new cases a year) and the 2nd-highest cause of death from cancer (17,000 deaths).

With regard to cancer in women, breast cancer is the leading cancer in terms of incidence (49,800 new cases) and remains the primary cause of cancer-related deaths in women (11,200 deaths a year). The annual incidence of cervical cancer has been falling for the last 30 years (3,068 new cases in 2005), but the mortality rate remains very high (over 1,000 deaths a year).

These cancers represent a real challenge for public health in France. There are a number of approved screening strategies that have proven their effectiveness in terms of impact on mortality, and these have led to the development of national programmes, for breast cancer screening in 2004 and colorectal cancer in 2008, following a series of pilots. A cervical cancer screening programme is being carried out in a small number of départements. The Developments in existing programmes and the use of new screening techniques (immunological tests for colorectal cancer, digital mammography for breast cancer, and the HPV test for cervical cancer) are based on better understanding and recommendations from the healthcare agencies, learned societies and the HAS.

OBJECTIVES

- ▶ Help general practitioners to ensure target groups are included in organised screening programmes or in an early detection strategy appropriate to each level of risk.
 - ▶ Develop the national organised cancer screening programmes in line with the most effective techniques and new strategies in optimal conditions in terms of efficacy and quality.
-

ACTIONS

16.1 Increase the involvement of referring doctors in the system of organised national cancer screening programmes.

The “Hôpital, patients, santé, territoires” law confirmed the pivotal role of the general practitioner, It is therefore important to give general practitioners a key role in ensuring that the population participates in cancer screening.

- ▶ Strengthen the agreement under which doctors practise through realistic, contractual measures and incentives designed to improve the level of inclusion in cancer screening programmes by referring doctors in line with national negotiated targets and recognise their public health role in preventing cancer.

Action coordinator: DSS.

In partnership with the relevant stakeholders.

- ▶ Ensure referring doctors have access to tools for training, information and inclusion in screening programmes.

These tools should enable general practitioners to propose early detection and screening strategies appropriate to each level of risk, help them to include target groups in screening programmes and ensure they receive systematic feedback of personalised information on screening take-up amongst their patients.

Action coordinator: INCa.

In partnership with the relevant stakeholders.



16.2 Define ways of developing new screening techniques and strategies for national screening programmes.

- ▶ Support trials for new cancer screening methods. These studies should examine the potential benefits of extending the age group for the portion of the population invited to take part in breast cancer screening. In particular, they must take account of medico-economic aspects and ethical / professional conduct issues.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.

16.3 Gradually roll out use of the immunological test for colorectal cancer screening to the whole of the country.

This involves defining optimal conditions of use for immunological tests and publishing benchmarks for good practice and quality assurance (purchase, dispatch through the post, interpretation of test results, etc..).

- ▶ Develop and disseminate training and information tools aimed at referring doctors and adapted to the new methods used in the organised colorectal cancer screening programme, focusing primarily on the benefits of the immunological test and how it is carried out.
- ▶ Ensure the continuity, quality and safety of the organised colorectal cancer screening programme by gradually integrating the applying cancer coordination centres and by the implementation of a system to monitor the impact of the immunological test on the performance and quality of the programme.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.

16.4 Define the technical conditions that will ensure full exploitation of the potential offered by digital mammography in breast cancer screening.

- ▶ Examine the feasibility of digital data transmission and archiving.
- ▶ Use pilot sites to test and evaluate the various options for computerised operation offered by digital mammography in order to define a national strategy.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

16.5 Examine the impact of new technologies in *papillomavirus* research and vaccination on the strategy against cervical cancer.

- ▶ Carry out trials to define practical conditions and decision-making algorithms in the event of a positive test and evaluate the appropriateness of organising screening based primarily on pilot schemes and the cost-effectiveness ratio.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

- ▶ Develop an information campaign aimed at healthcare professionals to support HPV vaccination, adapting it to target the most vulnerable individuals, as part of an integrated strategy against cervical cancer whilst reminding participants of the necessity of regular screening.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

- ▶ Contribute to monitoring changes in viral etiology, primarily in conjunction with the National Reference Centre for *papillomavirus* and the screening coordination centres by rolling out a cervical cancer screening programme.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.



- ▶ Produce recommendations for good practices in respect of cervical cancer screening: tests, frequency and behaviour depending on the situation.

Action coordinator: HAS.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

16.6 Test different strategies for integrated cervical cancer screening activities by ensuring women who have not been screened or screened infrequently have access to screening.

- ▶ In addition to tests carried out at three pilot sites, test the application of a set of specifications for organising cancer screening using cervical smear tests, carry out innovative trials on unscreened populations and create a surveillance network for pre-cancerous and cancerous lesions.

Action coordinators: DGS, INCa.

In partnership with the relevant stakeholders.

Measure 17.

Monitor a scientific watch and improve knowledge of early cancer detection.

BACKGROUND

For many cancers, early diagnosis is associated with less invasive treatment and a better chance of recovery by limiting the after-effects. Early diagnosis is reliant on screening where this is possible, carrying out medical examinations in the absence of symptoms, and early detection of warning signs as soon as they appear. The benefits of screening, however, vary depending on the location of the cancer and some actions may be more effective in targeting people with a high level of risk.

Prostate cancer is the most common of all cancers, with 62,245 new cases per year. With 9,202 deaths, this is the 2nd leading cause of cancer-related deaths in men. Significant questions about prostate cancer screening still need to be asked, in particular the impact of screening in terms of improving survival rates, but also the risks of over-diagnosis and especially over-treatment, principally in the case of a relatively non-aggressive cancer diagnosed at a very early stage. Cutaneous malignant melanoma causes 1,500 deaths every year in France. There were an estimated 7,500 cases in 2008. Oral cavity cancers are estimated at 7,500 new cases in France and cause 1,875 deaths every year. Lung cancer causes the highest number of deaths every year. There were 30,650 new cases in 2005 and lung cancer was responsible for 26,600 deaths.

Actions in relation to early diagnosis of these cancers, which are more or less relevant depending on the locations concerned, include: providing more information to the general public, training and involving several different categories of health professionals, improving early diagnosis and developing more sophisticated change markers, and validating new testing and screening strategies.

Setting up a system to monitor new scientific developments and research programmes would help to develop organised screening systems, recommendations and screening as well as early detection strategies for cancers that are screened on an individual basis or not yet recommended for screening.

OBJECTIVE

- ▶ Improve the conditions for early detection of certain cancers and take account of new screening opportunities in line with developments in understanding.



ACTIONS

17.1 Define an early detection strategy for prostate cancer.

- ▶ Define new national strategies for prostate cancer prevention and screening based on a programme of integrated research activities while taking account of scientific data, the risk-benefit ratio and ethical and organisational aspects.
- ▶ Develop clear information on the risks and benefits of prostate cancer screening in accordance with treatment methods (active monitoring, local treatment and radical treatment) and ensure this is disseminated by key opinion leaders.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

- ▶ Develop, as appropriate, recommendations in respect of prostate cancer screening aimed at healthcare professionals appropriate to the current state of understanding and to the different risk levels identified in order to specify methods of use for tests, particularly amongst men at the highest risk with a history of the disease in a 1st degree family member and men of West Indian or African origin.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

17.2 Improve early diagnosis of skin cancers.

- ▶ Analyse the stages of development at the point of diagnosis of melanomas and when the treatment begins (history prior to diagnosis, from detection to treatment) to identify areas for improvement.

Action coordinator: INCa.

Co-coordinator: InVS

In partnership with the relevant stakeholders.

- ▶ Develop partnerships with the healthcare professionals concerned and use an integrated approach in order to improve consistency and coordination between prevention campaigns and early detection of melanoma, as well as the extent to which messages are understood by the public.

Action coordinator: INPES

In partnership with the relevant stakeholders.

- ▶ Develop, and distribute to health care professionals (general practitioners and paramedical personnel), information and initial and in-service training tools for the early detection of skin cancers, the identification of high risk factors and specific prevention and surveillance methods requiring, in particular, early screening by a dermatologist.
- ▶ Inform the general public about the early detection of melanomas and raise health care professionals' awareness about this subject.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

17.3 Improve the early detection of oral cavity cancers.

- ▶ Track the progression of oral cavity cancers from the time they are diagnosed. Conduct research on patients' demographic and socio-economic characteristics and their course of action from detection to treatment, including any difficulties involving access to care.

Action coordinator: INCa.

Co-coordinator: InVS

In partnership with the relevant stakeholders.

- ▶ Develop or adapt various training tools, particularly those related to distance learning on the detection of oral cavity cancers.
- ▶ Develop and distribute informational material on oral cavity cancers to the general public, particularly through the most directly involved health care professionals, such as general practitioners, ENT doctors, stomatologists and dentists.

Action coordinator: INCa.

In partnership with the relevant stakeholders.



- ▶ Promote early-detection actions targeting high-risk populations through dedicated calls for proposals.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

17.4 Include new screening opportunities based on advances in knowledge and treatment.

- ▶ Monitor scientific developments in cancer epidemiology, risk factors and levels, and target populations. Promote research on new screening and early-detection tests and strategies adapted to the different risk levels, with a view to developing recommendations.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

- ▶ Conduct discussions on screening developments and challenges, and publish an annual review of cancer screening methods.

Action coordinator: INCa.

Co-coordinator: DGS

In partnership with the relevant stakeholders.



Patient Care

Guarantee each patient individualised and effective care management.

The 2009-2013 plan must sustain and further the progress achieved by the 2003-2007 Cancer Plan in the areas of care quality and organisation, but it will also strive to improve the care management of cancer patients, who too often still lack continuity between hospital and home. True coordination is now necessary to avoid feelings of disruption or abandonment, to provide better support for patients during their treatment and to help them prepare for the post-cancer period. The referring doctor is the legitimate medical professional for coordinating home care, together with other community health care professionals, including private practice nurses, pharmacists and cancer network stakeholders. To strengthen this coordination effort, nursing positions will be created to provide specific skills. These nurses will mainly oversee coordination between private practice and hospital doctors. To that end, the “Hôpital, patients, santé, territoires” (HPST) law adopted measures to support continuity and quality of care.

Other priorities include equal access to treatment and innovation and the development of certain highly specialised treatments for rare forms of cancer and childhood and adolescent cancer. Moreover, the expected growth in cancer rates among the elderly in the coming years highlights the attention that must be paid to geriatric oncology. It will also be necessary to monitor, and develop better responses to people with genetic predispositions to cancer.

7 MEASURES

MEASURE 18: INDIVIDUALISE CARE MANAGEMENT QUALITY AND STRENGTHEN THE REFERRING DOCTOR'S ROLE.

MEASURE 19: IMPROVE TREATMENT QUALITY FOR ALL CANCER PATIENTS.

MEASURE 20: SUPPORT THE ANATOMOPATHOLOGY SPECIALITY.

MEASURE 21: GUARANTEE EQUAL ACCESS TO INNOVATIVE AND EXISTING TREATMENTS.

MEASURE 22: SUPPORT RADIOTHERAPY.

MEASURE 23: DEVELOP SPECIFIC TREATMENTS FOR PATIENTS WITH RARE FORMS OF CANCER OR GENETIC PREDISPOSITIONS AS WELL AS FOR CHILDREN, ADOLESCENTS AND THE ELDERLY.

MEASURE 24: ADDRESS THE HEALTH PROFESSIONS' DEMOGRAPHIC CHALLENGES AND PROVIDE TRAINING IN NEW SKILLS.

Patients will be given significantly more information due to its role as a key driver of the health democracy process.

Two disciplines are the subject of special measures: anatomico-cytopathology and radiotherapy.

To support advances in cancer treatment, it is essential to increase the number of healthcare professionals and provide additional training so that they can acquire new skills.



Measure 18.

Individualise patient care and expand the referring doctor's role.

BACKGROUND

The complexity of cancer care and the many parties involved require better coordination to improve patient support during and after the acute stage of their treatment. Patients are seeking more consistent care management to avoid any feeling of disruption, especially between hospital and private practice doctors. The referring doctor, whose pivotal role is supported by the “Hôpital, patients, santé, territoires” law, is a key player in out of hospital care. As such, this doctor must be better informed and be more involved in care management to have every necessary resource for comprehensive treatment in the patient's community. The involvement of intermediaries between the hospital staff and local health care professionals is a key factor in the success of coordinated care. These intermediaries may be general practitioners, nurses in private practice, pharmacists or regional, multidisciplinary health networks. Training programmes will be developed for these local health care providers to ensure they have access to up-to-date information and tools to facilitate continuity of care in the community particularly *through* the electronic medical file (DCC in French).

OBJECTIVES

- ▶ Improve patient care management by creating nursing positions responsible for ensuring continuity of care between the hospital and the patient's home.
 - ▶ Seek greater involvement on the part of referring doctors and other local players, especially private practice nurses and pharmacists, so that they can provide care to cancer patients during and after treatment.
 - ▶ Develop tools to help health care professionals in hospitals and private practice coordinate and share resources.
 - ▶ Have INCa and ASIP (Health Information Systems Agency) develop and carry out a joint action plan to expand the DCC's use and services while implementing the Personal Medical File (DMP in French).
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ACTIONS

18.1 Coordinate patients' care management during the active treatment phase under the responsibility of the care coordinators.

- ▶ Develop terms of reference outlining the responsibilities expected of the nurse care coordinators. Outpatient, hospital and university players as well as patient representatives will participate in this effort.
- ▶ Set up a pilot project of nurse care coordinators *through* a call for proposals targeting health care institutions. These projects will include general practitioners, the health region's inpatient-outpatient coordination structures and the oncology coordination centres.
- ▶ Individualise patient pathway by implementing the coordination schemes developed by the nurse care coordinators, based on an assessment of the pilot project. The position of "infirmier d'annonce" (nurses involved in diagnosis disclosure) can be expanded to include these new responsibilities.
- ▶ Ensure that 80% of patients benefit from at least one personal care plan.

Action coordinator: DHOS.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

18.2 Expand the referring doctor's local role during the acute treatment phase and surveillance period.

- ▶ Develop recommendations on the shared surveillance between hospital and referring doctors, giving top priority to breast and colorectal cancers.
- ▶ Expand continuing medical education in oncology for general practitioners.
- ▶ Launch regional pilot projects on new ways of compensating private practitioners, conducted by the ARS (Regional Health Agencies) on the basis of article 44 of the 2008 LFSS budget law, about the shared surveillance recommendations and the results of the nurse care coordinators' pilot projects (cf. action 18.1).

Action coordinator: DHOS.

Co-coordinators: DSS, INCa, CNAMTS (French salaried workers' health insurance scheme)

In partnership with the relevant stakeholders.



18.3 Have health care professionals share medical data.

The sharing and exchange of medical data between health care professionals working in inpatient and outpatient settings, notably the general practitioner, and the provision of specific services that offer them practical help (directory and RCP [multidisciplinary conference meeting] management, for example) are means of improving quality through better coordination of patient care. The electronic medical file (DCC) and personal medical file (DMP) are the logical tools for sharing oncology information.

- ▶ Formalise and evaluate the basic content of the outgoing summary report sent to the referring doctor.
- ▶ Put the DCC to use in relaunching the DMP and develop a specifications and an action plan.

Action coordinator: INCa.

Co-coordinators: ASIP, GIP DMP (public interest group).

In partnership with the relevant stakeholders.

Measure 19.

Improve the quality of care for all cancer patients.



BACKGROUND

Creating an announcement procedure and expanding the use of multidisciplinary treatment planning meetings are widely recognised as measures that have improved the quality of cancer care. However, it would be best to go even further by extending these procedures to all institutions as part of a sector-wide quality approach and by supporting the development of an authorisation process. This process would be backed by criteria ensuring all parties an equal level of safety, quality and accessibility nationwide. Strengthening a coordinated multidisciplinary approach, largely based on new communication tools, is one guarantee of quality of care. The “Hôpital, patients, santé, territoires” law improves the regional coordination of health care resources and fosters sector-wide efforts by the various health care players.

OBJECTIVES

- ▶ Improve the quality of care for all patients.
- ▶ Help set up the new authorisation framework for the delivery of cancer care services and plan its development.
- ▶ Gain greater familiarity with waiting times for cancer treatment to reduce unequal access to care caused by delays.
- ▶ Provide patients with cancer reference information.

ACTIONS

19.1 Expand access to the sector-wide measures initiated by the previous Cancer Plan, thereby improving the quality of cancer care.

Expanding quality measures (announcement procedure, multidisciplinary, personal care plan, access to supportive care) must take effect by the end of 2011 because they are required for the authorisation given to health care institutions to treat cancer patients.

- ▶ Develop a plan for expanding the announcement procedure at each authorised health care institution and implement the plan by 2011.
- ▶ Have a patients' committee approve the format of the individualised care plan (PPS) to be given to each patient. This plan will be supplemented by a personal post-cancer plan covering the period following the first treatment phase (cf. measure 25.2).



- ▶ Develop national guidelines for multidisciplinary treatment planning meetings (INCa) and systematise their quality audits under the leadership of the regional oncology networks.
- ▶ Improve supportive care by paying more attention to pain management and palliative care whenever necessary.

Action coordinator: DHOS.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

19.2 Boost funding of quality measures.

The ongoing implementation of quality measures will be supported by new funding schemes.

- ▶ Develop new means of funding sector-wide quality measures for cancer care as of 2010 (announcement procedure, multidisciplinary approach, supportive care and an individualised care plan for the patient) to ensure continuous implementation.
- ▶ Update, at a constant cost, the common classification of medical procedures (CCAM in French) for outpatient chemotherapy treatments in the private sector.

Action coordinator: DHOS.

Co-coordinators: INCa, ARS (Regional Health Agency).

In partnership with the relevant stakeholders.

Links with other public health plans.

Chronic diseases plan. Palliative care plan. Pain management plan.

19.3 Support the implementation of certification criteria and cancer authorisation decrees and clarify the positioning and role of existing organisations.

- ▶ Prepare the 2013 version of certification criteria.
- ▶ Bring the health care institutions authorised to treat cancer patients into compliance by 2011, based on all criteria stipulated by the decree of March 2007.
- ▶ Create a national committee that will monitor the implementation of this procedure and will bring together the hospital federations and user and patient representatives under the leadership of DHOS, INCa, the ARSs and CNAMTSs. The committee will publish an annual report on the programme's implementation.

- ▶ Publish a reference document to clarify the existing organisations' positioning and role: oncology coordination centres (3C), regional cancer networks and regional oncology hubs.
- ▶ Publish specific guidelines for home hospitalisation programmes that provide chemotherapy.

Action coordinator: DHOS.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

Links with other public health plans.

Palliative care plan. Chronic diseases plan.

19.4 Conduct a study on treatment waiting times in several regions.

To ensure an objective review of treatment waiting times, it is necessary to monitor the impact of the authorisation process and ensure access for all patients, including the most vulnerable. A specific study will be conducted with the support of regional oncology networks in 2010 and 2011. This study will concern the four most frequently occurring types of cancer. Care management during crucial treatment phases will be analysed, as will unequal access to treatment.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

19.5 Provide patients with cancer reference information so that they can play an active role in the care system.

- ▶ Provide patients and their families with reference information guides based on the good practice guidelines designed for specialists and developed according to HAS (Higher Health Authority) and INCa methodologies. All cancer sites will be treated within five years.
- ▶ Set up the INCa cancer multimedia information platform in partnership with the Ligue nationale contre le cancer (National Cancer League). This service is primarily designed for patients and their families to provide them with up-to-date and comprehensive reference information on medical, social, legal and practical issues concerning different forms of cancer.

Action coordinator: INCa.

In partnership with the relevant stakeholders.



Measure 20.

Support the surgical pathologist speciality.

BACKGROUND

The surgical pathologist certifies the size and shape of the tumor and provides the clinical doctors with essential information about the disease's prognosis and even the predictive nature of the therapeutic response. This speciality, which plays a key role in the quality of care and in cancer research and monitoring, is going through a pivotal period. While facing an increasing number of general and public health challenges, anatomocytopathology (ACP) must face scientific mutations and demographic difficulties that justify developing specific actions further to the Pathology Plan supported by the profession.

OBJECTIVES

- ▶ Support the discipline.
- ▶ Encourage technical developments and new practices.
- ▶ Develop quality procedures.
- ▶ Stabilise the anatomopathology disciplines and maintain the public-private network.

ACTIONS

20.1 Support the anatomopathology discipline by hiring more staff and advancing the profession by adopting the latest practices.

- ▶ Add anatomo-cytopathology procedures to the Common Classification of Medical Procedures (CCAM in French). Update the CCAM to take account of the state of the art in diagnostic techniques.
- ▶ Teach new skills, particularly to surgical pathologists (cf. measure 24), and assign hospital practitioners and quality engineers in such a way as to reduce uneven regional distributions of this speciality.

Action coordinator: DHOS.

Co-coordinators: CNAMTS, INCa.

In partnership with the relevant stakeholders.

20.2 Bring anatomocytopathology in line with technological and scientific advances.

- ▶ Increase surgical pathologists' participation in the molecular analysis of tumors by involving them in 29 regional cancer molecular genetics platforms (INCa call for proposals) and recognising their expertise in this field.
- ▶ Increase access to health care tumor banks when it is recommended that the sample be preserved at very low temperatures for health reasons.
- ▶ Use and transmit anatomopathology reports that contain, at a minimum, the information defined by INCa, as part of DCC/DMP data sharing and in coordination with the cancer surveillance system's improvement measure (measure 7).

Action coordinator: INCa.

In partnership with the relevant stakeholders.

20.3 Support the anatomo-cytopathology profession's quality process.

- ▶ Evaluate HAS's second opinion and take advantage of it in choosing the appropriate procedures (expert laboratory and requesting laboratory).
- ▶ Systematise the double reading of lymphomas and all rare malignant tumors, which is essential for diagnostic confirmation.
- ▶ Set up an accreditation process for anatomo-cytopathology units to conduct molecular pathology procedures, which was stipulated in the "Hôpital, patients, santé, territoires" law as part of the reform of medical analysis laboratories.
- ▶ Expand quality assurance in the anatomo-cytopathology field by supporting continuing education and professional bodies committed to this effort.

Action coordinator: INCa.

In partnership with the relevant stakeholders.



Measure 21.

Guarantee equal access to innovative and existing treatments.

BACKGROUND

Access to cancer treatment, particularly to innovative treatments, must be guaranteed to all patients. That is one of the objectives of the cancer authorisation framework. However, maintaining access to innovative treatments, regardless of the patient's region or socioeconomic level, will be monitored particularly closely. It will involve innovative drugs, molecular genetic tests, specific surgical and interventional techniques and fertility preservation methods. Moreover, cancer follow-up and surveillance examinations must take place within an acceptable period of time. In conjunction with the research measures, the regional oncology hubs will be responsible for developing emerging expert projects on new drugs and cutting-edge imaging and radiotherapy platforms.

OBJECTIVES

- ▶ Support and structure current means of access to expensive and innovative cancer drugs.
 - ▶ Ensure that all patients have equal access to the molecular genetic tests that are essential for diagnosing cancer; the prescription of targeted treatments; and monitoring of their disease and care.
 - ▶ Organise referral surgery and technical services for cryobiology and interventional radiology.
 - ▶ Ensure more uniform geographic coverage for the diagnosis and radiological monitoring of cancer through MRI.
 - ▶ Promote the development of new and emerging efforts in regional oncology hubs.
-

ACTIONS

21.1 Facilitate access to treatment with innovative drugs.

The development and updating of national guidelines for good oncology practices must continue and must be applied nationwide. The Wide accessibility to innovative drugs is nevertheless costly, with cancer medications accounting for 60%. The 2009 “Loi de financement de la sécurité sociale” (LFSS), by introducing new regulatory methods and a forecast rate for cost trends related to these specialities, reflects the national determination to guarantee access to these treatments as long as they are prescribed according to good practice guidelines. The law also demonstrates the commitment to controlling costs in health care institutions.

- ▶ Update the list of innovative and expensive drugs, other than GHS (homogeneous groups of hospital stays), at least once a year.
- ▶ Apply and monitor national good practice guidelines for all forms of cancer at the regional level; monitoring will be mandatory. These guidelines will be updated at least once a year and immediately published and disseminated. Include cost trends.
- ▶ Include a report on the status of cancer-fighting drugs in INCa’s annual report.
- ▶ Design clinical studies on cancer treatments, particularly regarding metastases, in order to analyse their risk-benefit and cost-effectiveness ratios for patients. Publish guidelines on refractory metastatic cancers (HAS-INCa).
- ▶ Conduct pharmaco-economic studies to better assess the benefits and risks associated with the use of new drugs that have received marketing authorisation (AMM in French) and to gain a better understanding of the risk-benefit and cost-effectiveness ratios of these new cancer drugs (AFSSAPS - HAS).
- ▶ Monitor “ATU nominatives” (temporary authorisations for prescribing medicines for specific patients) by developing therapeutic use protocols (PUT in French), gathering information on anti-cancer drugs covered by ATUs and producing guidelines on using “ATUs nominatives” (AFSSAPS).
- ▶ Include institutions on the drug reimbursement list (excluding T2A - case mix-based hospital financing system) that participate in treating cancer patients as partner institutions.

Action coordinator: DSS.

Co-coordinators: DHOS, INCa.

In partnership with the relevant stakeholders.



21.2 Develop cancer molecular genetics hospital platforms and expand access to molecular testing.

By targeting the tumor's biological characteristics, individualised treatments that are less toxic and more effective can be prescribed, thus avoiding useless drugs. To do so, the tumor's biomarkers must be identified, most often by molecular genetic tests. Because the tests are so important and costly, they should be concentrated only at cancer molecular genetics hospital platforms.

- ▶ Consult with IGAS (Social Affairs Inspectorate-General) in 2010 to determine the eligibility of molecular tests, both predictive and follow-up, for regulatory status.
- ▶ Make innovative molecular tests available to all patients. Regional platforms will conduct all tests at no cost for all patients living in the region *through* samples sent by both public and private laboratories.
- ▶ Establish a monitoring and follow-up system at AFSSAPS and INCa for new tests to obtain a well-informed and independent opinion on the value of these tests (research or distribution).

Action coordinator: INCa.

In partnership with the relevant stakeholders.

21.3 Facilitate access to surgical and instrument techniques, particularly those that are complex and innovative.

Deploying new surgical, instrument and endoscopy techniques as well as benchmark technical services is essential for providing care targeting the treatment of certain tumors in regional cancer hubs, which would round out the region's services.

- ▶ Define quality criteria for the surgical treatment of ovarian, pancreatic, liver, esophageal and subperitoneal rectal tumors and rare tumors, in conjunction with reference and specialised centres that treat rare forms of cancer.
- ▶ Assess the medical and economic costs of extensive and complex surgical techniques and monitor surgical innovations.
- ▶ Support innovative technology through INCa calls for proposals.
- ▶ Identify sites and teams carrying out interventional radiology for treatment purposes and, if necessary, update the CCAM.

- ▶ Recognise, in conjunction with the Agence de la Biomédecine, the regional cryobiology centres (gametes and embryos) associated with the sperm research and preservation centres (CECOS) and/or the prenatal multidisciplinary diagnostic centres (CPDPN) to improve access to fertility preservation services for cancer patients.
- ▶ Guarantee fair access and affordable prices for reconstructive, symmetrisation and mammoplasty techniques.

Action coordinator: DHOS.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

21.4 Improve access to cancer detection and surveillance *through* medical imaging and PET.

Access to quality imaging is essential for the diagnosis and surveillance of many types of cancer. There are currently an adequate number and distribution of PET scanners (positron emission tomography). However, the number and distribution of MRI machines remain insufficient. Furthermore, MRI and PET scanners are important tools for cancer research. Access to an MRI machine located at university hospitals with a large number of cancer patients will allow inclusion of imaging in the sites' research-oriented policies and the development of a network for transmitting images.

- ▶ Modify the third-generation SROS (Regional Health Organisation Plan) to include the objective of 10 MRI machines per 1 million residents in each region by March 2011, or 74 additional machines compared to current plans.
- ▶ Increase the total number of MRIs to 12 machines per million residents by 2013, or 39 additional machines in the 10 regions with the highest cancer mortality rates.
- ▶ Develop guidelines on cancer imaging indications and techniques, taking into the account the need for better pain management during imaging-guided procedures. (Société française de radiologie, HAS/INCa certification)
- ▶ Provide each region with either an MRI with large measuring ranges dedicated to oncology or a dedicated MRI by 2013 under the existing or above-mentioned provisions. This would enable the implementation of joint university hospital/cancer centre research programmes.

- ▶ Monitor the waiting times for MRI and scanner exams conducted on an Outpatient basis through a special, multi-year survey examining the impact on patient care.
- ▶ Monitor charges exceeding statutory fees in outpatient.

Action coordinator: DHOS.

Co-coordinator: ARS.

In partnership with the relevant stakeholders.

21.5 Promote new and emerging procedures in regional oncology hubs.

Charged with carrying out the recommendations in the report of the FHF (French Hospital Federation) and FNCLCC (National Federation of Comprehensive Cancer Centres), the regional oncology hubs aim to promote innovative and emerging programmes in their respective regions. In conjunction with the research measures, three objectives will be given priority:

- ▶ identify teams with expertise in new drugs and expand information sharing on chemotherapy toxicity through an INCa call for targeted proposals in 2010;
- ▶ develop high-tech imaging for complex exams; and conduct research with cancer patients; (cf. measure 21.4);
- ▶ centralise leading-edge radiotherapy equipment at the regional hub level (Cyberknife® - tomotherapy-heavy ion IMRT) (cf. measure 22.1).

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Measure 22.

Support radiotherapy.

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BACKGROUND

During the patient pathway, 60% of cancer patients receive radiotherapy, making it a major technique in the fight against cancer. Its position in treatment protocols, the number and level of training courses taken by radiotherapy providers, the complexity of the equipment used, and the necessary safety practices make it necessary to support and prepare for changing practices. To meet these challenges, national measures were taken in November 2007 and, in December 2008, the health and sports minister set up a national committee to guide and lead their implementation. The committee will monitor measures regarding radiotherapy efforts during the 2009-2013 Cancer Plan.

OBJECTIVES

- ▶ Ensure that high-quality and safe practices are provided to all patients.
- ▶ Support professionals in this sector.
- ▶ Foster advances in treatment practices and help organise radiotherapy centres.

ACTIONS

22.1 Support high-quality and safe practices in authorised radiotherapy centres.

- ▶ Develop INCa guidelines on the types and levels of adequate care for technical territorial (standard) and regional (high-tech) platforms.
- ▶ Foster cooperative efforts between radiotherapy centres and test new tools to help radiotherapy staff meet this challenge.
- ▶ Set up an ongoing operational framework for special geographic situations in the form of a health care cooperative group with a support centre.
- ▶ Monitor the process while improving the current tracking of radiotherapy data to collect quantitative and qualitative data on an ongoing basis.
- ▶ Adapt radiotherapy funding to current challenges.

Action coordinator: Comité national de suivi de la radiothérapie (National Radiotherapy Monitoring Committee).

Co-coordinator: ARS.

In partnership with the relevant stakeholders.



22.2 Strengthen human resource capacity in radiotherapy centres.

Expanding staff size and capacity at radiotherapy centres is a crucial challenge despite the current difficult demographic situation. Financial reform and specific budgets, allotted to the regional hospital agencies for cooperative efforts, will help bring in new skills and initiate priority hiring. This skill enhancement, which will require a redefinition of each employee's roles and responsibilities, will involve all sector professionals.

▶ Radiotherapists

- Enhance the appeal of the oncology/radiotherapy speciality by offering post-residency and associate specialist positions as well as part-time hospital practitioners (job-sharing). (cf. measure 24.1).
- Develop INCa certification criteria for radiotherapy training sites and build management capacity in a targeted manner.

▶ Radiophysicists

- Enhance the appeal of the medical radiophysics field by continuing the recruitment effort and offering radiophysicists the opportunity to obtain university recognition.
- Create a continuing education requirement in medical radiophysics, with participation in the CEA's (Atomic Energy Commission) DOSEO project.
- Improve practice conditions in radiotherapy centres by encouraging recognition for medical radiophysics units and hubs directed by a radiophysicist.
- Improve staff expertise with an emphasis on training to develop safer practices and foster the discipline's advancement.

▶ Manipulators in radiotherapy

- Redefine the training content in line with the Bachelor's-Master's-Ph.D. reform.
- Open access to dosimetry skill training in support of career development.

▶ Quality control managers

- Redefine the roles and responsibilities of each professional at radiotherapy centres, taking advantage of quality control managers' contributions. The control managers can be shared among several centres.

Action coordinator: Comité national de suivi de la radiothérapie (National Radiotherapy Monitoring Committee).

In partnership with the relevant stakeholders.

22.3 Update good practice guidelines for radiotherapy treatment techniques and their indications.

- ▶ Treat all patients whose care requires total body irradiation (TBI) in their home region.
- ▶ Produce an expert report on the role of curietherapy in terms of indications and techniques, and publish national guidelines.
- ▶ Develop guidelines for the use of single-dose, stereotactic radiation therapy for intracranial tumors (radiosurgery).
- ▶ Update HAS's opinion on indications for innovative techniques.
- ▶ Update the French Radiotherapy Society's procedural guide.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Measure 23.

Develop specific care management for patients with rare forms of cancer or genetic predispositions as well as for children, adolescents and the elderly.

BACKGROUND

Specific care management must be developed to provide better solutions for specific patient pathways and to take full advantage of innovation and research.

Rare cancers and tumors in children and adolescents must be treated and monitored at clearly identified reference centres. Moreover, caring for an elderly cancer patient requires real coordination between oncologists and geriatricians to offer these patients the best chances for a cure, while maintaining the quality of life specific to the elderly. Lastly, once the risk is identified, families and individuals with genetic predispositions to specific cancers should receive individualised follow-up coordinated by specialised oncogenetic services.

OBJECTIVES

- ▶ Structure the patient pathway for rare malignant tumors.
 - ▶ Ensure that individuals with a hereditary predisposition to cancer are monitored according to the latest knowledge.
 - ▶ Improve the care of elderly cancer patients through better treatment coordination, which will combine medical care and social support, with full participation by the referring doctor and community health care professionals.
 - ▶ Increase the cure rate for adolescent and young adult cancers. Avoid any disruption and help the individual gain independence and self-esteem despite the disease's physical, psychological and social effects at this age. Help adolescents and young adults with cancer reintegrate into society.
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ACTIONS

23.1 Certify rare cancer reference centres.

The selection of rare cancer reference centres, in accordance with the provisions of the Rare Diseases Plan that began in 2009 with INCa's call for proposals, will continue until 2011. National in scope, these centres have clearly identified missions and must rely on a recognised research team. Each reference centre will set up a network with regional centres of excellence. This structure will enable the centres to provide optimal care to patients, offering both the expertise of a reference centre and the local care of a centre of excellence.

- ▶ Finalise the certification process for rare cancer reference centres.
- ▶ Develop and distribute HAS/INCa-certified clinical practice recommendations (reference centres).
- ▶ Have INCa develop a database for each rare disease based on a double reading of anatomico-cytopathology data.
- ▶ Disseminate information designed for health care professionals and patients with rare forms of cancer (ORPHANET and INCa).
- ▶ Develop international cooperative efforts and participate in the European information network on rare diseases, a priority in EU policy for the years 2008-2013.

Action coordinator: INCa.

In partnership with the relevant stakeholders.

Links with other public health plans.

Rare diseases plan.

23.2 Encourage the creation of clinical-biological databases (repeated cross-disciplinary surveys with a biosurveillance component).

In coordination with the PNSE2 (National Environmental Health Plan; particularly action 43: launch a multi-annual biosurveillance programme), the cancer component of environmental diseases must be explored more thoroughly. Working with university hospitals (CHU) and comprehensive cancer centres (CLCC), which treat large numbers of patients, especially for "rare" tumors, will encourage the development of new projects that seek to examine the role played by environmental risks.

Action coordinator: INCa, ITMO Cancer.

In partnership with the relevant stakeholders.



23.3 Monitor people at high genetic risk of cancer.

The Bonaïti report, published by INCa in late 2008, forecasts a significant rise in demand for oncogenetic services over the next 10 years due to a doubling of breast and ovarian cancer cases and a tripling of colorectal cancer:

- ▶ Provide additional resources for the oncogenetic programme in preparation for the planned expansion of consultations and oncogenetic testing:
 - Expand prescription criteria for BRCA1/2 genetic tests to isolated forms of ovarian cancer;
 - extend the recommendation to prescribe genetic tests to people with a predisposition to colorectal cancer;
 - provide additional resources for laboratories and consultations in response to the expected 50% growth in activity in five years (call for DHOS/INCa proposals to expand the oncogenetics field);
 - support the development of special expertise in the genetic predisposition to cancer as scientific knowledge advances (MYH, for example).
- ▶ Test pilot coordination centres for monitoring people genetically predisposed to cancer, then set up the the centres based on an evaluation of the results:
 - conduct the 2009-2011 multidisciplinary coordinating centre pilot project for people with hereditary predispositions to cancer, which will be implemented by the end of 2009 (INCa/DHOS call for proposals);
 - during a second phase, open the centres nationwide based on successful experiences, aiming for at least one reference centre per region by 2013.
- ▶ Research and set up a process for providing MRI exams to monitor women with the BRCA1 or BRCA2 gene without any out-of-pocket expenses.
- ▶ Develop analyses of colorectal and endometrial tumors of the MSI phenotype that indicate the need for an oncogenetic consultation.
- ▶ Provide more medical information to patients, general practitioners and specialist doctors on genetic predispositions (gastroenterologists, gynecologists and urologists, in particular).

Action coordinator: INCa.

In partnership with the relevant stakeholders.

23.4 Improve care management for elderly cancer patients.

The incidence of cancer increases steadily with age and nearly one-third of cancers occur after the age of 75. The first expert report on oncogeriatrics, published by INCa in June 2009, reviews the discipline's current status and future prospects. This report highlights the role of 15 pilot coordination units in oncogeriatrics (UPCOG), created on a trial basis at the initiative of INCa in 13 regions.

- ▶ Assess the oncogeriatrics pilot coordination units and develop recommendations on setting them up nationwide.
- ▶ Finalise the clinical study on the geriatric assessment tool (Onco-dage study) and expand its use beginning in 2011.
- ▶ Develop recommendations for treatment strategies tailored to the elderly for cancers with the highest incidence, starting in 2010.

Action coordinator: INCa.

Co-coordinator: DHOS.

In partnership with the relevant stakeholders.

23.5 Improve cancer management for children and launch a dedicated programme for adolescent cancer patients.

1,700 cases of cancer are diagnosed each year in children under the age of 15. The transition between paediatrics and adult medicine must be planned, coordinated and supported, which is one of the priorities of this new plan.

- ▶ Develop and implement a specific action plan for adolescent cancer patients and support the emergence of integrated and innovative projects (care, clinical research, social sciences, support and social integration). This action plan will be developed jointly with representatives from the non-profit sector.
- ▶ Produce an information guide on childhood cancer for families and children in 2009 and update it in 2012 (in conjunction with measure 19.5).
- ▶ Recognise expert centres in major paediatric oncology sub-specialities, such as neuro-oncology, in line with the organisational design of interregional, reference paediatric oncology hospitals.
- ▶ Set up, on a trial basis, multidisciplinary consultations for the care and prevention of long-term sequelae and complications among children and adolescents once they reach adulthood.

- ▶ Create a virtual tumor bank dedicated to paediatric oncology.
- ▶ In 2009, relaunch – in an efficient manner – the committee on the daily cash benefit for parents who stay home to care for seriously ill children. Recommend revising the benefit, emphasising the need to simplify and speed up the allocation process.
- ▶ Fund the increased preservation of cord blood, which may benefit patients with malignancies presenting an indication for an allogeneic haematopoietic stem cell transplantation.

Action coordinator: DHOS.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

Measure 24.

Address the health care professions' demographic challenges and provide training in new skills.

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BACKGROUND

Progress in the medical management of cancer is of great concern because the incidence of cancer will increase in the coming years and the number of practitioners significantly decline in several key oncology specialities. It is therefore a priority, in terms of both demographics and advances in cancer management, to replenish and increase the number of professionals and distribute them more evenly throughout the country. Meeting the demand for improving the quality of care also requires developing new professional skills for ensuring: 1) the coordination and support of patient care and 2) the safety and quality of treatment practices.

OBJECTIVES

- ▶ Train more doctors in the vital oncology specialities.
- ▶ Provide better support for changes in treatment practices, taking account of young doctors' expectations in terms of quality of professional life and new, emerging means of cooperation.
- ▶ Train professionals in new skills.

ACTIONS

24.1 Train more doctors in the field of oncology.

Research conducted by ONDPS (National Observatory of Health Profession Demographics) on oncology disciplines has led to a better understanding of professionals' status. This research must be updated annually to provide adequate monitoring of these training measures, which should not only take a quantitative approach but address regional needs as well.

- ▶ Create resident positions as part of the "filiarisation" system (choice of speciality and region), for oncology specialities (medical oncology, onco-radiotherapy and onco-haematology) and anatomocytopathology. Aim for a national objective of a 20% increase in the average density per speciality, with specific targets in regions with the greatest shortages.



- ▶ Increase the number of clinical directors and associate specialists at sites that provide training in the fields of medical oncology, radiotherapy-oncology, onco-haematology and anatomico-cytopathology. The medical oncology discipline should, in particular, receive special support due to a very uneven regional distribution, which will be taken into account when creating new positions.
- ▶ Update the description of training services for medical oncology, radiotherapy and haematology and establish certification criteria, including in particular multidisciplinary practices, cooperation with a certified research centre, and access to a tumor bank and a traditional cancer research platform.
- ▶ Increase the management capacities of training services in the fields of medical oncology, onco-radiotherapy, haemotherapy and anatomico-cytopathology. These support efforts will concern hospital and university hospital (UH) practitioners, either by creating new positions or by transferring vacancies that have not yet been filled.

Action coordinator: DHOS.

Co-coordinators: ONDPS, INCa.

In partnership with the relevant stakeholders.

24.2 Support advances in medical practice.

- ▶ Foster cooperative efforts by helping the regions create shared positions.
- ▶ Set up a working group to recommend new ways of distributing work, and foster a more group-oriented medical practice by rethinking oncologists' assignments and involving general practitioners.
- ▶ Develop training courses with a greater focus on social and ethical issues in the relationship between care providers and patients and encourage providers to analyse their practices.

Action coordinator: DHOS.

In partnership with the relevant stakeholders.

24.3 Develop university training programmes in three new skills in the oncology field: care coordinators, dosimetrists and anatomo-cytopathology technicians.

- ▶ Develop national practice guidelines for each discipline.
- ▶ Help create a nurse care coordinator Master's programme (cf. measure 18.1).
- ▶ Train technicians in the fields of dosimetry (cf. measure 22) and anatomo-cytopathology (cf. measure 20).

The technicians will benefit professionally from the training by expanding their scope of practice.

Action coordinator: DHOS.

In partnership with the relevant stakeholders.

Life during and after cancer

Improve the quality of life during and after the illness and fight any form of exclusion

The Cancer is often experienced by patients as a physical and psychological disruption and can have a major impact on their social life. The social support is a key factor in patients' quality of life throughout their course of treatment, from the disclosure of the diagnosis to the post-cancer period. It is important to plan a coordinated effort by all those involved in the health care sector (inpatient and outpatient), medical social welfare services (home nursing care, nursing assistants, home helpers, home meal delivery) and social secu-

6 MEASURES

MEASURE 25: DEVELOP INDIVIDUALISED SOCIAL SUPPORT DURING AND AFTER CANCER.

MEASURE 26: OBTAIN THE NECESSARY TOOLS AND RESOURCES FOR DEVELOPING INDIVIDUALISED SOCIAL.

MEASURE 27: IMPROVE RESPONSES TO POSSIBLE SITUATIONS OF TEMPORARY OR PERMANENT DISABILITY OR LOSS OF AUTONOMY RELATED TO CANCER.

MEASURE 28: IMPROVE CURRENT AND FORMER PATIENTS' ACCESS TO INSURANCE COVERAGE AND CREDIT.

MEASURE 29: REMOVE OBSTACLES FACED BY CANCER PATIENTS IN RE-ENTERING THE WORKFORCE.

MEASURE 30: CREATE A CANCER SOCIETAL OBSERVATORY.

city services (financial, administrative, occupational, family, etc.) to provide the best possible situation for individuals and their families throughout the course of the disease.

People who are cured or in remission must be able to pursue their life goals in the post-cancer period with assistance re-entering the workforce and better access to loans and insurance as well as individualised and ongoing follow-up.



Measure 25.

Develop individualised social support during and after cancer.

BACKGROUND

Social concerns must be addressed as soon as the patient is diagnosed and throughout the cancer patient's pathway in close alignment with the care provided. The individualised care plan must thus include a social support component, with a consultation offered to each patient.

More than 60% of cancers are curable, and the rate is much higher for certain types, including thyroid, testicle, breast, skin melanoma and childhood leukemia.

These prospects for a cure require planning and support for the post-cancer period: a personal post-cancer plan based on the individualised care plan will be tested. It is also important to address all the issues involved in the discharge of a patient with a long-term illness (ALD in French) and to remove obstacles in gaining access to insurance, credit and employment.

Regarding a long-term illness discharge, HAS published an opinion in June 2009 that recommends renewing the long-term cancer classification beyond the initial five-year period only when the patient requires extensive care or care for disease- or treatment-related sequelae. In the event of a recurrence after discharge, the patient would, of course, be readmitted with a chronic ailment classification. For cancer cases in which this classification would not be renewed due to the new criteria, regular medical surveillance nevertheless remains essential beyond this five-year period.

It thus appears desirable both to: 1) provide referring doctors with assessment criteria on whether to renew the long-term illness classification and 2) plan for 100% payment of medical examinations in cases in which the patients required continued medical surveillance after discharge. Discussions will be held with supplementary health insurance providers to organise this system. For patients without supplementary health insurance, the co-payment will be reimbursed by the prevention fund of the national health insurance scheme.

The discharge of a patient with a long-term illness signifies an objective improvement in health, which must be accompanied by a return to a normal quality of life. This involves facilitating access to insurance and credit, and re-establishing the conditions necessary for re-entering the workforce. These steps are outlined in measures 28 and 29, respectively.



OBJECTIVE

- ▶ Formalise and implement a plan for providing individualised care and social support during and after cancer treatment, including during the discharge of a patient with a long-term illness.

ACTIONS

25.1 Expand the use of social assessments during the announcement procedure and add social support to the Individualised Care Plan (PPS).

This action involves care coordinators, who will be able to rely on guidelines for identifying social vulnerability and insecurity (cf. action 26.2) and, if necessary, call upon social workers at health care institutions and regional networks. More such social workers will be hired.

Action coordinator: INCa.

Co-coordinator: DHOS.

In partnership with the relevant stakeholders.

25.2 Offer each patient a social support consultation during treatment in order to assess the implementation of the individualised care plan's social component and to plan for the post-cancer period.

This consultation is one element of the social assessment included in the announcement procedure. It meets the two-fold objective of a possible revision of the individualised care plan's social component and post-cancer preparation.

Action coordinator: INCa.

Co-coordinator: Ligue nationale contre le cancer.

In partnership with the relevant stakeholders.



25.3 Develop a post-cancer individualised care plan on a trial basis (PPAC in French).

The PPAC will be consistent with and supplement the individualised care plan already in effect. It will be based on a standard format and be subject to review. Tailored to the patient's personal characteristics, the plan can be revised over the course of the disease. It will include required monitoring, recurrence and sequelae risk assessment, prevention of second-cancer risk and a plan for returning to the workforce and normal life. A special section for children and adolescents will be developed and tested (cf. measure 23.5).

This programme also offers patients and their caregivers an option for psychological counselling during the post-cancer period.

A guide to patient associations will be published to give them a better understanding of their roles as partners after cancer treatment.

Action coordinator: INCa.

Co-coordinator: DHOS.

In partnership with the relevant stakeholders.

25.4 Develop medical criteria for the long-term illness discharge and take the necessary steps to ensure funding for regular medical surveillance after discharge in cases requiring such surveillance.

Action coordinator: DSS.

In partnership with the relevant stakeholders.

25.5 Cover treatment for oral implants for dental and maxillofacial prostheses used in the prosthetic rehabilitation of patients treated for cancers of the oral cavity, jaw or surrounding tissue.

Action coordinator: DSS.

In partnership with the relevant stakeholders.

Measure 26.

Obtain the necessary tools and resources for developing individualised social support.

BACKGROUND

Expanding personal social support during and after cancer treatment will require opening more shelters and “appartements thérapeutiques” (residential rehabilitation centres) and providing tools (national guidelines for identifying social vulnerability and insecurity, a funding scheme and local directories).

OBJECTIVE

- ▶ Support the rehabilitation and reintegration of cancer patients and provide individualised social support.

ACTIONS

26.1 Encourage the opening of shelters and residential rehabilitation facilities near medical centres.

This type of shelter avoids lengthy hospitalisation and supports rehabilitation and a gradual return to a normal family and social life.

- ▶ Develop terms of reference for pilot projects and launch a call for proposals.

Action coordinator: INCa.

Co-coordinator: Ligue nationale contre le cancer.

In partnership with the relevant stakeholders.

26.2 Develop and implement national guidelines for identifying social vulnerability and insecurity.

This checklist, developed with the help of social work professionals, identifies the most vulnerable patients likely to need immediate or later support.

Action coordinator: INCa.

Co-coordinator: DGAS (Social Services Directorate-General, Ministry of Health).

In partnership with the relevant stakeholders.



26.3 Develop, with the help of social services, funding mechanisms to ensure the provision of necessary services and benefits during and after cancer treatment.

Funding would primarily cover social workers and family helpers as well as other home services or benefits to compensate for the disability, such as adapting the home and car, home helpers for daily self-care activities and aides for life outside the home.

Action coordinator: DGAS (Social Services Directorate-General, Ministry of Health).

In partnership with the relevant stakeholders.

26.4 Publish a local (département level) directory of all social service professionals to whom the patient can turn for help during and after cancer treatment.

The directory will include the address of the local disability organisation (MDPH - Maison Départementale des personnes handicapées) for patients under 60 years of age and the local agency managing the personal autonomy allowance (APA - Allocation personnalisée d'autonomie). This guide will be regularly updated, distributed by the coordinators and given to the chronic illness patient by the referring doctor who writes up the ALD's request.

Action coordinator: Ligue nationale contre le cancer.

Co-coordinator: INCa.

In partnership with the relevant stakeholders.

Measure 27.

Improve responses to possible situations of temporary or permanent disability or loss of autonomy related to cancer.

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BACKGROUND

Cancer patients with restricted autonomy eligible for long-term follow-up (at least one year) can take advantage of measures specifically developed for people with disabilities. They may also receive services designed for the elderly, depending on their age. Few patients or the health care professionals who work with them are aware of these services.

OBJECTIVE

- ▶ Inform target audiences about new or existing tools and train professionals and volunteers in their use in order to provide the appropriate resources and devote the necessary time to patients with cancer-related disabilities or loss of autonomy.

ACTIONS

27.1 Conduct several pilot projects on providing support to cancer patients at the most aware and motivated disability organisations (MDPH), under the aegis of the Caisse nationale de solidarité pour l'autonomie (CNSA - National solidarity fund in support of autonomy.

Action coordinator: CNSA.

In partnership with the relevant stakeholders.

27.2 Publish and distribute to cancer organisations a booklet describing the statutory services relating to disability, loss of autonomy among the elderly, incapacity for work and other programmes that can be accessed to meet their needs.

Action coordinator: CNSA.

In partnership with the relevant stakeholders.

Links with other public health plans.

In the most unfavourable cases, this measure comes under the 2008-2012 Plan soins palliatifs (Palliative Care Plan). Plan qualité de vie (Quality of Life Plan) for people with chronic diseases (measures 12 and 13).



Measure 28.

Current and former patients' access to insurance coverage and credit.

BACKGROUND

It is currently difficult for cancer patients to buy insurance, which is often mandatory for a home, business or consumer loan. These obstacles prevent individuals from carrying out their life plans. Certain insurers either exclude the disease from the insurance cover requested by the credit institution or charge additional premiums at unaffordable rates for certain diseases based on the latest medical advances. These decisions often lead the credit institution to refuse the individual a loan.

Following on from the Belorgey Agreement, signed in 2001, the AERAS Agreement (s'Assurer et Emprunter avec un Risque Aggravé de Santé - insurance and loans for people with major health risks) was signed in July 2006 and implemented in January 2007 by banking and insurance professionals, patient and consumer organisations and the public authorities. This agreement, which represented major progress regarding loan and insurance options for people presenting a major health risk, is slated for renewal in 2010. The organisations party to the agreement recommended several areas for improvement, including:

- ▶ inclusion of the incapacity-for-work risk,
- ▶ a system for pooling additional premiums and
- ▶ access to alternative cover.

All parties must increase their efforts to ensure access to credit insurance and loans for people presenting a major health risk.

OBJECTIVE

- ▶ Reduce barriers to coverage in order to expand access to credit insurance and loans as much as possible.
-

ACTIONS

28.1 Conduct consultative discussions, under the aegis of the monitoring committee, with the various parties for the purpose of renewing the AERAS agreement. The goal is to improve insurance cover and access to loans for people who present or have presented a major health risk.

Action coordinator: Direction de la Sécurité Sociale (DSS - Social Security Directorate) and Direction Générale du Trésor et de la Politique Economique (DGTPE - Directorate-General of the Treasury and Economic Policy).

In partnership with the relevant stakeholders.



Measure 29.

Remove obstacles faced by cancer patients in re-entering the workforce.

BACKGROUND

An increasing number of cancer patients wish to quickly return to a normal work and social life. Cancer patients are insufficiently aware of their legal options for entering or re-entering the workforce. The same holds true concerning the opportunity for a consultation with the company doctor prior to returning to work, as stipulated by the law, and possible adaptations to the individual's workstation.

While the medical treatment for cancer is covered by the Assurance Maladie (Health Insurance Fund), any indirect and intangible costs related to transport, the need for caregivers to make changes to their own careers, adaptation of the home to illness-related restrictions on autonomy, the use of various care providers, a company's lost revenues, etc. remain the full responsibility of patients and their families, especially if they have rejected administrative complications and the stigma that may have ensued from a request for disability status.

OBJECTIVE

- ▶ Remove the obstacles to entering or re-entering society and the workforce faced by cancer patients, those who are in remission or those who have been cured.

ACTIONS

29.1 Examine ways to remove cancer patients' and their caregivers' barriers to re-entering or remaining in the workforce.

Action coordinator: DGEFP (employment and job training agency, Ministry of Employment).
In partnership with the relevant stakeholders.

29.2 Provide specific information to cancer patients about their legal options for entering or re-entering the workforce.

29.3 Include cancer patients on the list of priority populations to benefit from the upcoming subsidised contracts as part of the extension of the RSA (active solidarity revenue).

Action coordinator: DGEFP (employment and job training agency, Ministry of Employment).
In partnership with the relevant stakeholders.

Measure 30.

Create a Cancer Societal Observatory.

BACKGROUND

Ten years after the Cancer Patient Councils (organised by the Ligue nationale contre le cancer), which made significant contributions to the 2003-2007 Cancer Plan, the Ligue convened a major cancer convention (Convention de la société face au cancer) in November 2008. At the convention, over 2,000 participants discussed pioneering advances of the 2003-2007 Cancer Plan as well as measures yet to be taken in the new Cancer Plan. At the close of the convention, the Ligue pledged to create a Cancer Observatory as one of its commitments.

OBJECTIVE

- ▶ Provide all necessary information and analysis on social concerns affecting the cancer patient.

ACTIONS

30.1 Create a Cancer Societal Observatory under the aegis of the Ligue nationale contre le cancer with the support of all of the Ligue's district branches.

The Observatory will publish an annual report. It will, in particular, share INCa's Cancer Info Service information and support platform and will offer the free Aidéa service, which helps patients gain access to insurance and bank loans.

Action coordinator: Ligue nationale contre le cancer.
In partnership with the relevant stakeholders.





Glossary

A

- AAH:** Allocation aux Adultes Handicapés (disabled adults' allowance)
- AAP:** Appel à projets (Call for proposals)
- ABM:** Agence de Biomédecine (Biomedical Agency)
- ACOSS:** Agence Centrale des Organismes de Sécurité Sociale (Social Security system cash management agency)
- ACP:** Anatomomo-cytopathology
- ADELFI:** Association des Épidémiologistes de Langue Française (Association of French-speaking Epidemiologists)
- ADELI:** Electronic conversion of health care profession lists
- ADEME:** Agence Gouvernementale de l'Environnement et de la Maîtrise de l'Énergie (French Environmental and Energy Management Agency)
- ADEREST:** Association pour le Développement des Études et Recherches Épidémiologiques en Santé Travail (Association for Epidemiological Research in Occupational Health)
- AERES:** Agence d'Évaluation de la Recherche et de l'Enseignement Supérieur (Higher Education and Research Evaluation Agency)
- AERIO:** Association pour l'Enseignement et la Recherche des Internes en Oncologie et Radiothérapie (Association for Resident Education and Research in Oncology and Radiotherapy)
- AFAQAP:** Association française d'assurance qualité en anatomie et cytologie pathologiques (French Anatomical and Cell Pathology Quality Assurance Association)
- AFSSA:** Agence Française de Sécurité Sanitaire des Aliments (French Food Safety Agency)
- AFSSAPS:** Agence Française de Sécurité Sanitaire des Produits de Santé
- AFU:** Association Française d'Urologie
- AFSSET:** Agence Française de Sécurité Sanitaire Environnementale et du Travail (French Occupational and Environmental Safety Agency)
- AGEFIPH:** Association pour la Gestion du Fonds pour l'Insertion professionnelle des Personnes Handicapées (Vocational Rehabilitation Fund Management Association)
- AGEPS :** Agence Générale des Équipements et Produits de Santé (General Medical Products and Equipment Agency)
- AGESA:** Association pour la Gestion de la Sécurité Sociale des Auteurs (Authors Social Security Management Association)
- AHU:** University hospital assistant
- AICR:** Association for International Cancer Research
- AIS:** Acte Infirmier de Soins (nurse care procedure)
- AJPP:** Allocation Journalière de Présence Parentale (daily cash benefit for parents who stay home to care for seriously ill children)
- ALD:** Affection de Longue Durée (chronic ailment)
- AMI:** Acte Médical Infirmier (nurse medical procedure)
- AMM:** Marketing authorisation (drug)



ANACT: Agence Nationale pour l'Amélioration des Conditions de Travail (National Agency for the Improvement of Working Conditions)
ANAES: Agence Nationale d'Accréditation et d'Évaluation de la Santé (National Health Accreditation and Assessment Agency)
ANFH: Association Nationale pour la Formation Hospitalière (National Hospital Training Association)
ANIT: Association Nationale des Intervenants en Toxicomanie (National Drug Addiction Workers Association)
ANR: Agence Nationale de la Recherche (National Research Agency)
ANRS: Agence Nationale de Recherche sur le Sida (National AIDS Research Agency)
ANVAR: Agence Nationale de Valorisation de la Recherche (National Research Applications Agency)
APA: Allocation Personnalisée d'Autonomie (personal autonomy allowance)
APA: Adapted physical activity
AP-HP: Assistance Publique – Hôpitaux de Paris (Paris public hospitals)
API: Isolated Parent Allowance
APP: Allocation de Présence Parentale (daily cash benefit for parents who stay home to care for seriously ill children)
APVP: Years of potential life lost
ARC: Clinical research assistant
ARC: Association pour la Recherche sur le Cancer (Cancer Research Association)
AREAS: convention s'Assurer et Emprunter avec un Risque Aggravé de Santé (Agreement on insurance and loans for patients with major health risks)
ARECA: Alliances des Recherches sur le Cancer (Cancer Research Partnerships)
ARETASC: Association pour la Recherche Thérapeutique et l'Amélioration des soins en Cancérologie (Association for Therapeutic Research and Improvement of Treatment in Oncology)
ARCMSA: Association Régionale des Caisses de Mutualité Sociale Agricole (Agricultural Social Security Fund)
ARH: Agence Régionale de l'Hospitalisation (Regional Hospital Board)
ARS: Regional Health Agency
ARTAC: Association française pour la Recherche Thérapeutique Anti-Cancéreuse (French Cancer Therapeutic Research Association)
AS: Nurse assistant
ASCO: American Society of Clinical Oncology
ASH: Hospital Assistant
ASIP: Agence des Systèmes d'Information de santé Partagés (Agency for Shared Health Information Systems)
ASN: Nuclear Safety Authority
ATIH: Agence Technique de l'Information Hospitalière (Hospital Information Technical Agency)
ATU: Temporary authorisation to prescribe medicine

B

BECT: Bureau d'Études Cliniques et Thérapeutiques (Clinical and Therapeutic Research Office)
BO: Official bulletin
BPCO: Chronic obstructive lung disease
BRCA: Gene that causes a hereditary predisposition to breast cancer

C

- CAC:** Anticancer Centre
- CADA:** Commission d'Accès aux Documents Administratifs (Commission on Access to Government Documents)
- CAF:** Caisse d'Allocations Familiales (Family Allowance Fund)
- CANAM:** Caisse Nationale d'Assurance Maladie et Maternité des Professionnels Indépendants (National Health and Maternity Insurance Fund for the Self-Employed)
- CANSSM:** Caisse Autonome nationale de la Sécurité Sociale dans les Mines (Autonomous National Social Security Fund for Mineworkers)
- CAPS:** Centre d'Accueil et de Permanence des Soins(urgent care centre)
- CAPI:** Contrat d'Amélioration des Pratiques Individuelles (Individual Practices Improvement Contract)
- CARMF:** Caisse Autonome de Retraite des Médecins de France (French Doctors' Autonomous Pension Fund)
- CARPIMKO:** Caisse Autonome de Retraite et de Prévoyance des Infirmiers, Masseurs-Kinésithérapeutes, Pédiacre-Podologues, Orthophonistes et orthoptistes (Autonomous Pension and Provident Fund for Nurses, Massage Therapists, Physiotherapists, Podiatrists, Speech Pathologists and Orthoptists)
- CAVIMAC:** Caisse d'Assurance Vieillesse, Invalidité et Maladie des Cultes Caisse d'Assurance Vieillesse, Invalidité et Maladie des Cultes (health, old-age and disability insurance for clergy and members of religious congregations not otherwise covered)
- CCA:** Assistant Clinical Director
- CCAA:** Centre de Cure Ambulatoire en Alcoologie (Outpatient Alcohol Rehabilitation Centre)
- CCAM:** Common Classification of Medical Procedures
- CCAPS:** Common Classification of Health Care Procedures
- CCAS RAIP:** Caisse de Coordination aux Assurances Sociales de la RATP (RATP [Paris-region rail system] National Health Insurance Coordinating Agency)
- 3C:** Centre de Coordination en Cancérologie (Oncology Coordination Centre)
- CCIP:** Chambre de Commerce et d'Industrie de Paris (Paris Chamber of Commerce and Industry)
- FCTC:** Framework Convention on Tobacco Control (WHO)
- CCLIN:** Centre de Coordination de la Lutte Contre les Infections Nosocomiales (Nosocomial Infection Control Coordination Centre)
- CCMSA:** Caisse centrale de la mutualité sociale agricole (Central Agricultural Social Security Fund)
- CCNE:** Comité Consultatif National d'Éthique (National Ethics Advisory Committee)
- CCPPRB:** Comité Consultatif de Protection des Personnes dans la Recherche Biomédicale (Advisory Committee on the Protection of Biomedical Research Subjects)
- CdAM:** Catalogue of Medical Procedures
- CdARR:** Catalogue of Rehabilitation and Physiotherapy Techniques
- CE:** Conseil d'État (Council of State)
- CEA:** Commissariat à l'Énergie Atomique (Atomic Energy Commission)
- CECOS:** Centre d'Étude et de Conservation du Sperme (Sperm Research and Preservation Centre)
- CENGEPS:** Centre National de Gestion des Essais des Produits de Santé (National Management Centre for Health Product Testing)
- CepiDC:** Centre d'Épidémiologie sur les Causes Médicales de Décès (Epidemiological Centre on the Medical Causes of Death)



CEPR: European Risk Prevention Centre
CEPS: Comité Économique des Produits de Santé (Health Products Economic Committee)
CEREQ: Centre d'Études et de Recherche sur les Qualifications (Qualifications Research Centre)
CES: Centre d'examens de Santé (Medical Examination Centre)
CETAF: Centre Technique d'Appui et de Formation des centres d'examen de santé (Technical Support and Training Centre for Medical Examinations)
CGOS: Comité de Gestion des Œuvres Sociales des établissements hospitaliers (Hospital Social Services Management Committee)
CGSS: Caisse Générale de Sécurité Sociale (General Social Security Fund)
CH: Hospital
CHG: General Hospital
CHR: Regional Hospital (non-university)
CHRU: Regional University Hospital
CHSCT: Comité d'hygiène, de sécurité et des conditions de travail (Health, Safety and Working Conditions Committee)
CHT: Communauté Hospitalière de Territoire (new healthcare jurisdictions in which competencies can be more efficiently shared between small medical facilities)
CHU: Hospital-University Complex
CIADT: Comité Interministériel d'Aménagement du Territoire (Interministerial Town and Country Planning Committee)
CIFCOT: Conférence Internationale Francophone pour le Contrôle du Tabac (International Tobacco Control Conference for French-speaking countries)
CIM (IDC IN ENGLISH): International Disease Classification
CIM-9 (IDC-9): International Disease Classification, 9^e forecast
CIM-10: International Disease Classification, 10^e forecast
CIRCE: International Agency For Research on Cancer
CIRCE: Cancer Inégalités Régionales, Cantonales et Environnement (environmental, local and regional cancer inequities)
CIRE: Cellule InterRégionale d'Epidémiologie
CISS: Inter-Association Health Collective
CLCC: Centre de Lutte Contre le Cancer (Comprehensive Cancer Centre)
CLIN: Centre de Lutte Contre les Infections Nosocomiales (Nosocomial Infection Control Centre)
CM: Major category
CMA: Complications and Associated Morbidity
CMAS: Complications and Serious Associated Conditions
CMAS-NT: Complications and Serious Associated Conditions Non-traumatic
CMC (MCC IN ENGLISH): Major Clinical Categories
CMD (MDC IN ENGLISH): Major Diagnostic Categories
CME: Commission Médicale d'Établissement
CMPU: Comité des Malades, des Proches et des Usagers (Patients, Family and Users Committee, INCa)
CMR: Caisse Maladie Régionale (Regional Sickness Fund)
CMR: Carcinogenic, mutagenic and/or reprotoxic
CMU: Universal health coverage
CNAMTS: Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (French salaried workers' health insurance scheme)
CNAV: Caisse Nationale de l'Assurance Vieillesse (French Insurance Federation)
CNC: Comité National du Cancer (National Cancer Committee)
CNCT: Comité National Contre le Tabagisme (National Anti-Smoking Committee)

CNED: Comité National Élargi des Dépistages (Expanded National Screening Committee)

CNEH: Centre National de l'Expertise Hospitalière

CNHIM: Centre National Hospitalier d'Information sur le Médicament (National Hospital Drug Information Centre)

CNID: Centre National d'information sur les drogues (National Drug Information Centre)

CNIEG: Caisse Nationale des Industries Électriques et Gazières (National Fund for Electric and Gas Industries)

CNIL: Commission Nationale de l'Informatique et des Libertés (French Data Protection Authority)

CNIS: Conseil National de l'Information Statistique

CNMSS: Caisse Nationale Militaire de Sécurité Sociale (National Military Social Security Fund)

CNOM: Conseil National de l'Ordre des Médecins (General Medical Council)

CNOP: Conseil National de l'Ordre des Pharmaciens

CNOSF: Conseil National de l'Ordre des sages-femmes

CNOSS: Comité National de l'Organisation Sanitaire et Sociale (National Committee for the Organisation of Health and Social Services)

CNPS: Centre National des Professions de Santé (National Health Professions Centre)

CNR: Comité National des Registre (National Registries Committee)

CNR: Centre National de Référence

CNRACL: Caisse Nationale de Retraite des Agents de Collectivités Locales (National Pension Fund for Local Government Employees)

CNRD: Centre National de Ressources de la Douleur (National Centre for Pain Management Resources)

CNRS: Centre National de la Recherche Scientifique (National Scientific Research Centre)

CNS: Conseil National du Sida (AIDS National Council)

CNSA: Caisse Nationale de Solidarité pour l'Autonomie (National Autonomy Support Agency)

CNSP: Comité National de Santé Publique (National Public Health Committee)

CNU: Conseil National des Universités (National Council of Universities)

CODESS: Comité Départemental d'Éducation Sanitaire et Sociale (Département [district] Health and Social Services Committee)

COFRAC: Comité Français d'Accréditation

COG: Convention d'Objectif et de Gestion (Objective and management agreement)

COM: Contrat d'Objectif Moyen (Medium-term contract)

COM: Collectivité d'Outre-Mer (Overseas Département)

COMIOR: Comité ministériel d'orientation de la recherche (Ministerial Research Advisory Committee)

COS: Comité d'Orientation Scientifique (Scientific advisory committee)

COSET: Cohorte pour la surveillance épidémiologique en milieu du travail (Cohort for epidemiological surveillance in a workplace setting)

COSMOP: projet de Cohorte pour la Surveillance de la Mortalité par Profession (Cohort project on mortality surveillance by profession)

CP: Multidisciplinary consultative meeting

CPAM: Caisse Primaire d'Assurance Maladie (National health insurance scheme)

CPER: State-region project contract

CPR SNCF: Caisse de Prévoyance et de Retraite de la SNCF (SNCF [French railways] Employees Provident and Pension Fund)



CPS: Comité de Promotion de la Santé (Health Promotion Committee)
CPS: Professional health card
CRAM: Caisse Régionale d'Assurance Maladie (Regional health insurance scheme)
CRAP: Anatomopathology Report
CREDES: Centre de Recherche, d'Étude et de Documentation en Économie de la Santé (Centre for Health Economics Research and Documentation, now called IRDES)
CREDOC: Centre de Recherche pour l'Étude et l'Observation des Conditions de Vie (Research Centre for the Study and Monitoring of Living Standards)
CRES: Comité Régional d'Éducation pour la Santé (Regional committee for Health Education)
CRESIF: Comité Régional d'Éducation pour la Santé d'Île-de-France (Ile-de-France Regional committee for Health Education)
CRF: Centre de Rééducation Fonctionnelle (Functional Rehabilitation Committee)
CRH: Centre René Huguenin (Saint-Cloud)
CRISAPIF: Centre de Regroupement Informatique et Statistique des données d'Anatomie et Cytologie Pathologiques d'Île-de-France (Ile-de-France Anatomy and Cell Pathology Data Warehouse)
CRO: Cancer Surgery Report
CROS: Comité Régional de l'Organisation Sanitaire
CROUS: Centre Régional des Œuvres Universitaires et Scolaires (Regional Scholarly and University Works Centre)
CRPCEN: Caisse de Retraite et de Prévoyance des Clercs et Employés de Notaires (Provident and pension fund for clerks and employees of solicitors)
CSAPA: Centre de soins, d'accompagnement et de prévention en addictologie (Addiction prevention and rehabilitation centre)
CSDM: Centre de Sociologie et de Démographie Médicales (Medical Sociology and Demography Centre)
CSH: Conseil Supérieur des Hôpitaux (National Hospital Council)
CSP: Code de la santé publique (Public Health Code)
CSPPM: Conseil Supérieur des Professions Paramédicales (National Paramedical Council)
CSPPRP: Conseil Supérieur de la Prévention des Risques Professionnels (High Council for the Prevention of Occupational Hazards)
CSS: Social Security Code
CT: Computerized Tomography (Scanner)
CTE: Comité Technique d'Établissement
CTV: Vaccination Technical Committee
VCM: Vinyl chloride monomer

D

DA: Associated diagnosis
DA: Announcement Procedure
DAC: Additional Annual Contribution
DAEI: Department of European and International Affairs
DAF: Annual Funding Contribution
DAGEMO: Direction de l'Administration Générale et de la Modernisation des services (Department of General Administration and Service Modernisation, Ministry of Labour)
DAGPB: Direction de l'Administration Générale, du Personnel et du Budget (Health Ministry)
DARES: Direction de l'Animation de la Recherche, des Études et des Statistiques

DARH: Directeur d'Agence Régionale de l'Hospitalisation (Regional health agency director)

DAtIM: Dépistage des Atypies des Informations médico-administrative (Screening of atypical medical-administrative information)

DCC: Cancer Communication File

DCEM: Second cycle of medical school

DDASS: Public Health and Social Services Department (département level)

DDTEFP: Labour, Employment and Occupational Training Department (département level)

DEA: Diplôme d'Études Approfondies (Advanced research degree)

DEAVS: Diplôme d'État d'Auxiliaire de Vie Sociale (home health aide diploma)

DES: Diplôme d'Études Spécialisées (Professional degree)

DESC: Diplôme d'Études Spécialisées Complémentaires (Advanced professional degree)

DGAS: Direction Générale de l'Action Sociale - ministère santé (Social Services Directorate-general - Ministry of Health)

DGCCRF: Direction Générale de la Consommation, de la Concurrence et de la Répression des Fraudes (Directorate-General of Consumer Affairs, Competition and Anti-Fraud)

DGDDI: Direction générale des douanes et droits indirects (Directorate-General of Customs and Indirect Taxes)

DGEFP: Délégation Générale à l'Emploi et à la Formation Professionnelle (Employment and Job Training Agency)

DGF: Dotation Globale de Fonctionnement (State funding to regional authorities)

DGRI: Direction générale de la recherche et de l'innovation (Directorate-General of Research and Innovation)

DGS: Direction Générale de la Santé (Directorate-General of Health)

DGSNR: Direction Générale de la Sécurité Nucléaire et de la Radioprotection (Directorate-General of Nuclear Safety and Radioprotection)

DGT: Direction générale du travail (Directorate-General of Labour)

DHOS: Direction de l'Hospitalisation et de l'Organisation des Soins (Hospitals and Health Care Organisation Directorate)

DIM: Département d'Information Médicale (Information and Support Centre)

DIRC: Délégation Interrégionale à la Recherche Clinique (International Clinical Research Commission)

DLF: Direction de la législation fiscale (Tax Law Department)

DMP: Dossier Médical Personnel (Personal Medical File)

DMSI: Département Méthode et Systèmes d'information (Information Methodology and Systems Department)

DMT: Discipline médico-tarifaire (service code)

DNDR: Dotation Nationale de Développement des Réseaux de santé (National Health System Funding)

DNF: Droit des Non-Fumeurs (Non-smokers' rights association)

DO: Dépistage Organisé (Organised screening)

DO: Déclaration obligatoire (Mandatory statement)

DOM: Département d'Outre-Mer (Overseas département)

DP: Main Diagnosis

DPM: Population and Immigration Department (Ministry of Employment and Social Cohesion)

DQPRM: Diplôme de Qualification en Physique Radiologique et Médicale (Qualifying degree in radiological and medical physics)

DR: Related diagnosis

DRASS: Direction Régionale des Affaires Sanitaires et Sociales (Regional Public Health and Social Services Department)



DRC: Délégation à la Recherche Clinique (Clinical Research Commission)
DRCI: Délégation à la Recherche et à l'Innovation (Research and Innovation Commission)
DRDJS: Direction Régionale et Départementale de la Jeunesse, des Sports et de la Vie associative (Regional and District [département] Department for Youth, Sports and the Non-Profit Sector)
DRDR: Dotation régionale de Développement des Réseaux (Regional health system funding)
DREES: Direction de la Recherche, des Études, de l'Évaluation et des Statistiques (Research, Assessment and Statistics Department, Ministry of Health)
DRG: Diagnosis Related Groups
DRP: Direction des Risques Professionnels (Occupational Hazards Department)
DRSM: Direction Régionale du Service Médical (Regional Medical Service Department [health insurance])
DRT: Labour Relations Department (Ministry of Employment)
DSS: Direction de la Sécurité Sociale (Social Security Department)
DTE: Diagnostic Tabagisme Établissement (smoking diagnostic centre)
DTS: Diplôme de Technicien Supérieur (Advanced Technician's Diploma)

E

ECBU (MSU IN ENGLISH): Midstream Urine Test
ECR: Relative Cost Scale
EFs: Établissement Français du Sang (French blood bank)
EHESP: École des Hautes Études en Santé Publique (French School of Public Health)
EHIS: Environment and Health Information System
EHP: Survey of Private Hospitals
EHPA: Établissement d'Hébergement pour Personnes Âgées (Residential Facility for Elderly Dependents)
EMEA: European Medicines Evaluation Agency
EMSP: Équipe Mobile de Soins Palliatifs
ENC: Étude Nationale des Coûts
ENC: National Qualifying Exam
ENCR: European Network of Cancer Registry
ENIM: Établissement National des Invalides de la Marine (National Social Security Fund for Disabled Marine Personnel)
ENNS: National Health & Nutrition Survey
ENSP: École Nationale de Santé Publique (National Public Health School)
ENV: École Nationale Vétérinaire (National Veterinary School)
EORTC: European Organization for Research and Treatment of Cancer
EPC: Ongoing Cancer Survey
EPHAD: Établissement d'Hébergement pour Personnes Âgées (Residential Facility for Elderly Dependents)
EPC: Ongoing Cancer Survey
EPIC: European Prospective Investigation into Cancer and Nutrition (Study)
EPP: Assessment of Professional Practices
EPRD: État Prévisionnel de Dépenses et de Recettes (estimated budget for revenues and expenditures)
ERI: Espace de Rencontre et d'Information (information and support centre)
ERSM: Échelon Régional du Service Médical (medical service regional section)
ESCAPAD: Enquête sur la Santé et les Consommations lors de l'Appel de Préparation à la Défense (health and consumer survey during the civil defence day call-up)

ESPAD: European School Survey Project on Alcohol and other Drugs

ESPS: French Health, Health Care and Insurance Survey

ETP: Full-time equivalents

ETS: Établissement de Santé (Health institution)

F

FAQSV: Fonds d'Amélioration de la Qualité des Soins de Ville (Funds for improving the quality of outpatient care)

FCRISAP: Fédération des Centres de Regroupement Informatique et Statistique en Anatomie et Cytologie Pathologiques (Federation of Anatomy and Cell Pathology Data Warehouses)

18F-FDG: a cyclotron-produced molecule used for isotropic imaging in the field of nuclear medicine

FEHAP: Fédération des Établissements Hospitaliers et d'Assistance Privés à but non lucratif (Non-profit private hospitals)

FFB: Fédération Française des Banques (French Banking Federation)

FFSA: Fédération Française des Sociétés d'Assurance (French Insurance Federation)

FG: Fonction groupage (software tool for classifying groups with related diagnoses)

HFH: Fédération Hospitalière de France (French Hospital Federation)

FHP: Fédération de l'Hospitalisation privée ((French Private Hospital Federation)

FICQS: Fonds d'Intervention pour la Qualité et la Coordination des Soins (Care Quality and Coordination Improvement Fund)

FIHP: Fédération Intersyndicale des Établissements d'Hospitalisation Privée (Federation of Private Hospital Trade Unions)

FINES: National database of health and social service institutions

FINPS: Fichier d'Identification Nationale des Professions de Santé (National health care professions identification database)

FIVA: Fonds d'Indemnisation des Victimes de l'Amiante(Asbestos Victims Compensation Fund)

FMC: Continuing medical education

FMES: Fonds de Modernisation Sociale des Établissements de Santé (Social Services Modernisation Fund for Health Institutions)

FNCCH: Fédération Nationale de Cancérologie des Centres Hospitaliers (National Hospital Oncology Federation)

FNCLCC: Fédération Nationale des Centres de Lutte Contre le Cancer (National Federation of Comprehensive Cancer Centres)

FNES: Fédération Nationale des Comités d'Éducation pour la Santé (National Federation of Health Education Committees)

FNORS: Fédération Nationale des Observatoires Régionaux de la Santé (National Federation of Regional Health Observatories)

FNPEIS: Fonds National de Prévention, d'Éducation et d'Information Sanitaire (National Prevention, Education and Health Information Fund)

FOIN: Fonctions d'Occultation des Informations Nominatives (personal data privacy software)

FRANCIM: Réseau Français des registres du cancer (French network of cancer registries)



G

- GENRSA:** Générateur de Résumés de Sortie Anonymes (Generator of anonymous exit summaries)
- GERS:** Groupement d'Études et de Recherche sur la Santé (Health Research Group)
- GBM:** Biomedical engineering
- GCS:** Health Cooperation Group
- GEC:** Groupe d'Études Cliniques (Clinical Studies Group)
- GHJ:** Homogeneous groups of days
- GHM:** Homogeneous groups of patients
- GHS:** Homogeneous groups of hospital stays
- GIE:** Economic interest group
- GIP:** Public interest group
- GIP AIS:** Public interest group "Alcool Info Service" (Alcohol Helpline)
- GIP-DMP:** Public interest group "Personal Medical File"
- GIP-CPS:** Public interest group « Carte des professionnels de Santé » ("Health Care Professionals Card" public interest group)
- GIS:** Scientific Interest Group
- GIS IbisA:** Scientific interest group "Infrastructures en Biologie Santé et Agronomie"
- GNS:** National Monitoring Group
- GRSP:** Regional Public Health Group
-

H

- HAD:** Home hospitalisation
- HAS:** Haute Autorité de Santé (Higher Health Authority)
- HCSP:** Haut Conseil de la Santé Publique (High Council for Public Health)
- HNPCC:** hereditary, non-polyposis colorectal cancer
- HPST:** Hospital, Patients, Health Care and Regions (Law)
- HPV:** human papillomavirus
-

I

- IADE:** Registered nurse anaesthetist
- IARC:** International Agency for Research on Cancer (CIRC: Centre International de Recherches sur le Cancer)
- IBODE:** Infirmier de Bloc Opératoire Diplômé d'État (Registered surgical nurse)
- IC (CI IN ENGLISH):** Confidence interval
- ICD-9-CM:** International Classification of Disease, 9th edition, Clinical Modification
- ICR:** Relative Cost Index
- ICT (TBI):** Total body irradiation
- IDE:** Infirmier diplômé d'État (Registered Nurse)
- IDS:** Institut du Développement Social (Institute of Social Development)
- IFEN:** Institut Français de l'Environnement (French Environmental Institute)
- IFMK:** Institut de Formation en Masso-Kinésithérapie (Physiotherapy Training Institute)
- IFS:** Institut de Formation en Soins Infirmiers (Nursing Care Training Institute)
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IGAS: Inspection Générale des Affaires Sociales (Inspectorate-General of Social Affairs)
IGR: Institut Gustave Roussy
IGS: Simplified gravity index
IMC (BMI): Body mass index
INCa: Institut national du cancer (National Cancer Institute)
INERIS: Institut National de l'Environnement Industriel et des Risques (National Industrial Environment and Hazards Institute)
INPES: Institut National de Prévention et d'Éducation pour la Santé (National Health Prevention and Education Institute)
INRS: Institut National de Recherche et de Sécurité (pour la prévention des AT-MP) (National Research and Safety Institute [for the prevention of work-related accidents and diseases])
INS: National health identifier
INSEE: Institut National de la Statistique et des Études Économiques (National Institute of Statistics and Economic Studies)
INSERM: Institut National de la Santé Et de la Recherche Médicale (National Institute of Health and Medical Research)
INSTN: Institut National des Sciences et Techniques Nucléaires (National Institute of Nuclear Science and Technology - working to transfer knowledge developed at the CEA)
InVS: Institut national de Veille Sanitaire (National Health Monitoring Institute)
IPP: Permanent Personal Identifier
IRD: Institut de Recherche pour le Développement (Development Research Institute, formerly ORSTOM)
IRSN: Institut de Radioprotection et de Sûreté Nucléaire (Nuclear Safety and Radioprotection Institute)
IRDES: Institut de Recherche et de Documentation en Économie de la Santé (Institute of Health Economics Research and Documentation, formerly CREDES)
IReSP: Institut de recherche en santé publique (Public Health Research Institute)
IRM (MRI): Magnetic Resonance Imaging
ISA: Indice Synthétique d'Activité
ISAr: Indice Synthétique d'Activité régionale
ITMO: Instituts Thématiques Multi-Organismes (multi-organisational specialist institutes)

J

JO: Journal Officiel (Official Journal)

K

KIS: Health Information Kiosk

L

LEEM: Pharmaceutical companies
LIR: International research laboratories
LMD: Bachelor's-Master's-Ph.D.
LNCC: Ligue nationale contre le cancer
LOLF: State Authorities Act relating to the Budget and Finance Acts
LRPSP: Public Health Policy Law



M

- MAE:** Ministry of Foreign Affairs
MCO: Medecine, Surgery, Obstetrics
MCU-PH: University Lecturer – Hospital Doctor
MDPH: Maison Départementale des Personnes Handicapées (disability organisation)
MEAH: Mission nationale d’Expertise et d’Audit Hospitalier
MEN: Ministry of National Education
MEP: Doctor in private practice
MERRI: Mission d’Enseignement, de Recherche, de Référence et d’Innovation (Education, Research, Information and Innovation Programme)
MESONAT: Registre multicentrique national du mésothéliome pleural (National Multi-centre Pleural Mesothelioma Registry)
MESR: Ministry of Higher Education and Research
MIG: Mission d’Intérêt général (Mission of general interest)
MIGAC: Mission of general interest and contract support
MILDT: Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie (Interministerial Programme to Fight Drugs and Drug Addiction)
MIRE: Mission Recherche du ministère de la santé et des solidarités (Research project, Ministry of Health and Solidarity)
MMR: gene causing a predisposition to colorectal cancer
MSA: Mutualité Sociale Agricole (Agricultural Social Security Fund)
MYH: gene causing a hereditary predisposition to cancer

N

- NACRe:** National Alimentation Cancer Recherche network
NCHS: National Center of Health Statistics
NFS: Numération Formule Sanguine (blood platelet count)
NGAP: Nomenclature Générale des Actes Professionnels (General Nomenclature of Medical Procedures)
NIHES: National Institute of Environmental Health Sciences
NCI: National Cancer Institute (USA)
NCRI: National Cancer Research Institute (UK)
NHS: National Health Service (UK)
NIH: National Institutes of Health

O

- OCDE (OECD):** Organisation for Economic Cooperation and Development
OEI: Organisation of European Cancer Institute
OFDT: Observatoire Français des Drogues et Toxicomanies (French Drug and Drug Addiction Observatory)
OFT: Office Français de prévention du Tabagisme (French Smoking Prevention Office)
OMIT: Observatoire des Médicaments et des Innovations Thérapeutiques (Observatory of Drugs and Innovative Treatments)
OMEDIT: Observatoire des Médicaments, des Dispositifs médicaux et des Innovations Thérapeutiques (Observatory of Drugs, Medical Devices and Innovative Treatments)
OMS (WHO): World Health Organisation
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ONDAM: Objectif National des Dépenses d'Assurance Maladie (National Health Insurance Scheme)
ONDPS: Observatoire National de la Démographie des Professions de santé (National Observatory of Health Profession Demographics)
ONG (NGO): Non-governmental organisation
ONIAM: Office National d'Indemnisation des Accidents Médicaux (National Medical Accidents Compensation Office)
OPPBTP: Organisme Professionnel de Prévention du Bâtiment et des Travaux Publics (Building and Public Works Trade Organisation for Preventing Occupational Accidents)
OQN: National quantified objective
OR: Odds ratio
ORL: Otorhinolaryngology (ENT)
ORS: Observatoire Régional de la Santé (Regional Health Observatory)
OST: Observatoire des Sciences et Techniques (Sciences and technics Observatory)

P

PAIR: Programme d'actions intégrées de recherche (Programme for integrated research projects)
PASS: Permanence d'Accès aux Soins de Santé (Hospital health care and social services programme for vulnerable populations)
PCEM: First cycle of medical school (two years)
PCRD: Research and Development Framework Programme (European Commission)
PED: Developing countries
PERNNS: Pôle d'Expertise et de Référence Nationale des Nomenclatures de Santé (National Reference Centre for Medical and Health Classifications)
PH: Hospital doctor
PHRC: Hospital clinical research programme
PHIP: Full-time hospital doctor
PLF: Government budget and finance bill
PLFSS: Social Security budget bill
PLHPST: Government bill on Hospitals, Patients, Health Care and Regions
PMI: Maternal and child health
PMSi: Programme de Médicalisation des Systèmes d'Information (Programme for the Medicalisation of Information Systems)
PNAPS: National plan for prevention through physical education
PNNS: Programme National Nutrition Santé (French National Nutrition and Health Programme)
PNSE: Plan National Santé Environnement (National Environmental Health Plan)
PNSM: Programme National de Surveillance du Mésothéliome (National Mesothelioma Surveillance Programme)
PPAC: Programme Personnalisé de l'Après Cancer (Post-cancer Preparation)
PPS: Programme Personnalisé de Soins (Individualised Care Plan)
PRAPS: Programme Régional pour l'Accès à la Prévention et aux Soins (Regional Programme for Access to Preventive and Therapeutic Care)
PREDECOB: Plateforme de recherche et de développement des grandes cohortes biomédicales (Research and Development Platform for Large Biomedical Cohorts)
PRH: Programme Régional Hospitalier (Regional Hospital Programme)
PRSP: Plan Régional de Santé Publique (Regional public health plan)
PS: Health care profession



PSPH: établissement de santé privé Participant au Service Public (Private non-profit hospitals incorporated into the public hospital)
PST: Occupational health plan
PTT: Temporary treatment protocol
PU: University hospital doctor
PUI: Pharmacie à Usage Intérieur (hospital pharmacie)
PU-PH: University professor – Hospital doctor
PUT: Treatment use protocol

R

RBU: Good practice guidelines
RCMI: Intensity-modulated radiation therapy (IMRT)
RCP: Multidisciplinary consultative meeting
REACH: Registration, Evaluation and Authorisation of Chemicals
NACRe network: National Alimentation Cancer Recherche Réseau
RHA: Anonymous weekly summary
RHS: Standardised weekly summary
RIC: Interdisciplinary coordination meeting
RMN: Nuclear magnetic resonance
RNIPP: Répertoire National d'Identification des Personnes (National Individual Identification Directory)
RPPS: Répertoire Partagé des professionnels de Santé (Shared Directory of Health Professionals)
RPC: Clinical practice recommendation
RR: Relative risk
RRC: Réseau Régional de Cancérologie (Regional Oncology Network)
RSA: Résumé de Sortie Anonymisé (Anonymous exit summary)
RSA: Revenu de Solidarité Active (Active solidarity revenue)
RSF: Résumé Standardisé de Facturation (Standardised invoicing summary)
RSFAC: Résumé Standardisé de Facturation Anonyme Chaînable (Chainable anonymous standardised invoicing summary)
RSH: Résumé de Séjour Hebdomadaire (Weekly stay summary)
RSS: Résumé de Sortie Standardisé (Standardised stay summary)
RUM: Résumé d'Unité Médicale clinique (Clinical medical unit summary)

S

SAE: Statistique Annuelle des Établissements de santé (Annual statistics on health care institutions)
SAI: Sans autre indication (Without other indication)
SAIO: Service Académique d'Information et d'Orientation (Academic Information and Counselling Service)
SAMU: Service d'Aide Médicale d'Urgence (Emergency medical assistance)
SCI: Société Civile Immobilière (non-trading real estate investment company)
SDFE: Service des Droits des Femmes et de l'Égalité (Office for Equal Rights and Opportunity for Women)
SEP: Multiple sclerosis
SFAP: Société Française d'Accompagnement et de Soins Palliatifs (French Society for Palliative Support and Care)
SFC: Société Française du Cancer (French Cancer Society)
SFETD: Société Française d'Étude et de Traitement de la Douleur (French Pain Management and Research Society)
SFH: Société Française d'Hématologie (French Haematology Society)

SFN: Société Française de Nutrition (French Nutrition Society)
SFP: Société Française de Pathologie (French Pathology Society)
SFRO: Société Française de Radiothérapie Oncologique (French Oncoradiotherapy Society)
SHS: Humanities and social sciences
SICAP: software developed by the Ministry of Health to strengthen toxicovigilance efforts
SICOM: Service de l'Information et de la Communication, ministère santé (Information and Communication Department - Ministry of Health)
SIDA (AIDS): Acquired immuno-deficiency syndrome
SIG (GIS): Système d'information géographique
SIGMED: Système d'Information et de Gestion des Personnels Médicaux
SIIPS: Soins Infirmiers Individualisés à la Personne Soignée (individualised nursing care)
SMPF: Syndicat des médecins pathologistes français (French Pathologists Union)
SMUR: Service Mobile d'Urgence et de Réanimation (Mobile Rehabilitation and Emergency Service)
SNIIRAM: Système National d'Information Inter-Régimes de l'Assurance Maladie (National Health Insurance Inter-Scheme Information System)
SNIREP: Système National Inter-Régimes des Établissements privés (National Inter-Scheme System for Private Institutions)
SNITEM: Syndicat National des Industriels et des Technologies Médicales (National Manufacturers and Medical Technologies Union)
SOR: Standards, Options, Recommendations
SPC: Particularly expensive care
SPH: Service Public Hospitalier (Public Hospital Care)
SPORT: Strategic Partnership for Reach Testing (NCI)
SREPS: Schéma Régional d'Éducation Pour la Santé
SROS: Schéma Régional de l'Organisation Sanitaire (Regional Health Organisation Scheme)
SSIAD: Service de Soins Infirmiers À Domicile (Home Nursing Care Service)
SSR: Soins de Suite et de Réadaptation (Follow-up and Rehabilitation Care)
SSRHA: Suites Semestrielles de Résumés Hebdomadaires Anonymes (half-yearly supplements to anonymous weekly summaries)
STIC: programme de Soutien aux Techniques Innovantes Coûteuses (funding programme for costly innovative techniques)

T

T2A: Tarification À l'Activité (case mix-based hospital financing system)
TCAM: Annual average growth rate
TEC: Technicien d'Études Cliniques
TEP: Positron Emission Tomography
TGIR: Extensive research infrastructure
TIPS: Tarif Interministériel des Prestations Sanitaires (Interministerial cost for health services)
TIS: Tabac Info Service (smoking helpline)

U

UCANSS: Union des caisses nationales de sécurité sociale (Union of National Social Security Funds)
UCOG: Unité de Coordination en Oncogériatrie (Oncogeriatric coordination unit)



UCSA: Unités de Consultations et de Soins Ambulatoires, en milieu pénitentiaire (Outpatient care and consultation units, in a prison setting)
UFR: Unité de Formation et de Recherche (Research and training unit)
UGECAM: Union de Gestion des Établissements des Caisses d'Assurance Maladie (Management Association for Health Insurance Funds)
UICC: International Union Against Cancer
UM: Medical unit
UNCAM: Union Nationale des Caisses d'Assurance Maladie (National Health Insurance Scheme)
UNHPC: Union Nationale de l'Hospitalisation Privée en Cancérologie (National Union of Private Cancer Hospitals)
UPCOG: Union Pilote de l'action de coordination en Oncogériatrie
URCAM: Union Régionale des Caisses d'Assurance Maladie (Regional Union of Health Insurance Funds)
URML: Union Régionale des Médecins Libéraux (Regional Union of Private Practice Doctors)
USEN: Unité de Surveillance et d'Épidémiologie Nutritionnelle (Nutritional epidemiology and surveillance unit) (mixed InVS-CNAM unit)
USP: Unité de Soins Palliatifs (Palliative care unit)

V

VADS: Upper aerodigestive tract
VAE: Validation des Acquis de l'Expérience (Approval of experiential skills)
VHB: Virus de l'Hépatite B
VHC: Virus de l'Hépatite C
VPN: Negative predictive value
VPP: Positive predictive value

W

WCRF: World Cancer Research Fund
WHI: Women's Health Initiative
WHO: World Health Organisation

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Cancer plan 2009 2013

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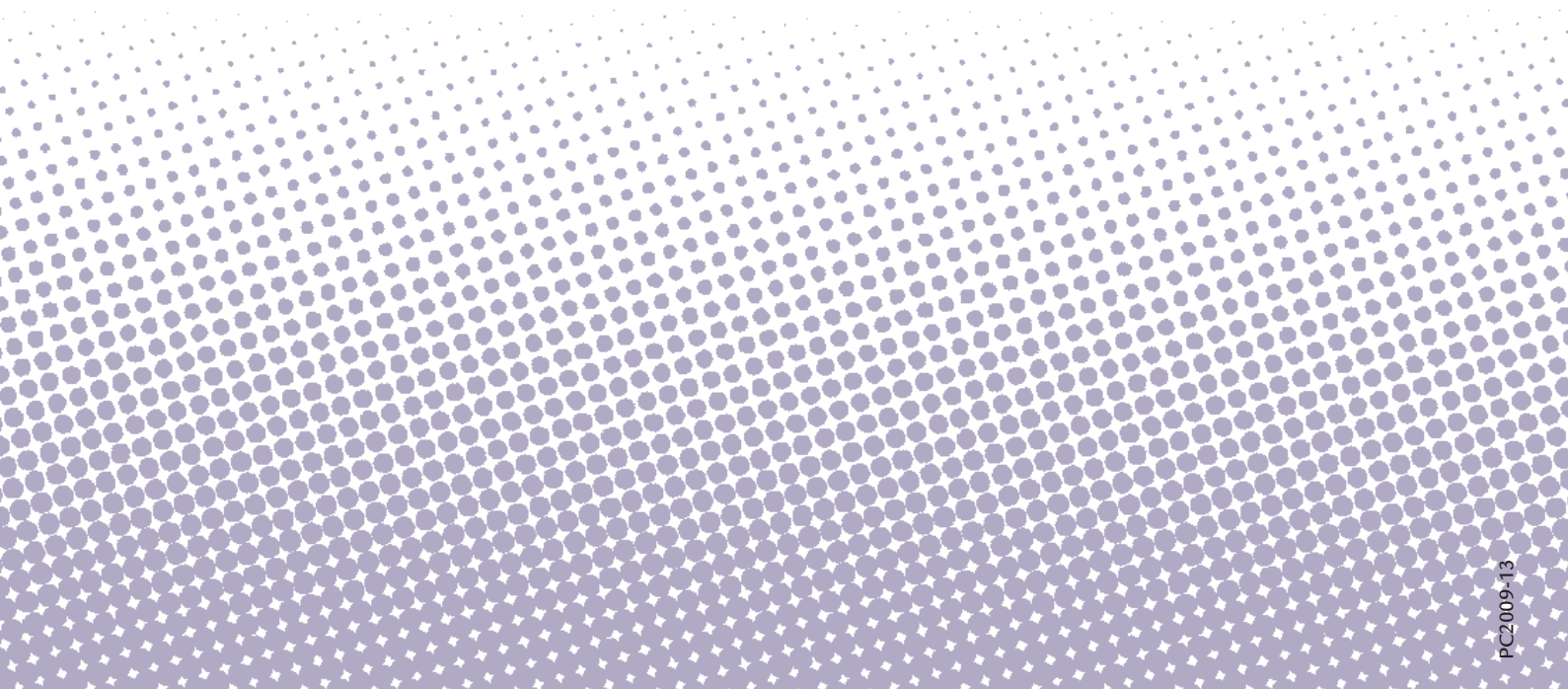


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