Policy Brief

Good practices for delivering high value cancer care in EU countries

25 June 2026

Key messages

- **Cancer is a growing public health issue in EU countries**. In 2024, there were an estimated 2.7 million cancer cases diagnosed in the EU (representing 5.1 new cancer diagnoses per minute). Since 2000, the number of new cancer cases has surged by over 28% for both men and women.
- **Cancer care systems in Europe are falling short in delivering the best value of care**, as demonstrated by delays in access to cancer care services, unnecessary differences in care quality and outcomes, and services not systematically aligned with people's needs:
    - Between 15-40% of patients with colorectal cancer are diagnosed via the emergency department, a route that is associated with significantly worse outcomes.
    - Variation in early-stage prostate cancer diagnoses among men aged 75+ (from 53% in the Netherlands to 81% in Luxembourg), reflects inconsistent screening practices that leave some cancers detected too late and expose others to needless treatment of slow-growing tumours.
    - Fewer than one in three primary care cancer patients report people-centred care, with rates ranging from 42% in Belgium to 16% in Greece, driven by fragmented data, poor care co-ordination, and limited patient co-production.
- **Four policy priorities can help improve the value of cancer care system:**
    1. **Build integrated cancer pathways, linking diagnosis, treatment and survivorship**. As demonstrated in Denmark and Sweden, defined referral routes, time-bound diagnostics, and multidisciplinary teams play a key role in delivering timely and equitable access to care.
    2. **Optimise resource use while embracing technological innovation.** Policies such as risk-stratified screening, day versus inpatient care, and biosimilar uptake can yield large efficiency gains without compromising quality, as demonstrated in Austria or Estonia.
    3. **Strengthen data infrastructure to implement and monitor evidence-based standards.** Germany's cancer care certification and clinical quality standards, and the Netherlands' transparent quality feedback mechanisms are good practices of continuous care quality improvements.
    4. **Make people-centred care a pillar of the cancer care system** – through greater involvement in decision making, self-management support, and co-ordinated follow-up – while ensuring psychological, social and financial well-being, as demonstrated in France.

Opportunities remain to improve the value of cancer care in Europe

Cancer remains one of the most significant public health challenges. It is the second-leading cause of death in EU countries, and the number of cancer cases has been rising. In 2024, there were an estimated 2.7 million cancer cases diagnosed across EU countries, roughly 5 new cases per minute. Over the past two decades, total cancer cases rose by 28% in men and women. By 2040, the EU is projected to reach 3.2 million annual cases, an 18% rise from 2022 estimates. While cancer-related health spending already accounts for 7% of total health spending in the EU, opportunities remain to deliver higher value in cancer care for patients and health systems.

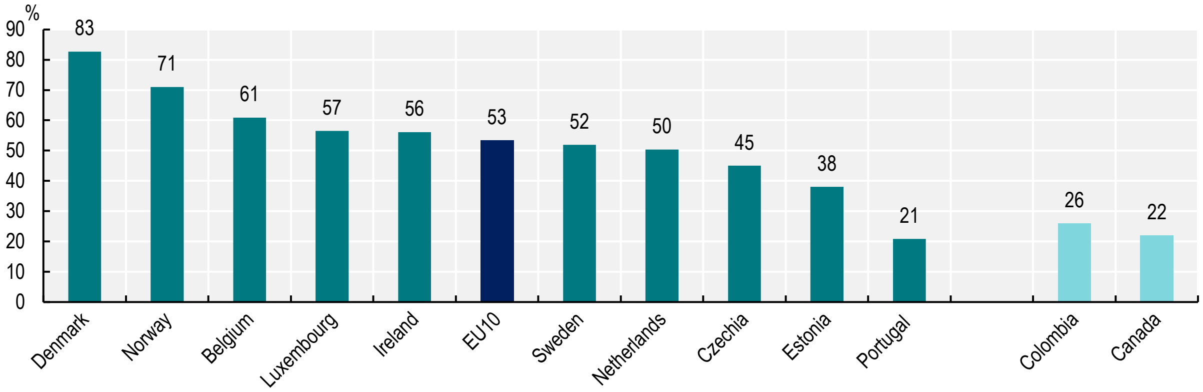
Delays in access to cancer diagnosis and treatment underscore significant unmet needs

While population-based cancer screening programmes have proven cost-effective – significantly improving early detection and leading to higher survival – their uptake remains highly uneven across countries and social groups. Breast cancer screening rates vary five-fold between EU countries in 2023 (from 15% in Greece to 83% in Denmark and Sweden) and colorectal cancer screening rates vary eight-fold (from 9% in Hungary to 74% in Finland). Socio-economic inequalities in screening uptake also persist across EU+2 countries. People with high education levels on average are 25 percentage points (p.p.) more likely to report undergoing a mammogram in the previous two years, compared to those with low education; for self-reported colorectal cancer screening there is a similar 8-p.p. gap between people with higher and lower education.

These gaps result in delayed diagnoses and missed opportunities for early treatment. Across all age groups, between 15%-40% of patients with colorectal cancer are diagnosed via emergency care presentation – a route that is associated with significantly worse outcomes. Among those aged 50-69 years (the screening age eligible population), the share of colorectal cancers diagnosed through emergency care presentation ranges from 8% in Luxembourg to 29% in Belgium.

Furthermore, while delays in cancer treatment have adverse impacts on cancer survival (Hanna et al., 2020[1]), there are major cross-country differences with regard to timeliness of treatment initiation. For example, only three countries (Belgium, Denmark and Norway) reported that at least 60% of female breast cancer cases began treatment within 30 days of diagnosis, suggesting more efficient care pathways in these countries (Figure 1).

Figure 1. In only 3 countries, more than 60% of female breast cancer cases began treatment within 30 days of diagnosis



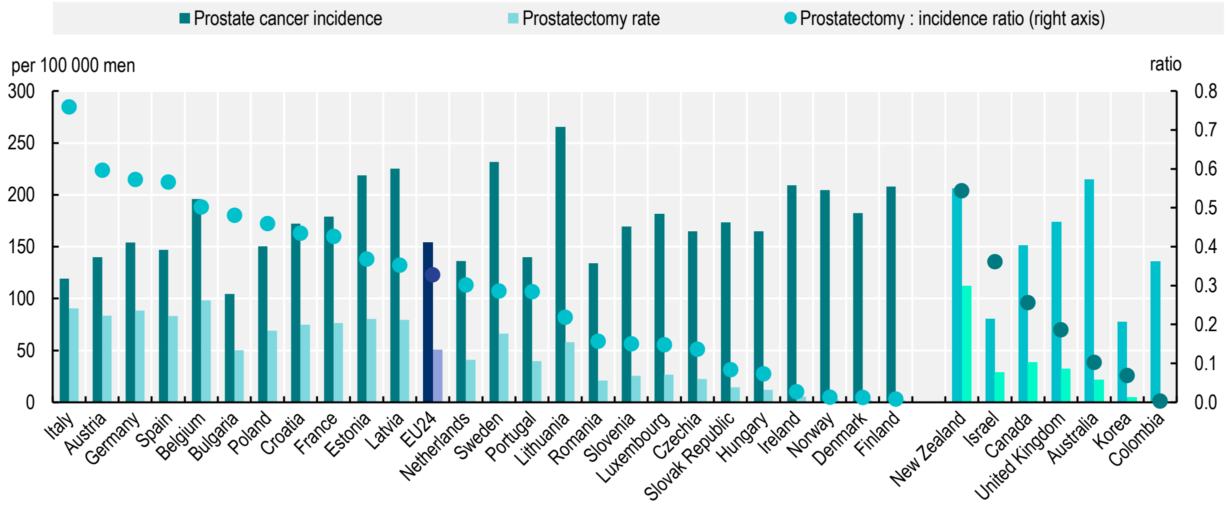
Source: OECD/European Commission (2026), *Delivering High Value Cancer Care: European Cancer Inequalities Registry Analytical Report*, https://doi.org/10.1787/060869fe-en.

Unnecessary variations in care practices and quality contribute to health system waste

Medical practice for cancer care varies greatly across countries, raising questions as to whether current care delivers the best value for patients and health systems. For example, the share of partial mastectomies, which are less invasive and offer similar survival benefits to full mastectomies, ranges from 79% in Spain to 50% or lower in Romania and Poland.

Similarly, the share of early-stage prostate cancer diagnoses in men aged 75+ ranges from 53% in the Netherlands to 81% in Luxembourg, reflecting variation in prostate cancer screening practices. These differences lead to some patients being diagnosed too late, while other patients – whose slow-growing cancer would not affect their life expectancy – are diagnosed unnecessarily, leading to needless treatment and generating waste for the health system. Accordingly, treatment patterns also differ dramatically. While prostatectomy carries significant long-term side effects and may not be the most people-centred option for many patients, countries such as Italy, Austria, Germany and Spain perform about six or more prostatectomies per ten cancer cases compared to Ireland, Norway, Denmark and Finland who do very few (with less than one prostatectomy per ten cancer cases) (Figure 2).

Figure 2. EU+2 countries reported as much as a 70-fold variation in the ratio of prostatectomy surgeries to prostate cancer cases



Source: OECD/European Commission (2026), *Delivering High Value Cancer Care: European Cancer Inequalities Registry Analytical Report*, https://doi.org/10.1787/060869fe-en.

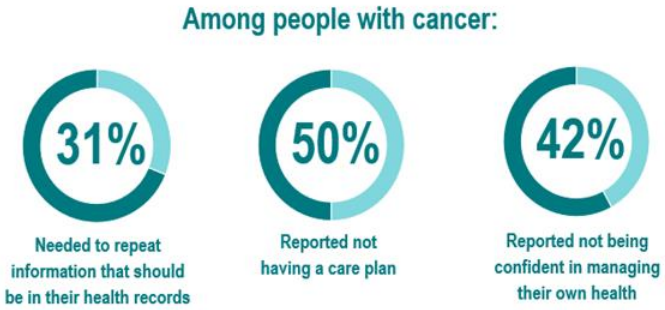
In addition, age-standardised 30-day mortality rates following colorectal cancer surgery range substantially – from about 1.5% in Denmark and Norway to above 5% in Croatia. Disparities may stem from differences in health conditions, cancer stage, standardisation of surgical techniques and processes that help improve outcomes for colorectal surgery (Eto et al., 2018[2]), as well as differences in surgical and post-surgical care safety and care practices (de la Portilla et al., 2018[3]). Importantly, 30-day mortality rates following emergency colon surgery were up to seven times higher than those for planned surgery, highlighting the importance of early detection not only for finding cancers at less aggressive stages, but also to allow appropriate surgical planning and patient preparation prior to the procedure.

Primary healthcare systems are not sufficiently centred-around the needs of cancer patients

The OECD PARIS survey suggests that people living with cancer are more vulnerable than other primary healthcare patients. They report worse physical health, well-being and social functioning. For example, on average, only 44% of primary healthcare patients with a cancer diagnosis in the last five years rated their health as good, very good or excellent, compared to 66% for other primary healthcare users.

People-centred care places individuals' needs, preferences, and values at the core of healthcare decisions, supporting co-ordination, continuity, and communication throughout the care journey and leading to better well-being and overall health outcomes (OECD, 2025[4]). While people-centred care is associated with better health outcomes, less than a third of primary healthcare patients with cancer report high levels of people-centredness in the EU11 countries included in the PARIS survey,[1] ranging from 42% in Belgium to 16% in Greece. Several factors impede people-centred care for patients living with cancer such as poor data integration, lack of care co-ordination, and limited co-production of care. Almost one-third of primary healthcare patients living with cancer needed to repeat information that should have been in their health records, signalling weak integration of care, insufficient data systems, and limited capacity to support smooth care transitions (Figure 3). In addition, half of people living with cancer in EU11 report not having a care plan (50%) and just two out of five reports being confident in managing their own health, suggesting that there is scope to better support them in self-management and involve them in decision making.

Figure 3. Almost a third of primary healthcare patients living with cancer had to repeat information that should be in their health records, while half reported not having a care plan



Note: Results based on the EU11 average. The item "not being confident in managing your own health" includes those responding being "not confident at all" and "somewhat confident" (versus those responding being "confident and "very confident").
Source: OECD/European Commission (2026), *Delivering High Value Cancer Care: European Cancer Inequalities Registry Analytical Report*, https://doi.org/10.1787/060869fe-en.

Good practices to improve value in cancer care

Building integrated cancer pathways to deliver timely, co-ordinated and equitable access to care

Moving away from fragmented services into integrated cancer care pathways linking diagnosis, treatment and survivorship is required to control cancer and its related cost. In Denmark and Sweden, fast-track diagnostic and treatment pathways reduce delays in cancer care by standardising and co-ordinating every step, from a cancer diagnosis to treatment. They help to align primary healthcare, diagnostic services and oncology teams around clear timelines and responsibilities, thereby reducing fragmentation and poor co-ordination. As of 2025, 18 EU+2 countries have fast-track diagnostics pathways, and 17 EU+2 countries have developed cancer care pathways with clear time benchmarks.

Best practices in Denmark and Sweden

Experience from Denmark and Sweden shows that defined referral routes, time-bound diagnostic targets, and multidisciplinary teams reduce waiting times and improve survival.

- In Denmark, cancer packages are standardised, time-defined pathways covering diagnosis, treatment, follow-up, and supportive care. They were introduced to reduce diagnostic delays and improve outcomes through better co-ordination between primary care, hospitals, and specialist centres. Evidence suggests improved cancer survival rates for high-grade soft-tissue sarcoma following the introduction of a specific cancer pathway.
- Sweden has implemented 31 cancer patient pathways across its 21 regional health authorities to reduce waiting times, harmonise diagnostic approaches and ensure equitable access to timely treatment. Each pathway defines referral criteria, required diagnostic steps, and often maximum timeframes from suspicion of cancer to treatment initiation. Since its introduction, regions report waiting times nationally, publish performance data and collect patient experience surveys, which shows positive care experiences.

Experiences from EU+2 countries also show that investments in digital platforms (as in Sweden), care navigation roles and regional co-ordination (as in Austria, Spain or Slovenia) are key to build integrated care pathways and reduce delays in cancer diagnosis and treatment.

Optimising resource use while embracing technological innovation

Policies such as risk-stratified screening, day versus inpatient care, and biosimilar uptake, can yield large efficiency gains without compromising quality. Moving toward specialised infusion centres, ambulatory surgery and treatment at home are good examples of practices that can ensure high quality, more people-centred care in less expensive venues. At the same time, 20 clinician-led Choosing Wisely recommendations to reduce the use of low-value care are implemented in two or more EU and OECD countries. These recommendations – including not using chemotherapy at the end of life, ensuring early access to palliative care, using shorter radiotherapy schedules in certain cases, and reducing unnecessary screenings or scans for cancer patients – highlight opportunities for improved efficiency and better people-centred care across countries. Technological innovation such as AI-assisted screening, molecular diagnostics or robotic-assisted surgery also help ensure resources are directed to interventions that deliver value.

Best practices in efficient cancer care

Reducing inpatient care: Austria, Bulgaria, Estonia and France have undertaken policy measures such as defined lists of permitted day surgery procedures, changes in payment mechanisms to require or incentivise use of day surgeries, and policy targets or national strategies on day surgery expansion. Nordic countries have particularly advanced the use of day surgeries in cancer care, with a quarter to half of mastectomies done on a day basis in Denmark, Finland, Norway and Sweden.

Implementing hospital at home programmes. France's 2021-2026 national cancer roadmap sets out home care for systemic treatments, relying on close co-ordination between hospitals, community health professionals, and families, supported by information-sharing systems. The National Institute of Oncology in Warsaw, Poland offers portable chemotherapy infusers allowing for the prolonged administration of chemotherapy at home.

Uptake of biosimilars: On average, oncology biosimilars have been associated with a 33% price reduction in medication costs following introduction in EU markets. Denmark has been a particular leader, with 96% of treatment days for relevant oncology medications in 2023 covered by biosimilars, supported by hospital procurement policies that use centralised tendering. Other countries have relied on mandatory or optional substitution – that is using/dispensing one biosimilar instead of an equivalent – or pricing policies that require discounts for biosimilars to encourage uptake.

Using AI to improve screening efficiency*:* Interviews with 20 EU/OECD countries found that eight are using AI for cancer diagnosis – including for breast (Norway), lung (Portugal and Lithuania) and skin (Germany and Portugal), while a study in Germany found improved cancer detection rates as well as costs savings in breast cancer screening with AI-assisted double reading of mammography. Estonia is testing a personalised breast cancer screening approach for women under 50 using AI-generated polygenic risk scores. High-risk women are offered more frequent screening, while low-risk women follow lighter schedules to avoid over-screening and improve efficiency.

Implementing and monitoring evidence-based standards via improved data infrastructure

To support high quality, evidence-based care, 19 EU+2 countries report having either structural standards (such as equipment or personnel requirements) or minimum volume norms for providers of cancer care, with many utilising both approaches. Accreditation and certification systems further support efforts to ensure quality across the pathway from diagnosis to treatment and supportive services. To catalyse these processes, the EU Network of Comprehensive Cancer Centres (EUnetCCC) initiative is developing a harmonised quality framework for cancer centres to ensure that cancer patients have access to co-ordinated, high-quality and comprehensive care across Europe.

Monitoring of cancer care quality can help track outcomes – including patient-reported outcomes – to drive transparency, accountability and continuous improvement to reduce low-value cancer care. Germany's cancer care certification and measurement of clinical quality standards, and the Netherland's transparent quality feedback mechanisms demonstrate examples of continuous care improvements that can raise survival rates.

Best practices in Germany and the Netherlands

Certification/accreditation mechanisms are key approaches to assess alignment with established structural and process standards, while cancer monitoring systems are a complementary approach to driving continuous quality improvement.

- Germany uses a national accreditation/certification mechanism for cancer care since 2003, which is led by the German Cancer Society. It includes yearly internal audits on technical and medical requirements for oncology centres. Recent evidence found that access to accredited cancer centres significantly reduces breast, colon, and prostate cancer mortality risk and increases five-year survival estimates by 2-7 p.p. for five cancer types (Brand and Blankart, 2025[5]).
- The Netherlands operates a clinician-led national cancer quality monitoring system through the Dutch Institute for Clinical Auditing, covering 20 audits across major cancer types (such as colorectal, breast, lung, gynaecological, head and neck, prostate, and skin cancers) and providing hospitals with direct treatment outcome insights to drive continuous improvement. The institute produces regular dashboards, on both process and outcome indicators to compare results across centres, identifies top-performing participants, and share best-practices across hospitals.

In this vein, cancer registries in EU+2 countries play an essential role for evidence-based prevention and control, allowing robust monitoring of incidence, care, and outcomes. Linking registry data with clinical, genetic, and administrative datasets further expands opportunities to study treatments, referral patterns, and patient trajectories while adding socio-economic indicators supports identification of gaps across populations. Today, 26 of 29 EU+2 countries have national cancer registries that cover the entire population, with the exception of Italy, Romania and Spain who have regional registries. Funding cancer registries is a highly cost-effective investment, but fully realising their potential requires improving the timeliness, quality, and standardisation of data. Harmonised data collection, consistent coding standards, systematic quality control, and better linkage with other health and administrative databases will strengthen registries as a core infrastructure for supporting better cancer care, service planning, and evaluation of cancer control policies. The CancerWatch Joint Action, a new EU initiative to improve the quality and timeliness of cancer registry data, represents a meaningful step toward producing timely and more reliable cancer burden indicators.

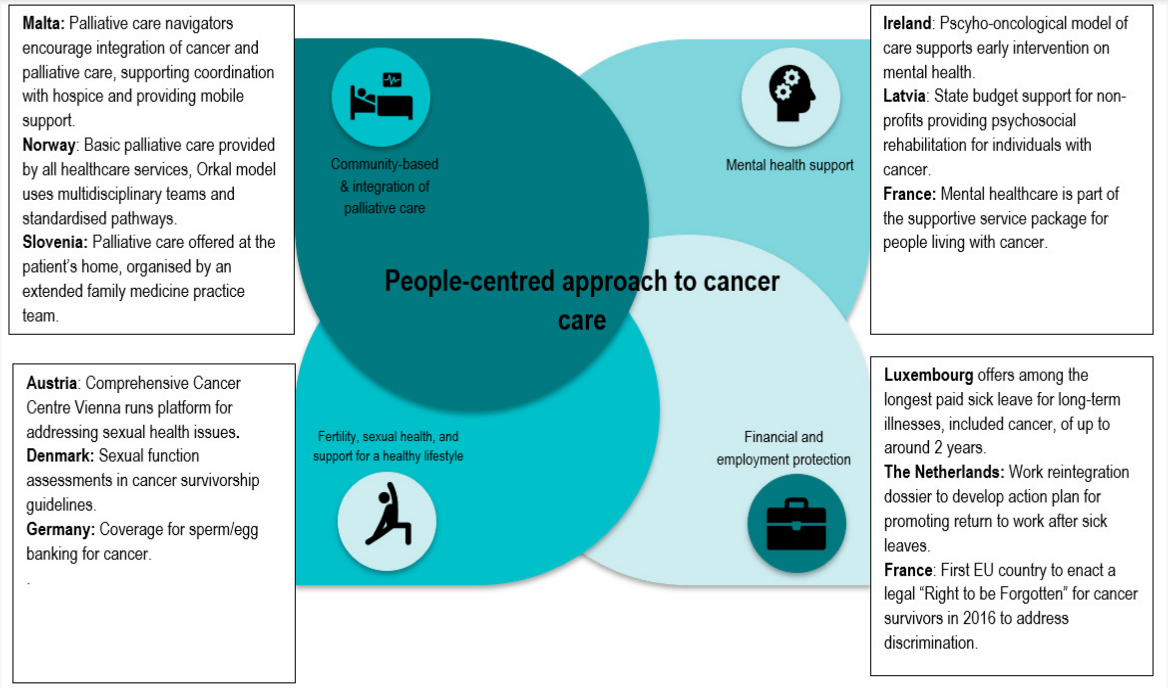
Making people-centredness a pillar of cancer-system performance

Greater involvement in decision making, self-management support, and co-ordinated follow-up matter greatly to people living with cancer. Policy levers include personalised cancer care plans, navigation support for care co-ordination, as well as leveraging digital tools for patient empowerment.

Cancer care must also go beyond curative treatment to address the broader health, social, and economic needs of patients and their caregivers. Early integration of palliative care significantly improves quality of life, yet progress remains uneven across EU+2 countries. While all have palliative care structures, many lag in advanced care planning policies (including Bulgaria, Croatia, Cyprus, Greece, Latvia, Lithuania, Malta, Poland and the Slovak Republic), which are essential for early integration. Italy and Norway are among the most advanced, though both face disparities in accessibility. Community-based palliative care, expanded in countries such as Belgium, Poland and Slovenia, aligns with patient preferences to die at home and reduces hospitalisation, but requires strong support for primary care providers and informal caregivers.

People-centred cancer care also involves fertility preservation, sexual health, mental health support, and survivorship planning. Several EU+2 countries successfully ensure insurance coverage for fertility preservation (including France, Germany, the Netherlands, Nordic countries, Poland and Slovenia), while sexual health services remain underdeveloped across much of the EU. Mental health is expanding progressively but remain uneven: around half of EU+2 countries integrate psychological support into oncology pathways. Ireland and France offer good policy examples. Finally, financial and employment protections are critical. Cancer reduces employment likelihood by an average of 14%, with greater impacts on lower-educated individuals. Strengthened labour policies, paid sick leave, return-to-work support (such as in Germany, the Netherlands and Sweden) and expanded "Right to be Forgotten" legislation are essential to reduce financial toxicity and discrimination.

Spotlight on policy levers to foster a people-centred approach to meet the health, social and economic needs of people living with cancer



Malta: Palliative care navigators encourage integration of cancer and palliative care, supporting coordination with hospice and providing mobile support.
Norway: Basic palliative care provided by all healthcare services, Orkal model uses multidisciplinary teams and standardised pathways.
Slovenia: Palliative care offered at the patient's home, organised by an extended family medicine practice team.

Austria: Comprehensive Cancer Centre Vienna runs platform for addressing sexual health issues.
Denmark: Sexual function assessments in cancer survivorship guidelines.
Germany: Coverage for sperm/egg banking for cancer.
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Ireland: Pscyho-oncological model of care supports early intervention on mental health.
Latvia: State budget support for non-profits providing psychosocial rehabilitation for individuals with cancer.
France: Mental healthcare is part of the supportive service package for people living with cancer.

Luxembourg offers among the longest paid sick leave for long-term illnesses, included cancer, of up to around 2 years.
The Netherlands: Work reintegration dossier to develop action plan for promoting return to work after sick leaves.
France: First EU country to enact a legal "Right to be Forgotten" for cancer survivors in 2016 to address discrimination.

Source: OECD/European Commission (2026), *Delivering High Value Cancer Care: European Cancer Inequalities Registry Analytical Report*, https://doi.org/10.1787/060869fe-en.

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Notes

[1] Belgium, Czechia, France, Greece, Italy, Luxembourg, the Netherlands, Portugal, Romania, Slovenia, Spain.

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