PUBLIC POLICY

LBA66_PR Disparities in access to oncology clinical trials in Europe in the period 2009-2019

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Background: Clinical trials are essential for advancing cancer treatment. Yet, there is limited data on their distribution and access in Europe. To ascertain the extent of potential inequalities in access to clinical trials in Europe, we compared their distribution among European countries.

Methods: The Clinicaltrials.gov database was searched for interventional clinical trials in adults with neoplasms. Available data from phase I-III trials between 06/2009 to 06/2019 in Europe were retrieved. We considered the number of clinical trials registered in each country and one "trial-entry" was defined as one trial/country.

Results: In total, 18454 trial-entries were identified, of which 12% were phase I, 10% phase I/II, 32% phase II, 2% phase II/III and 44% phase III; 74% were industry-sponsored, 15% were academic and 11% were an academic/industry partnership. The number of trials per country varied from 2.48 in Central/Eastern Europe to 5.33/100 000 inhabitants in Northern Europe. The proportion of phase I-II trials was higher in the Southern and Western regions (13-15%) compared to Central/Eastern and Northern regions (4-9%). The number of trial-entries/100 000 inhabitants/country ranged from 0.14 (Albania) to 10.7 (Belgium). Between 2010 and 2018, the total number of trials per country in Europe increased by 33%. The increase in early-phase trials was larger (phase I-II, 61%) than in late-phase trials (phase II-III, 7%). Portugal, Ireland, Finland, Greece and Norway registered the largest percentage increase in early-phase trials, while Ireland, Spain, Norway, Italy and Belgium led the largest percentage increase in late-phase trials. Five countries dominated in terms of an increase in the absolute number of total trial-entries in both early- and late-phase trials: Spain (90/40), France (45/16), UK (45/13), Italy (38/19) and Belgium (35/12). During this period there was no significant variation in the distribution of industry and academic sponsored trials but an increase in industry/academic partnerships was observed ($\approx$ 8%).

Conclusions: The number of clinical trials varies greatly among European regions resulting in potential asymmetries in patients' access to clinical trials. The disparities in access to oncology trials need to be addressed by all the stakeholders.

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1581O Estimation of European cancer burden for the year 2020

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Background: Up-to-date cancer burden indicators provide an important source of information for supporting political decision making, as well as for epidemiological research and the general public. Nevertheless, observed cancer incidence and mortality suffer from an inherent registration delay in the data production workflow. To overcome this, the European Commission's Joint Research Centre in collaboration with the WHO's International Agency for Research on Cancer have computed estimates of cancer incidence and mortality, for the year 2020 and for European countries, in the framework of the European Cancer Information System (ECIS).

Methods: Predicted values for the year 2020 are based on the incidence data of more than 150 European population-based cancer registries included in ECIS, and on mortality data provided by WHO. Ad-hoc statistical models were developed on the basis of the most recent time trends of observed data to estimate cancer incidence and mortality rates in each EU country for the year 2020. Estimated rates were then applied to the projected population figures for 2020 from EUROSTAT in order to calculate the predicted number of new cases and deaths for 2020 in 40 European countries.

Results: The number of new cancer cases and deaths in 2020 has been estimated per country by sex and age group, for 25 major cancer sites. The results are included and disseminated through the European Cancer Information System (ECIS) web application.

Conclusions: The release of up-to-date cancer incidence and mortality estimates is of great importance to support EU evidence-based cancer policies. The homogeneity of the estimation methods applied throughout Europe guarantees the comparability of the estimated values between countries. Reliable and comparable estimates highlight differences between countries in cancer incidence and mortality, thus facilitating the identification of possible intervention areas. The applied methodology couldn't take into account the possible impact of the COVID-19 pandemic on the projected rates. A future exercise to evaluate the discrepancy between projected and observed rates will allow quantification of this impact.

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