The important thing about promoting safe cycling and walking is that the environment, transport, and urban planning sectors are essential partners. Since 1999 when European Member States adopted the WHO Charter on Transport, Environment and Health, health policymakers have worked alongside colleagues from other sectors to place health and environmental considerations firmly on the agenda of transport and land-use policy-makers. There is no time to lose. Physical inactivity has become one of the leading risk factors for the health of Europeans. Across the WHO European Region, the proportion of deaths attributable to physical inactivity is estimated at 5–10% of the total number of deaths—ie, about 600,000 deaths per year.

Children’s health is of immediate concern. In countries where figures are available, the levels of physical activity among children have declined greatly in the past 15 years. The prevalence of overweight and obesity has increased in parallel.

World Health Day was dedicated to “Move for Health” in 2002 and since then a World Day on physical activity takes place annually on May 10.

In 2000, the WHO Global Strategy on Diet and Physical Activity will be launched at the World Health Assembly. In the European Region, we have emphasised safe walking and cycling, not only to achieve higher levels of physical activity but also better quality of urban life through reduced air pollution, noise, traffic, and congestion.1 The joint UNECE–WHO Transport, Health and Environment Pan-European Programme (THE PEP) established in 2002 is pushing the agenda forward in the European Region, and at WHO’s Fourth Ministerial Conference on Environment and Health, to be held in Budapest, Hungary, in June, 2004, the emphasis will be on children and how to protect their health from environmental hazards. Inactivity is a hazard. It also costs society dear. Work is also underway to develop guidelines for health impact assessment and cost-benefit analysis of transport-related policies and interventions that might have implications for levels of physical activity through walking and cycling.

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A network of excellence

Sir—Nathan Clumeck and Christine Katlama’s ambitious proposal of a network of centres of excellence in clinical research across Europe (Mar 13, p 901) is to be welcomed. They identify the threat posed to non-commercial academic research, which is especially difficult in oncology because surgery and radiotherapy attract little commercial support.

Optimum delivery of radiotherapy can make substantial contributions to improving local control. Currently, about 90% of all cancers are cured by local treatment with surgery and radiotherapy. Kogelnik and Lukas have estimated that, if a 100% local control rate could be achieved, cancer survival rates would rise from 45% to 60%.1 At present, there are many opportunities to improve local control—eg, advances in radiation planning and delivery such as intensity-modulated radiotherapy, and integration of structural (CT, MRI) and functional (positron emission tomography) scans into the radiotherapy planning process. In addition, positron emission tomography imaging could provide valuable information on response to multimodal therapy—eg, with radiotherapy and inhibitors of tumour angiogenesis.

There are rising clinical and laboratory needs to obtain cellular and molecular information in vivo.1 Developments in molecular imaging could allow us to identify the optimum timing in the cell cycle for radiotherapy and chemotherapy to be delivered for individual tumours.

Ring-fenced European Union research funding for biological and clinical aspects of combined modality therapy for cancer could help redress the current imbalance in the provision of funding. Networks of excellence would facilitate the collaboration needed to deliver these research priorities.

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Sir—In their Correspondence letter (Mar 13, p 901),1 Nathan Clumeck and Christine Katlama put forward the intriguing idea that clinical research in Europe should be done only by networks of centres of excellence appointed by research specialists and selected from European agencies. Centres of excellence in basic research already exist since their establishment represents a priority for the recently launched European Commission Framework Project 6. However, the negative consequences of the establishment of such clinical networks should be carefully considered and weighed against the advantages pointed out by Clumeck and Katlama.

The criteria by which clinical centres across Europe will get the status of “excellence” might not be easy to identify. Should clinical centres be drawn up on the basis of the number of patients referring to them, the availability of high-tech equipment, or compliance with the national standards of care? Any of these criteria will influence the applicability of the results of clinical trials to the general population. Clumeck and Katlama correctly state that there are great differences in quality of clinical investigation and in standards of care across Europe. But are we sure that results obtained in top-level clinical centres can be easily applied to less than optimum clinical settings? As an example, if high-tech centres are included in the networks of excellence, then large areas of Europe will not benefit from the results. Conversely, if clinical trials are done in small and less-equipped centres, results might not represent the best available treatment for any given disease. Similar arguments have been used to criticise evidence-based medicine.2

Networks of centres of clinical excellence will be of limited usefulness for individual patients across Europe, and their research priorities will not match the needs of patients and the health-care system.1 In this light, I do not think that the establishment of such networks will generate data which in turn will determine standards of care across Europe. Rather, the minimum standards of care should be set first; only then will clinical trials done in any European country yield results applicable to the general European population.

Finally, I agree with Clumeck and Katlama in their criticism of the procedure by which the European Commission financially supports scientific proposals, since it is burdened with unnecessary bureaucratic difficulties. These limitations are known by the Commission, which is working to improve its procedures. However, I would not say that it “claims to support investigative centres of excellence, but in practice the political will is not apparent”.1 To my knowledge, any decision on a proposal’s scientific accuracy and adequacy of budget is not taken by “Eurobureaucrats” but by independent international peer-reviewers with expertise in the field.

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