ACHIEVING TREATMENT FOR ALL

All people have the right to access quality, effective cancer treatment and services on equal terms, regardless of geography and without suffering economic hardship as a consequence.

THE WORLD CANCER DECLARATION STATES BY 2025:

- Health systems will be strengthened to ensure sustained delivery of effective and comprehensive, people-centred cancer control programmes across the life-course (Target 1)
- Access to accurate cancer diagnosis, quality multimodal treatment, rehabilitation, supportive and palliative care services, including the availability of affordable essential medicines and technologies, will have improved (Target 7)
- Effective pain control and distress management services will be universally available (Target 8)

MEETING THIS CHALLENGE IS NOT BEYOND US IF WE WORK TOGETHER TO:

- Strengthening health systems to deliver high quality cancer care
- Achieve equity in access to essential cancer medicines and technologies
- Strive for universal health coverage

THE CHALLENGE

Every country has now signed up to at least one treaty that acknowledges the right to health. This includes the right to access quality, effective cancer prevention, treatment and care. However, under-resourced health systems and a lack of social protection in many countries are widening gaps in access to cancer services while at the same time heightening financial risk.

Access to affordable, quality essential cancer medicines and technologies including radiotherapy falls dramatically short of demand most notably in low- and middle-income countries (LMICs) (1, 2). As a result, many cancer patients are denied cancer services, causing unnecessary suffering and deaths from cancers that are treatable in high resource settings. For example, up to 70% of cancer patients in LMICs who may benefit from radiotherapy (RT) do not receive this essential curative or pain relieving treatment.

There are a number of factors that contribute to the lack of universal access to cancer treatment. The major barriers to the adequate use of opioids for pain relief are predominantly related to policy and legislative restrictions (3). Limitations on availability; outdated policies that discourage access; unnecessary administrative obstacles and costs; and inadequate clinician education and empowerment all contribute to many people living and dying in untreated pain (3). Lack of infrastructure is another key barrier. The International Atomic Energy Agency (IAEA) estimates that there is currently a deficiency of at least 5,000 radiotherapy machines in developing countries (4).

Cost of medicines and vaccines can also have a significant impact on access to effective cancer prevention and care. For example, affordable pricing of human papillomavirus (HPV) vaccines has limited the wide implementation of HPV vaccination programmes in LMICs. Additionally, there is a substantial financial burden associated with cancer for patients and their carers, both in out-of-pocket expenses and in lost income and benefits. Surveys in LMICs show that poor households spend up to 9.5% of their household expenditure on medicines, with many relying on borrowing and asset sales to finance their healthcare (5, 6). Overall, the impact of cancer-related death and disability on labour supply poses a tangible threat to national productivity and development, with the global cost of cancer alone estimated to reach US $458 billion per year in 2030 (7).

MEETING THE CHALLENGE

STRENGTHENING HEALTH SYSTEMS TO DELIVER HIGH QUALITY CANCER CARE

Cancer is a complex disease. Appropriate treatment of most cancers requires a multidisciplinary approach that spans the entire cancer care continuum from prevention to supportive and palliative care. A multidisciplinary approach to cancer is feasible in all settings when based on existing health resources and infrastructure; the national cancer burden; country-specific cancer risks; political and social conditions; and cultural beliefs and practices, as part of a National Cancer Control Plan (NCCPs) to deliver locally appropriate,
effective cancer services. Additionally, resource-sensitive clinical guidelines can be used to assist with the planning and delivery of early detection and treatment (8,9).

NCCPs play a vital role in strengthening health systems by addressing key constraints to the provision of effective, quality cancer treatment. This includes the delivery of a skilled health workforce; infrastructure; adequate financing; and focusing research where it is most needed so that existing knowledge is translated into practical outcomes for patients. An investment in strong health systems will also ensure access and availability of services for rare cancers, which represent about 20% of the total global cancer burden and include all cancers affecting children and adolescents.

CASE STUDIES

The Breast Health Global Initiative (BHGI)

BHGI has been leading efforts to develop, implement and study economically feasible and culturally appropriate evidence-based guidelines for breast health care and breast cancer screening, detection and treatment for women in LMICs (10). Effective and efficient breast cancer early detection methods, including screening mammography and clinical breast examination (CBE), can be tailored to the resource setting and population-based need. Combined with the development of culturally-sensitive, linguistically-appropriate local education programmes to teach the value of early detection, breast cancer risk factors and breast health awareness, there is also potential to improve outcomes, particularly in areas where the majority of breast cancers are diagnosed at an advanced stage. For more information on BHGI go to: http://portal.bhgi.org/Pages/Default.aspx

Delivering Radiotherapy as part of Comprehensive Cancer Control

In 2004, IAEA launched a Programme of Action for Cancer Therapy (PACT) whose mission is to contribute to the improvement of cancer survival in developing countries by integrating radiotherapy investments into public health systems. PACT works to maximise the impact and effectiveness of radiotherapy by integrating it with comprehensive cancer strategies within the framework of a national cancer control plan to ensure that all relevant cancer services are delivered via timely, planned and balanced investments across the health system.

Working with the WHO and other leading international and national organisations in cancer prevention and control, including UICC, PACT core activities include developing and initiating sustainable, integrated cancer control programmes in PACT Model Demonstration Site (PMDS) countries. To date, eight IAEA Member States are participating as PMDS, namely Albania, Ghana, Mongolia, Nicaragua, Sri Lanka, the United Republic of Tanzania, Vietnam and Yemen. Since its launch, more than US $18 million has been mobilised through PACT for the eight PMDSs. This funding has been used for advocacy, cancer control capacity building (training of cancer control health professionals and sponsorship of participation in international events), and the provision of radiotherapy units and implementation of expert missions.

For example, in Yemen, as the number of cancer cases continues to grow, capacities to treat patients remain underdeveloped and limited. The country’s only cancer therapy centre, located in Sana’a, relies on two radiotherapy machines, too few to cater for the population of more than 24 million. To increase the availability and accessibility of cancer care in the country, the government of Yemen is now planning the construction of the first oncology centre in the seaport city of Aden, with the help of PACT and the IAEA’s technical cooperation programme. At a consultative meeting to discuss this important undertaking in 2013, the meeting delegates from Yemen, together with an IAEA team, completed the proposed design for the new oncology centre and finalised a bankable document that sets out the purpose of the programme and its requirements needed for resource mobilisation.

For more information on PACT go to http://cancer.iaea.org/
ACHIEVING EQUITY IN ACCESS TO ESSENTIAL CANCER MEDICINES AND TECHNOLOGIES

Improved access to effective, affordable and multimodal treatment for cancer should be a genuine priority for the post-2015 development agenda. Specific actions are needed to meet the agreed target of 80% availability of affordable and essential medicines and basic technologies required to treat non-communicable diseases (NCDs) that was adopted by governments in the WHO Global Monitoring Framework (11). Effective prevention, treatment and care require access not only to affordable, high-quality medicines but also to vaccines and effective cancer treatment modalities. This includes radiotherapy, which is recognised as an essential tool in the cure and palliation of cancer and is indicated in more than half of new cancer patients (12).

The safe and effective delivery of cancer medicines and radiotherapy, as part of a team-based approach to cancer care, is achievable in both high- and low- income settings if implemented as part of a NCCP and according to evidence-based clinical guidelines appropriate for the level of available resources.

Achieving access to cancer medicines

National cancer planning processes should first identify a list of essential cancer medicines for training, supply, and reimbursement in conjunction with the development of evidence-based national clinical guidelines. The majority of critical anti-cancer drugs are off-patent and are included on the WHO Model List of Essential Medicines (EML). This list presents a set of medicines that are cost-effective and are of critical public health importance in all countries. In informing national pharmaceutical policies, the WHO EML serves as a key lever to improve access to essential medicines including medicines for pain and palliative care. As a result of a current review, the expert committee is considering a revision of the cytotoxics and adjuvant medicines section to ensure that the WHO EML best serves cancer patients worldwide.

The evaluation of newer, more costly cancer drugs should be done on an individual basis within the NCCP process or any other relevant body to make the best possible use of resources. As the resources available to a country increase, so should the number and variety of cancer medicines available for cancer treatment, with governments using the full flexibilities of international trade agreements to provide access to on-patent medicines where appropriate (13).

Ensuring access to quality cancer medicines requires national authorities to also consider mechanisms to increase efficiency in procurement, supply and use within the existing health budget (13). Key recommendations include the promotion of generic NCD medicines through legislation, quality assurance, advocacy, and financial incentives; the creation of a dedicated national body responsible for the promotion of safe and efficient use of medicines; and the review of laws and practices and removal of unnecessary constraints on use of opioid analgesics.

Achieving access to radiotherapy

For radiotherapy, greater awareness of the benefits of modern radiotherapy is an integral part of addressing the access challenge. Advances in technology means that treatment times are shorter, side effects are reduced and survival rates are increased. Radiotherapy has been shown to be a cost-effective approach to cancer treatment in high-income countries, and evidence to further support cost-effectiveness is also emerging from developing countries.

Specific actions are also required to address overall capacity constraints and to replace outdated, less effective machines. Additionally, there is a need for greater investment in education and training of healthcare professionals to ensure the safe and proper administration of radiotherapy.
CASE STUDIES

A coordinated global response to addressing access to radiotherapy

A Global Task Force on Radiotherapy for Cancer Control (GTRC) has been convened by UICC to provide a clear global assessment of the cancer treatment shortfall of radiotherapy to raise awareness, facilitate planning, attract investment, and improve global access to this essential treatment modality. By bringing cancer leaders together with radiotherapy professionals, industry partners, cancer control organisations, patient groups, economists, and enablers of healthcare change, the GTRC seeks to clarify the challenge, identify opportunities, and quantify the investment needed to provide equity in global access to RT.

For more information, go to: http://www.uicc.org/advocacy/our-campaigns/global-task-force-radiotherapy-cancer-control.

The GAVI alliance driving affordable vaccine pricing

In September 2013, the GAVI Alliance announced a record-low price for HPV vaccines of US$4.50, representing a two-thirds drop on the lowest current available public price. By 2015, GAVI plans to support vaccination of one million girls in more than 20 countries, with the goal of reaching more than 30 million girls vaccinated in more than 40 countries by 2020. Likewise, while WHO has recommended global immunisation against hepatitis B infection since 1992, uptake of the vaccine was slow in poorer countries due in part to the high price. The GAVI Alliance support of HBV vaccines has been instrumental in accelerating its introduction into national immunisation programmes by addressing affordability. The price of the pentavalent vaccine, a 5-in-1 shot vaccine that combines protection against hepatitis B with diphtheria, tetanus, pertussis and Haemophilus influenzae type b (Hib), has dropped by 30% from US$3.61 per dose in 2007 to US$2.49 per dose in 2011. In 2014 South Sudan became the 73rd and last of all GAVI-supported countries to introduce the pentavalent five-in-one vaccine.

For more information, go to: http://www.gavi.org/support/nvs/pentavalent/#sthash.MFi6qkN3.dpuf

The PAHO Revolving Fund: protecting the people of the Americas through vaccination.

The PAHO Revolving Fund is a large part of what makes the Americas one of the biggest successes in delivering vaccines to protect people against some of the world’s worst diseases, including polio, measles, yellow fever, rotavirus and HPV, to name just a few. By buying in bulk, the Fund greatly improves its purchasing power. In other words, it takes advantage of economies of scale.

Through the fund, 41 countries and territories pool their resources to procure high-quality vaccines, syringes and related supplies for their populations at the lowest price. Since its inception in 1977, the Fund has helped to vaccinate tens of millions of children and save millions of lives. This helps explain why the Region of the Americas was the first of the six WHO regions to eliminate polio, why it is the only one, so far, to eliminate measles and rubella, and why its infant mortality rate is so low. At the same time, the Fund has facilitated the rapid and equitable introduction of new vaccines, including vaccines against HPV which is associated with cervical cancer.

The Fund is highly popular with the Region’s Member States. In September 2013, the Directing Council said the “operational and financial capacity to deliver vaccinations has made the Americas a world leader in the elimination of vaccine-preventable diseases.” It called the Fund “a pillar of the regional immunization program’s leadership position.”

For more information, go to: www.paho.org/revolvingfund
STRIVING FOR UNIVERSAL HEALTH COVERAGE

The provision of universal health coverage (UHC) and other social protection measures can play an important role in closing the unacceptable gaps in access to cancer services. Through the integration of UHC in the post-2015 framework, the international community has the opportunity to provide a country-driven strategy for ensuring that all people obtain good-quality essential health services without suffering financial hardship (14). The capacity for low-income countries to move towards UHC has been demonstrated in at least nine low-income and lower-middle-income countries in Africa and Asia. Each of these countries have implemented varied national health insurance models, with some countries (India, Kenya and the Philippines) which originally covered only in-patient services now moving towards the expansion of benefits to cover primary and preventive services (15). Additionally, a review of evidence from six countries found that conditional cash transfers, in which cash payments are made in return for using health services, resulted in an 11-20% increase in children being taken to health centres and 23-33% more children making visits for preventive healthcare (16). Many more countries are now undergoing reforms towards UHC including South Africa, Vietnam, Ghana and Rwanda.

UHC can be an enabler for strong health systems that are able to respond to major healthcare challenges, including cancer and other NCDs, as well as communicable diseases and injuries, many of which share common underlying determinants and are inter-related (17). At the same time, governments should address other key barriers to accessible quality cancer care, including investment in infrastructure and a skilled and supported cancer workforce, social and cultural beliefs and practices that hinder access to care such as stigma, and regulatory and policy restrictions.

Importantly, UHC will not be sufficient on its own to address the global cancer and NCD burden due to its focus on health. The post-2015 framework must seek to strengthen links outside of health to address the underlying social, economic, political, environmental and cultural factors that influence an individual’s capacity to maximise their health and well-being across the life-course (18).

CASE STUDIES

Integrating the poor into universal health coverage in Vietnam

The trajectory of Social Health Insurance (SHI) in Vietnam is similar to that of many other countries in the East Asia and Pacific region. Initially, the poor were covered under a separate Health Care Fund for the Poor. The 2009 Law on Health Insurance merged all of the different programs into one. Health insurance premiums for the poor were fully subsidized by the government and enrolment became mandatory, resulting in almost complete enrolment of the poor by 2011. Vietnam has combined elements of contributory social health insurance with substantial levels of tax financing to provide coverage for the poor and informal sector.

IT IS NOT BEYOND US TO MEET THE CHALLENGE IF...

Governments invest in NCCPs that deliver an effective and comprehensive cancer control programme that can reduce cancer incidence and mortality and improve the quality of life of cancer patients, their families and carers.

Governments take specific actions to meet the target of an 80% availability of affordable and essential medicines and basic technologies adopted by governments in the Global Monitoring Framework on NCDs.

Governments adopt policies that support the use of generic quality essential cancer medicines.

Access to new, patented, and expensive cancer medicines is considered on an individual basis according to priorities identified within national cancer control planning or other relevant processes with the number and variety of cancer medicines increasing with the level of available resources.

It is understood that radiotherapy is an essential tool in the cure and palliation of cancer, and is indicated in more than half of new cancer patients.

Governments recognise that UHC is a commitment to equity and ensuring access to quality essential health services based on need and not on the ability to pay.

The next generation of global development goals and targets address UHC and acknowledge equity and health as a human right with the ultimate consequence of maximising healthy lives at all stages of life.

REFERENCES


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