Global inequalities in cancer care

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Poverty, disease and exploitation are synonymous in describing urban slums of Victorian and Edwardian cities as well as today's 'Third World' shanty towns. John Evans, in the Shattuck Lecture, described 3 stages in health system evolution (Evans et al., 1981). The first is dominated by infectious diseases, linked with poverty, malnutrition and lack of personal hygiene. Chronic diseases, especially cardiovascular, cancer, diabetes, arthritis and mental disorders, predominate in stage 2. Stage 3 is concerned with environmental hazards such as chemical plants, nuclear power industry, acid rain and problems of food additives. The industrialized countries evolved through the 3 stages over the course of a century. The less developed countries face the challenge of coping with all 3 simultaneously.

The future of health policies remains controversial in the rich and poor countries alike. The rich industrialized countries have been spending an ever increasing proportion of their national income on health. They have not, however, been able to demonstrate satisfactorily to themselves and to the world that higher spending leads to better health. That being so, should the poor countries follow in their footsteps?

Development is increasingly viewed as a process which involves not just economic but also social values. Development in the context of good health entails universal education and good working conditions, as well as suitable amenities in the home and the environment. According to Sigerist (1962), 'The task of medicine is to promote health, to prevent disease, to treat the sick when prevention is broken down and to rehabilitate the people after they have been cured'. These are social functions and medicine should thus be viewed as a social science. 'Third World' countries would be best advised to take a social view of medicine. Well-integrated social services are needed to facilitate a shift from the traditional medical to the social model of health. This southern paradigm model of good health, as it has been referred to, is beginning to bear fruit in such countries as China, Sri Lanka, Kerala State in India, and Costa Rica (Warren, 1990). The key elements in this model include political and social will, universal education with emphasis on primary and secondary schooling, equitable distribution of public health measures, and primary health care and the assurance of an adequate caloric intake.

Lack of resources in some countries is clearly one of the main reasons for global inequality in health care. Money for health is simply not there. It is being diverted and spent on defence, roads and purchase of consumer goods. This unfortunately is the trend in most developing countries where, tragically, expenditure on social services has been slashed in response to the debt crisis. Such a multitude of competing needs within the context of shrinking resources should force developing countries to prioritize. However, cancer is not even on the priority list of the health planners, who are still inundated with infectious diseases. The recent pandemic, acquired immune deficiency syndrome (AIDS), has further disrupted the precarious socio-economic balance with dire consequences.

Globally, cancer, cardiovascular diseases and accidents are the 3 major causes of death. Numerically, however, there are more cancer victims in the 'Third World' than in the industrialized countries (WHO, 1984). Although more than half the world's cancer patients live in developing countries, less than 10% of the resources committed to cancer control are available to them (WHO, 1990). It is sad to note that Africa, a prototype 'Third World' continent with a population of over 400 million people, has fewer than 100 cancer specialists of all categories, a handful of cancer treatment centres, and no population-based cancer registry to speak of. The World Health Organization (WHO) initiative of training radiotherapists in Harare, Zimbabwe, is therefore a commendable venture. Such a programme offers several advantages. First, specialists are trained in an environment where they will practice. Second, it provides for an interdisciplinary interaction with local staff. Lastly, it encourages the training hospital to develop an appropriate cancer control infrastructure. In Harare, a population-based cancer registry is being developed and suitable diagnostic and therapy equipment has been installed.

Treating cancer is an expensive high technology process that few developing countries can afford. Prevention must therefore be their primary focus. Smoking is the commonest single preventable cause of ill health (WHO, 1983a). According to the United Nations Food and Agriculture Organization, developing nations currently produce over 60% of the world's tobacco. While tobacco consumption is on the decline in industrialized countries, it is actually on the increase in developing countries. WHO estimates that in India and China, the most populous nations, one-quarter to one-third of males aged 18–20 years are tobacco addicts (WHO, 1983a). Lung cancer incidence doubled in China's largest city, Shanghai, between 1963 and 1975, and is now higher than in many industrialized cities. Most 'Third World' countries are threatened by lung cancer epidemics. This phenomenal increase is attributed to the highly sophisticated and ruthless smoking campaign by the tobacco companies; 'Third World' countries constitute their last big market. It is, however, not enough to persuade individuals to give up smoking or...
governments to legislate against tobacco. There are powerful economic interests served by the production, promotion and sale of tobacco products which seek to maximize consumption at all cost. Tobacco is the main source of foreign exchange earnings in some countries.

Another very common cancer in the developing world is primary liver cancer. Liver cancer kills over a quarter of a million victims every year (WHO, 1983b). About 80% of liver cancers result from infection with hepatitis B virus which is second only to tobacco as a known single cause of human cancer. An effective vaccine exists and is currently undergoing clinical trial in The Gambia to assess its efficacy in preventing chronic liver disease and hepatocellular carcinoma in particular (Whittle et al., 1991). The questions are whether the results of such a study can be extrapolated to the general community and whether the vaccine will be within the financial capability of those nations that need it most? Can resources currently ploughed into the development of expensive weapons be diverted to vaccine subsidy for Third World countries? The World Bank noted that, if a 10% reduction in military spending by NATO were directed to the poor, it would double global aid.

Cervical cancer is known to affect one in 1000 women aged 30–55 years annually in Latin America, the Caribbean and sub-Saharan African countries. It takes about 5 years for localized cervical cancer to develop and approximately 10 years for it to become advanced. Thus cancer of the uterine cervix offers a unique prospect for secondary prevention (screening). If detected early the cure rate, currently of the order of 45%, can be increased to 100%. The problem here, as with other cancers, is lack of proper education and paucity of fiscal and appropriate human resources. Whenever a screening facility is developed, the group that needs it most uses it least.

While considerable emphasis should be placed on cancer prevention, it would be inappropriate merely to divert funds from acute services to prevention. Curative and preventive services are not mutually exclusive. Both are necessary and indeed complement each other. Similarly, while biomedical research is vital and continues to attract research funds, there is an urgent need to shift the balance of effort from purely laboratory research to epidemiological studies, and to recognize that improvement in health is likely to come in the future, as it did in the past, from modification of conditions which led to disease rather than the intervention in the mechanisms of disease once it has occurred.

Unfortunately most cancer patients in developing countries present with advanced disease when palliation is the only viable option. One half of the world's cancer patients suffer needlessly from pain. In the rural Third World' nothing at all is offered for pain relief. What is needed is to educate health administrators to make pain relief drugs readily available, to instruct health professionals on the proper use of pain killing drugs, and to make patients aware that these drugs are within easy reach. A WHO pain management workshop is planned for October 1991 to address the above issues with health care providers in Harare, Zimbabwe. A similar workshop was successfully conducted recently in China.

It is hard to cost injury, unhappiness or dissatisfaction. In other words, it is difficult to measure matters pertaining to positive health. There is a universally felt need to measure health in ways which take into account life's real experience. Instruments that combine indicators of pain and restricted activity, reflecting social, physical, and psychological functioning, are urgently required. Health is man's vigorous, creative and joyous involvement in his environment. The presence or absence of disease is only a minute portion of it. The above concepts reflect what has come to be known as quality of life. The assessment of quality of life in cancer care is becoming increasingly recognized and appreciated. It is particularly relevant in situations where treatment is given with palliative intent. Thus in Third World countries the impact of measuring quality of life in cancer patients can be profound, as most patients present with very advanced disease when cure is no longer possible.

Again, WHO is to be commended for setting up collaborating centres on quality of life in cancer care. One of these, the Winnipeg Centre, is expected to forge links with the Third World. The Winnipeg Centre plans to study quality of life in patients with advanced cancers in India, Uganda and Zimbabwe.

References


