Putting public health back into the global cancer agenda

The majority of cancer patients will live and die in health care settings far removed from that enjoyed by citizens in high-income countries. The stark reality is that most will present late, be undertreated (or not at all), possibly be bankrupted by the costs associated with treatment and for those who die with cancer many will not have a ‘good death’ [1]. Despite this harsh reality, cancer and indeed all non-communicable diseases (NCD) have been off the global health menu until relatively recently with the UN high-level meeting on NCD in New York in September 2011 [2]. What should have been a chance to make a strong public health stand against global cancer instead turned into a pot pourri of competing political agendas. So Richard Love et al. timely and welcome call to re-plant the public health flag back deep into global cancer territory is a much needed wake-up call to the cancer community and policymakers [3]. It is a reminder that global cancer control is not the exclusive domain of World Health Organization (WHO) and other august international bodies but needs help from individuals and long-term commitments from national institutions such as cancer centers and representational organizations. Indeed, this is already happening and with great effect. Indiana University’s twinning with Eldoret in West Kenya over the last decade has built impressive cancer services and bicultural understanding. More of this is needed. However, beyond the immediate needs of training, education, manpower and infrastructure support for treatment remains the thorny issue of long-term cancer control in emerging, low- and middle-income countries (LMIC). And let us be clear. The experiences of high-income countries have little if nothing to teach us. Love rightly points out to the huge differences in the epidemiological transition being experienced by LMIC. Global cancer burden is taking place against a wholly untested background in which multiple disease burdens (double, triple and quadruple burden) [4] across all age cohorts and socio-economic classes intersect with marginal health care systems development and globalization [5]. Yet there remains precious little research into how to construct a public health cancer system taking into account these complex and broad social determinants of health [6]. What is clear is that the current policy approaches are far too ‘one size fits all’ with little sensitivity for the real breadth of differences between LMIC. The context for cancer control in Sub-Saharan Africa with the range of countries’ human development index from 182 to 62, where the life expectancy is as low as 36 to >60 and where, from a linguistic standpoint, there are over 2000 different cultures gives some idea of the complexity of the situation [7]. And as Love points out we have yet to grasp the thorny issue of the systemic national dysfunction, including corruption. It is difficult to talk of cancer control in many LMIC because they fail to meet the basic set of criteria for a functioning society. But even when there is a functioning system with which to engage, the approach taken to date in addressing cancer public health in LMIC has too often been inadequate and misdirected. In the former case, the levels of funds assigned to cancer control through high-income partnerships have been disgracefully low. We know from our own studies into research outputs that <4% of global R&D knowledge is applicable to LMIC settings and in terms of funding from major federal or philanthropic organizations, the figure is also equally embarrassing, <2% [8, 9]. Any notion that we are addressing the needs of global cancer patients is quixotic. Our high-income techno-centric cancer control paradigm is, as Love points out dangerously out of touch with the reality of what is needed for population-based solutions. Putting the lack of a public health approach to cancer aside for a moment even the paradigms for treatment lag far behind the curve. Over-focus on cancer medicines completely misses the point. The modalities of cancer control and cure are surgery and radiotherapy [10]. Even though where medicines play an essential or significant additive role the impact of TRIPS and other intellectual property protection mechanisms is depriving most LMIC of essential cancer medicines; the WHO list becoming nothing more than a paper tiger.

So what needs to be done? The first is a genuine political recognition that public health does include cancer and other NCDs. Too many voices continue to whisper against their inclusion. Granted it will need to be tailored; cancer is not Afghanistan’s most pressing public health issue, for example. But this needs to be spelled out. The cancer community needs to engage with global onco-politics and use the considerable means at their disposal to direct a rational, sensitive and effective partnering programming. There is also a clear need for more in field R&D, for example apart from tobacco control there is a dearth of cost-effectiveness studies to guide policymakers in developing affordable care packages. Prevention also needs a fresh approach with more transdisciplinary approaches to the complex socio-cultural ecology of cancer risk factors. There is, for example, no consensus on the pathways and mechanisms through which globalization affects cancer burden. These areas are crying out for actionable policy research. Whilst Love et al. call for more
‘awareness-raising’ as part of population oncology in LMIC, the fact remains that the gap between ‘awareness’ and timely diagnosis and treatment is, in most settings, vast. Cancer patients and their families are faced with Escher’s endless steps with one hurdle leading to another; lack of education in recognizing ill health and acting promptly, critical delay or journey arrest due to the usage of traditional medicines as a first port of call [11], lack of any effective cancer treatment system, and the financial impact of cancer due to not working and/or the cost of treatment. Systems research is urgently needed to left shift the current stage distribution of cancer from palliative to controllable. And this needs to be a public health systems approach not just a site-specific challenge. Love et al. also challenge the current ecological and moral space for the public health challenge in cancer. There is a strong case here for linking research in population and development with cancer control, as it stands there are no really good models of social entrepreneurship in global cancer. Moreover, we need to be constantly vigilant to the central place that injustice, inequity and poverty play in overall outcomes, cancer, or otherwise. There is a need for less free market and more social justice in global cancer public health. This means more political engagement by the oncology community in social affairs and distributed projects that include social and political science. Global health is a tough arena littered with the bodies of good ideas that perished before their time [12]. If the public health agenda for cancer control is to be realized in LMIC, then we are all going to need to step outside our comfortable ‘little’ world of oncology to embrace the players (World Bank, IMF, global commodities, trade agreements, etc.) that will really shape future outcomes for patients [13].

funding

This work is supported by Umberto Veronesi Foundation.

disclosure

The author has declared no conflicts of interest.

references