Foreword: Addressing health inequities to close the care gap

As individuals and organisations in countries around the globe join forces for World Cancer Day, the central theme of the campaign, 'Close the Care Gap,' is more relevant than ever.

This campaign theme is not just a slogan; it's a commitment to action. Cancer touches lives indiscriminately, but the level of care that people receive is far from equitable. Over three years, the campaign has focused on raising awareness, encouraging tangible change, making sure that quality health services are accessible to all, irrespective of their personal circumstances.

This vision of a fairer and more equitable world when it comes to health is what we aim to address in this report. Our goal is to bring to light the contrasts in cancer journeys experienced in different geographies and how can we improve access to cancer care and health for all. It's about putting people and their diverse experiences at the centre of our discussion and our actions.

Nations around the world are actively working to bridge the gaps in their countries. But there is still much work that can and needs to be done to ensure that everyone, everywhere has access to the care they need and deserve.

This World Cancer Day Equity Report offers heartfelt testimonies, experiences, perspectives and expert insights from current and former UICC Board Members into the issue of equity in cancer care. It's about understanding, addressing, and ultimately overcoming the disparities that exist in cancer treatment and access worldwide.

A common thread in the report is the fact that cost-efficient, accessible measures to improve awareness of cancer risk factors, and early detection of disease with accessible quality treatment, could help prevent up to 50% of all cancers.

Another essential, though sadly often overlooked, component of effective response to cancer is the pivotal role of a fully funded and trained healthcare workforce. This report emphasises the critical need to support, expand and empower healthcare workers and caregivers – from frontline nurses and primary care physicians to radiologists, surgeons and supportive care staff.

In writing this foreword, we don't just reflect on the challenges; we also offer a vision for the future. A future where healthcare equity is the norm, not the exception. Our collective mission is clear: we must work together to ensure that everyone, regardless of where they come from, has equitable access to cancer care.

In this last year of the 'Close the Care Gap' campaign, we are calling on world leaders to act. We are doing so with a global call to action, offering nine recommendations listed in this report, which can be adapted to local contexts to reduce disparities in cancer care.

This report is a tool for change, intended to inform and inspire policymakers, advocates and the broader healthcare community to work towards more inclusive health services. Equitable cancer care should not be a privilege, but a universal standard.

Dr Cary Adams,
CEO Union for International Cancer Control

Executive Summary: Global inequities in health and cancer care

The World Cancer Day Equity Report is a collection of testimonials by past and present UICC Board Members to illustrate the global cancer care gap through a local lens, relate how countries are responding and suggest further measures to close the care gap by 2030.

While each testimonial is unique and is particularly relevant to a specific country or region, the commonalities weave together a shared narrative of health inequities based on who someone is – their gender, race, ethnicity, socioeconomic background – where they live and how much money they have.

In the Western Pacific, there are widening gaps of cancer care in rural Australia where screening rates are significantly lower. In China, differing diagnosis and treatment standards between hospitals contribute to disparities, while Japan faces an increase in cervical cancer incidence after suspending active promotion of the HPV vaccine.

In South-East Asia, the cost of cancer treatment is simply out of reach for most people in India, especially those lacking health insurance. In Malaysia, community-level programmes for screening and early detection of the 'screenable' cancers (notably breast, cervical and colorectal) are slowly being reactivated post-pandemic.

In Europe, people with low socioeconomic status in Sweden face a notably higher risk of dying from cancer compared to those who belong to more privileged groups, while in Portugal three out of the 10 most common cancer causes are associated with tobacco consumption. In the UK, the largest known cancer inequity exists between areas of higher and lower disadvantage, with more than 30,000 additional cancer cases a year associated with socioeconomic deprivation.

In the Eastern Mediterranean, social and political instability have exacerbated existing challenges, leading to delays in treatments, shortages of cancer medicine, and soaring prices in Lebanon. In Jordan underprivileged populations, especially refugees, contend with poor access to cancer diagnosis and treatment.

In Africa, limited resources dedicated to the health workforce and cancer care as well as cultural, geographical and other considerations negatively impact access to screening, early diagnosis and treatment. Testimonies in this report reveal how patients in Kenya, Nigeria and South Africa are often diagnosed with cancers at advanced stages, undermining treatment options, survival and quality of life.

In the Americas, those who live in the North and Northeast regions in Brazil are more likely to die from cancer types associated with poverty, such as lung cancer fuelled by increased smoking rates; and in Mexico, for people with no social security, there is currently no policy or programme to provide access to affordable healthcare.

These testimonials paint a vivid picture of the range of social, economic, and environmental factors – the wider determinants of health – that shape a person's access to cancer care. They are the major root cause of health inequity.

In the final year of the 'Close the Care Gap' campaign, UICC together with the cancer community, calls on leaders to eliminate health inequities by addressing their root causes, ensuring that everyone has access to quality health services when, where and how they need them.

Recommendations for greater equity in cancer control

UICC recognises the diverse cancer burdens faced by different nations, each with their unique context of challenges and resources available to tackle them.

The following recommendations are crafted to serve as a universal blueprint, adaptable to the specific needs and capacities of individual countries.

UICC urges governments to implement the following key actions to improve equity in health and cancer care, make it easier for all populations to enjoy affordable and accessible cancer services, reduce disparities in cancer incidence and mortality and in quality of life, and close the gap in cancer care.

1. **Foster patient-centred care that acknowledges and addresses the unique needs and experiences across patient populations, including older adults.** Train healthcare providers on cultural competency and how to provide patient-centred care. Encourage patient engagement in decision-making around their care.

2. **Increase funding for cancer research to understand the country's cancer burden, the main disparities in cancer outcomes and the barriers that prevent certain populations from accessing care even when it is available.** Prioritise funding for research that aims to understand and address cancer disparities in different populations. Encourage collaboration between researchers, healthcare providers, and community organisations to ensure that research is relevant and addresses the needs of underserved populations.

3. **Establish a population-based cancer registry,** to facilitate research and understand incidence, stage at diagnosis, mortality and survival and other indicators of cancers in the population; track trends over time and identify specific at-risk groups; guide policy decisions and allocate healthcare resources effectively; and evaluate the effectiveness of control strategies.

4. **Design and implement an effective national control cancer strategy,** the actions to take for the prevention, diagnosis, treatment, palliation, survivorship care, data collection and monitoring of cancer, founded on an evidence-based assessment of the country's cancer burden and which addresses financial hardship and the barriers faced by underserved populations in accessing care. Use this national cancer control plan to guide the inclusion of cancer in a national Universal Health Care (UHC) package.

5. **Incorporate comprehensive cancer services into national health benefit packages to achieve universal health coverage, including a comprehensive package of quality cancer services:** prevention, screening, diagnosis, treatment (medicines, radiotherapy, surgery), supportive and palliative care and survivorship services in basic health insurance benefits packages. UHC cannot be achieved if cancer, as the second leading cause of death globally, is not covered by national health benefits packages.

6. **Enhance health literacy and education around cancer.** Develop culturally appropriate educational materials and programmes that are accessible to all populations. Provide training to healthcare providers and community leaders on how to communicate effectively with patients. Ensure that reliable information on cancer risk factors and how to reduce exposure to them, as well as on the need to participate in routine screening of common cancers, is made widely available and accessible.

7. **Address the commercial determinants of health by heavily regulating the production, sales and marketing of carcinogenic products** such as tobacco, alcohol, and ultra-processed foods and beverages. Measures include in particular:

    a. *Increase taxation*

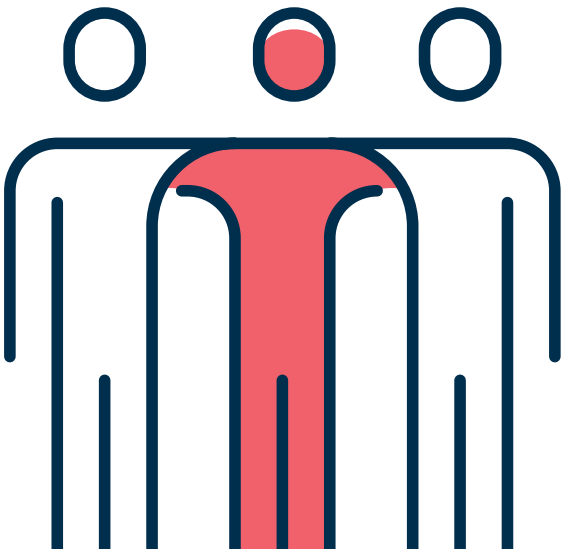
    b. *Enforce marketing limitations*

    c. *Improve labelling: Impose product warning and information labels.*

    d. *Run extensive public education campaigns* to improve knowledge of risk factors and further counter misleading advertising, market promotion and policy interference.

8. **Implement programmes for the routine screening of common cancers (breast, cervical, colorectal and prostate) and vaccination against HPV and hepatitis B, and ensure that access to these early detection programmes is available and affordable.** Integrate cancer screening/early diagnosis interventions into existing primary healthcare programmes. Develop partnerships between community organisations and healthcare providers to bring screening programmes to areas with high rates of cancer incidence and mortality. Coordinate with other outreach programmes, such as HIV, and integrate health services. Implement telemedicine services and mobile screening units to help reach populations in remote or rural areas.

9. **Address systemic social determinants of health that impede an individual's ability to access cancer care,** tackling prejudices and assumptions based on diverse social markers (including education, poverty, geographical location and prejudices and assumptions based on race and ethnicity, gender norms, sexual orientation, age and disability), by working with communities for more effective and people-centred programmes.



South Africa

South Africa: Seeing the human in the right to health

As a country, South Africa is recognised to have a progressive constitution that both promotes and respects human rights. And yet, the country has a huge disparity in the healthcare of its people.

Section 27 of the Constitution outlines access to equal healthcare services for all; but what has not been tested, is the individual right of people affected by cancer.

Inequities experienced across the cancer care continuum

With a population nearing 60 million people – many of whom live in rural areas – 84% access the public healthcare system, while the remaining 16% of the population have health insurance, accessing world-class private healthcare systems and hospitals.

The treatment offered by public hospitals varies, with those linked to academic institutions offering more specialised cancer treatment. Such treatment centres are found in only five out of the nine provinces.

In most provinces, there are challenges with diagnostic and radiation equipment, and this is compounded by poor maintenance, lack of funds, and lack of trained staff.

Early detection and screening are mainly centred around primary healthcare facilities, with breast and cervical cancer the only cancers included in the Ideal Clinic Guidelines – a programme aimed at improving quality of care.

This places the responsibility in the hands of healthcare professionals at these clinics and assumes that they have the associated attitudes, skills, and knowledge to manage people who may present with early symptoms.

Sadly, most cancers in the public sector are diagnosed as late-stage disease, impacting on treatment and survival.

Entrenched barriers to equity

In South Africa, only 20% of healthcare professionals are working in the public sector, and of these, 70% are white males responsible for treating a majority of patients that are people of colour.

This can exacerbate challenges for diagnosis and treatment if they do not speak the same language or understand, respect, and consider the cultural background of their patient.

With cancer incidence and mortality set to rise, gender and racial equity must be addressed with increased urgency as integral to improving cancer outcomes.

Affordability and out-of-pocket expenses

For people using the public health system, most of the cancer care services are free, however, there are associated costs to treatment and care that are not covered – or in some cases, the services are not even available.

Despite being on the Essential Medicines List, oncology medicines are often unavailable in the public health system due to the cost.

People affected by cancer also have expenses relating to treatment, such as transport costs; accommodation costs, as many come from a distance; and may be affected by job loss or loss of income.

For people who can afford private healthcare, their experience is very different, but it is not without its problems and inequities still exist.

For members of private healthcare, only 10% can access high-cost cancer medicines as treatment guidelines differ between health insurance schemes, and unless the required treatment is registered, it is not available to the member.

This means that many members have heavy out-of-pocket expenses to obtain the required treatment, or they face the daunting task of looking for a substitute treatment.

This is the human cost of cancer – and this aspect has never been quantified, but it cannot be understated.

Addressing the inequities and barriers across sectors

At an organisational level

The Cancer Alliance is hopeful of changing the face of cancer in South Africa, alongside a coalition of more than 30 registered not-for-profit cancer organisations, working collaboratively to address the gap in cancer care across our country.

We work to the principle of five Ps: Patient, Public, Private, Partnerships, Philanthropy – always ensuring the patient comes first and is prioritised at every stage of the cancer pathway.

Based on the evidence and recommendations of our research reports, we are implementing a series of solution labs with key policy and decision makers across the health sector.

The solutions will be submitted to the National Department of Health for them to consider and include in the proposed National Health Insurance Bill (NHI).

At a government level

A draft Bill was published nearly three years ago. There remains a lack of clarity around some key issues: how will it be funded; the role of private health insurance; and whether there will be an exodus of skilled health professionals.

The Bill is hailed as the equalizer for the current inequities, but the private health sector is sceptical, as are many healthcare professionals and citizens.

While there's agreement across both the private and public health sector that all citizens need better access to quality healthcare, the public health system remains extremely challenged with many of the provincial hospitals unable to cope.

At a cancer community level

South Africa has a long history of citizen advocacy to defend and uphold human rights, such as the right to health for people affected by the Human Immunodeficiency Virus (HIV). However, that same fire is not there, or at least not visible, for the rights of people affected by cancer.

The Cancer Alliance has established a partnership with the Treatment Action Campaign, which advocates for access to quality healthcare for people with HIV, as cancers linked to HIV are increasing.

By strengthening relations between health organisations, we hope to improve and leverage advocacy opportunities.

Closing the cancer care gap by 2030

To close the cancer care gap by 2030 in South Africa is an ambitious task, but there are actions we can take to make progress:

1. To establish proper referral pathways for the top 10 cancers between the various healthcare settings – primary, secondary, and tertiary healthcare – including the appropriate staff and resources to manage cancer care across each of the settings.
2. To establish a cervical cancer elimination strategy, with the current Cervical Cancer Policy to inform the strategy.
3. To establish standardised treatment protocols for the main cancers associated with the burden of disease for both the public and private health sector.

By prioritising these actions, and putting the patient and their experience first, South Africa can uphold and propel the human right to health for people affected by cancer.

We've had great success at this in the past, and taking what we have learned in our other advocacy efforts, we can light the fire to effect change and begin to close the cancer care gap.

About the author

Ann Steyn

Ann Steyn is the Past President of Reach for Recovery International and a past UICC Board Member, serving two terms from 2016 to 2020. Her work includes supportive care and advocacy for cancer patients.