WORLD CANCER DAY 2015
GLOBAL RELEASE – Q&A

This question and answer (Q&A) document is designed to support media interviews / questions on the 2015 global World Cancer Day press release.

Q: Can I have a simple breakdown on the total figure and what the implications are for LMICs?

An overall spend of US$18bn per year will reduce cancer deaths by >3m pa by 2030 (a reduction in 3m deaths per year is a 30% reduction on current projected total global deaths).

The breakdown of $18bn as suggested by the report is to be allocated as: $6bn is cancer system strengthening - $12bn on targeted interventions.

Recommended interventions include: tobacco control measures (including tax hikes), HBV and HPV vaccinations, screen and treat cervical cancer and (opportunistic) breast cancer, treat paediatric cancers <15, screen oral and treat, (palliative care and pain control).

Distribution:

	Low	Lower middle	Upper middle	Total
Population	849m	2561m	2409m	5819m
Current health spend	$11bn	$89bn	$534bn	
% of GDP	2%	3%	3%	
Health spend from ODA	28.7%	6.7%	0.7%	
Total new spend required	$1.3bn	$4.2bn	12.2bn	18.0bn
% of current hlth spend	+12%	+4.7%	+2.3%	
Per capita cost ($)	1.52	1.62	5.08	8.22

Q: Can I have a simple breakdown about how much higher-income countries (such as the UK, US, Australia, France and Germany) need to contribute in total each year to the $18billion figure per year?

The DCP3 report focuses on low- and middle-income countries (LMICs) and supports the identification of priority areas that need strengthening in disease control. Therefore, the rationale for achieving the $18billion per year investment is targeted at these countries. In particular, it is targeted at Ministries of health/finance; Communities of practice and aid agencies.

NB: *See Appendix for breakdown of LMICs*

The report suggest that the lower-middle and upper-middle-income countries have the scope to cover this moderate increase in health spend, particularly from interventions such as increased tobacco taxation as well as the projected growth of official development assistance (ODA), which is currently 1% of $30bn pa.

The countries that need greater support are those that fall at the bottom of the lower-middle and low-income countries, providing a likely gap of between $1.3bn - $2bn.

Q: If it is unclear how much higher-income countries such as the UK, US, Australia, France and Germany need to contribute in total each year to the $18billion figure per year, will they need to contribute at all?

High-income countries do have a role to play supporting the LMICs in the achievement of this target – whether it be knowledge transfer or financial support - in turn having a positive impact on reducing the burden on LMICs.

The Union for International Cancer Control (UICC)'s purpose is to unite the cancer community to reduce the global cancer burden, to promote greater equity, and to integrate cancer control into the world health and development agenda. Along with its multisectoral partners, UICC is committed to encouraging governments to

look towards the implementation and scale-up of quality and sustainable programmes that address the global burden of cancer and other NCDs.

UICC urges all countries to work towards:

- Developing specific time-bound targets and indicators to measure the national implementation of policies and approaches to prevent and control cancer
- Raising the priority accorded to cancer in the global health and development agenda
- Promoting a global response to cancer

Q: Will this funding be an increase on existing health spending or international aid funding?

This is a funding request in addition to countries health or aid funding. It is however considered affordable in most low- and middle-income countries (LMICs) (constituting about 3% of total spending on health) and, importantly, could be mitigated in all or part by tobacco tax increases. Contributions to this funding are affordable in all but the world's poorest countries, where support from the international community will be required.

This support is a likely gap of between $1.3bn - $2bn.

Q: Is increased health funding feasible for low-income countries?

It is expected that low-income countries – where services are least developed, facilities largely absent and trained cancer experts few – will need support from the international community to build capacity, a process that is likely to take a decade or more. To achieve this, middle-income countries with the means to increase spending on cancer, are asked to do so by 2-5% of their health budgets. By focusing on the World Health Organization's (WHO) best buys for NCD's countries would not only address the current burden of cancer in the most cost-effective way, but also support future generations through vaccination programmes against hepatitis B and cervical cancer.

Q: Is this $18billion per year funding request new or has it been discussed previously with world leaders?

This is a new funding request based on the latest projections on the increasing burden of cancer. These figures were presented to the cancer community at the 2014 World Cancer Congress in Melbourne, Australia last December and are now being made more publically available to support funding decision-making.

Q: Why should wealthier countries pay for cancer services in other, poorer countries and how can they guarantee this extra funding, if provided, will be spent on cancer services and facilities?

High-income countries do have a role to play in supporting the LMICs in the achievement of this target – whether it be knowledge transfer or financial support - in turn having a positive impact on reducing the burden on LMICs.
Provision of funding is always accompanied by monitoring and reporting mechanisms that guarantee that the funds are used for the agreed spending areas.

Q: What is UICC's stand on the need for increased cancer funding?

The Union for International Cancer Control (UICC) fully supports increased affordable cancer funding across the world, but particularly in low- and middle-income countries (LMICs) where the impact will be greatest. For this to be achievable, low-income countries will need support from the international community to build capacity, a process that is likely to take a decade or more. By focusing on the World Health Organization's best buys for non-communicable diseases (NCD's), countries would not only address the current burden of cancer in the most cost-effective way, but also support future generations through vaccination programmes against hepatitis B and cervical cancer.

Q: How important to the control of cancer is increased tobacco taxation and control?

As most tobacco-related cancer can be prevented with higher taxes and other interventions, universal adoption of the World Health Organization's Framework Convention on Tobacco Control (and implementation of its articles) is crucial to all cancer control efforts.

As an example of how effective increasing tobacco taxes is, when tripling these taxes alone, the tax revenue available to governments would raise from US$300 to US$400 billion annually and then enable the implementation of many cancer control measures.

Q: Can I have a simple breakdown of what countries are classified as higher, middle and lower income countries in the DCP3 report?

This has been made based on the World Bank's classification of the world's economies based on gross national income (GNI) per capita for 2013:

- Low-income= $1,045 or less in 2013
- Middle-income
    - Lower-middle-income = $1,046 - $4,125
- Upper-middle-income = $4,125 - $12,7456
- High-income = $12,746 or more

Q: When will the DCP3, Cancer volume be officially published and in what publication?

The statistics supporting today's announcement went live on the DCP website today. Further publication of the full data package is expected in a leading international journal in the coming months; further information about this is unavailable at this stage.

Q: Do we have information about the authors of DCP3, Cancer?

DCP3, Volume 6 Cancer has been authored by some of the world's leading experts in cancer prevention, treatment and control.

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Q: Who is available for interview about the DCP3 report?

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APPENDIX

Breakdown of Low- and Middle-Income Countries (LMICs)

For the current 2015 fiscal year, low-income economies are defined as those with a GNI per capita, calculated using the *World Bank Atlas* method, of $1,045 or less in 2013; Lower-middle-income and upper-middle-income economies are separated at a GNI per capita of $4,125.

Low-Income
GDP (current US$) $612.7 billion 2013
Population, total 867.6 million 2014
GNI per capita, Atlas method (current US$) $709 2013
Urban population (% of total) 30% 2014
Eg

Afghanistan	Korea, Dem. Rep.
Bangladesh	Liberia
Benin	Madagascar
Burkina Faso	Malawi
Burundi	Mali
Cambodia	Mozambique
Central African Republic	Myanmar
Chad	Nepal
Comoros	Niger
Congo, Dem. Rep.	Rwanda
Eritrea	Sierra Leone
Ethiopia	Somalia
Gambia, The	Tajikistan
Guinea	Tanzania
Guinea-Bissau	Togo
Haiti	Uganda
Kenya	Zimbabwe

Lower-Middle
GDP (current US$) $5.234 trillion 2013
Population, total 2.596 billion 2014
GNI per capita, Atlas method (current US$) $2,074 2013
Urban population (% of total) 39% 2014
Eg

Armenia	Mongolia
Bhutan	Morocco
Bolivia	Nicaragua
Cabo Verde	Nigeria
Cameroon	Pakistan
Congo, Rep.	Papua New Guinea
Cote d'Ivoire	Paraguay
Djibouti	Philippines
Egypt, Arab Rep.	Samoa
El Salvador	Sao Tome and Principe
Georgia	Senegal
Ghana	Solomon Islands
Guatemala	South Sudan
Guyana	Sri Lanka
Honduras	Sudan
India	Swaziland

Upper Middle
GDP (current US$) $18.69 trillion 2013
Population, total 2.433 billion 2014
GNI per capita, Atlas method (current US$) $7,598 2013
Urban population (% of total) 63% 2014
Eg

Albania	Lebanon	Azerbaijan	Marshall Islands	Brazil	Palau
Algeria	Libya	Belarus	Mauritius	Bulgaria	Panama
American Samoa	Macedonia, FYR	Belize	Mexico	China	Peru
Angola	Malaysia	Bosnia and Herzegovina	Montenegro	Colombia	Romania
Argentina	Maldives	Botswana	Namibia	Costa Rica	Serbia