Preparing for cancer II – Cancer control plans: Being prepared and ready to implement

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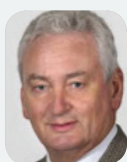
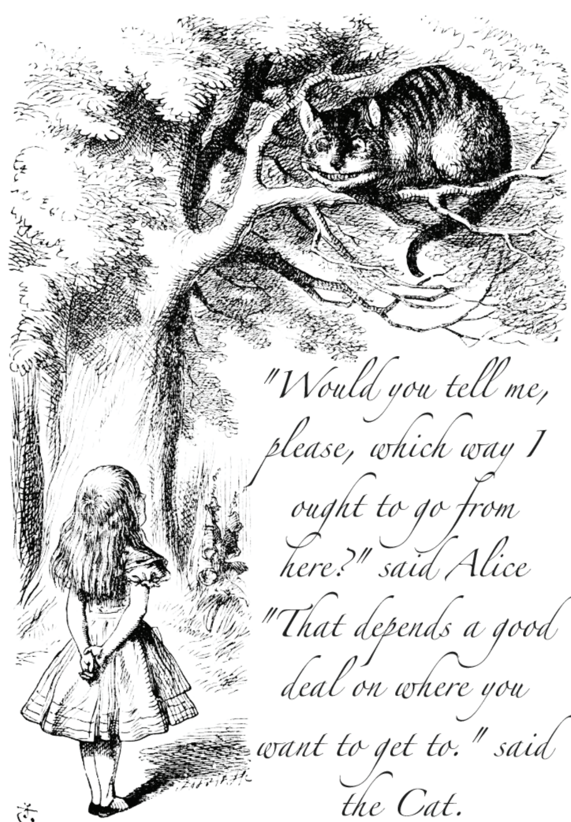


Cancer preparedness cannot be seen as a just as medical issue. In this companion piece to the previous article, the author considers the factor outside of government policy-making and National Cancer Plans, that need to be thought about – such as culture, leadership, responsibility, local context and the abilities to collaboration effectively – when considering "Preparedness".



Approximately 9.6 million people die of cancer each year *(1)*. Cancer incidence is estimated to increase by 50% by 2035 *(2)*. The disease burden is greatest in low- and middle-income countries (LMICs), where 70% of cancer deaths occur; the number of cancer cases is rising most rapidly due to demographic change, and where health systems are neither well prepared nor equipped to manage this growing burden. While an estimated 59% of cancer cases occur in LMICs, only 6% of global spending on cancer is directed to these countries *(3)*. Furthermore, only 1% of global health financing is directed to non-communicable diseases (NCDs), which include cancer *(4)*. The growth in oncology cost is expected to rise 7%–10% annually throughout 2020, when global oncology costs will exceed US$ 150 billion *(5)*.

The institution of large population national cancer control plans (NCCPs) has been accepted as a critical and necessary step to address this challenge for all nations, recognizing that the greatest challenge for low-income countries (LICs) and middle-income countries (MICs) is to build the capacity necessary, whereas for the high-income countries (HICs), the greater challenge might be to sustain the capacity that has been built. For all, NCCPs represent a way to "know where we are going, and how to get there".

The content of NCCPs

Comprehensive cancer control (CCC) addresses cancer across the continuum of prevention to end-of-life care, rather than as one cancer site, or one aspect of care delivery (e.g., prevention). It brings together partners from multiple sectors to collectively address the cancer burden in a community by leveraging and sharing existing resources and identifying and addressing cancer-related issues and needs.

The ICCP (International Cancer Control Partnership) hosts an online multilingual inventory of NCCPs from every world region at www.iccp-portal.org. All registered NCCPs have been reviewed by the ICCP over the last year to provide guidance upon their content and to highlight where further development might be appropriate. Unsurprisingly, given that the knowledge and data underlying NCCPs is available through similar websites, international meetings and publications (i.e., "the evidence is the evidence"), these plans have much in common. Although most UN member countries have an NCCP,

Table 1: Contextual components of preparedness for implementing cancer control

The Disease Control Plan	Contextually appropriate content aligned to goals and targets
Data: Information Public Policy	Registry: Surveillance: Outcomes: Projection: health economic data. Equity: Fairness: Integration: "Greatest good for the greatest number…"
Societal Responsibility	Disease as an "all of society" issue: inclusivity: engagement: priorities: mobilization & participation
Leadership and Governance Organizational Structure	Coherent, comprehensive, leadership & stewardship Relationships, reporting, responsibilities, accountabilities
Health Workforce	Supply: skills appropriateness: retention: incentivization
A Financial Plan and Budget Sustainability	Secure new, re-allocated or transferrable funds Ethical, professional, socio-economic accountability and sustainability
Collaboration Communication	All disciplines, institutions, organizations and sectors (PPP). All of government; all of society (political, professional; public &private

relatively few have actually put their plan into implementation, notwithstanding entirely appropriate content. There are good plans in implementation, e.g., Australia, France, New Zealand, United Kingdom, Canada, etc.; more commonly in high-resource countries. The challenge with NCCPs is that medical and scientific content and validity are essential, but insufficient to implement an NCCP. Knowing what the route forward should be is not synonymous with undertaking, or even understanding, what the journey will entail.

The context and collaborations of NCCPs

Understanding country context and the availability of collaboration and relationships are necessary prerequisites for implementation of NCCPs. Contextually, the issues of culture, population composition, levels of literacy and poverty, health infrastructure, geography, climate, economy, human resources, technology are amongst the key determinants of whether a country could actually put what is known and desired into implementation. But knowing whether the constituencies whose participation is necessary to implement the plan are present, constructively engaged and actively collaborating to achieve population goals proves to be equally important. NCCPs are societal plans requiring engagement and action by all constituents of society. They are not the plan of any one constituency – the government, the ministry of health, or the medical profession, etc. They are society's plan to control cancer in their population and they must be owned and supported by all components of society.

Whether NCCPs are likely to be implemented successfully or not has less to do with the content of the plan and more to do with the state of preparedness and readiness to implement the NCCP. This is more about functions, structures , funding and execution (a strategic plan, a business plan, an operating plan, a budget, a governance structure, leadership, an executive and operational structure, reporting and accountability), and the existence of an understanding between necessary collaborating entities (government, MoH, institutions, academia, NGOs, advocacy groups, patients, advocates, public and private sector) as to how they will relate, contribute and hold themselves accountable for delivering the elements of the plan.

The Cancer Preparedness Index described elsewhere in this publication identifies Policy & Planning, Care Delivery and Health System & Governance attributes as key determinants of understanding preparedness for implementation of NCCPs (6). Whilst the authors at the Economist Intelligence Unit (EUI) position the value of the Index primarily in terms of government policy formulation and comparability between nations in their level of preparedness to enact NCCPs, an understanding of preparedness and readiness by each of the partners in the execution of an NCCP is fundamental for collaborative implementation.

Which begs the question "What does 'preparedness and readiness' look like? What does it mean from the perspective of each partner?" Some of the possible components are presented in Table 1.

A key issue, however, notwithstanding preparedness, is to identify the individual or group who is both capable and willing to take on the responsibility of overseeing that the strategy delivers the outcomes for which it has been created. Finding such a steward can be as challenging as the task itself. Who is able to coordinate the "content" – the medical and scientific enterprise – with the "context"- the socio-political enterprise? Who will convene, facilitate and enable the necessary "collaboration" between the multiplicity of different, independent parties and at the same time align strategic, business (financial) and operational implementation? Who is sufficiently trusted, respected and knowledgeable across the elements of the strategy, while at the same time independent of individual, organizational or institutional pre-set mission agendas. Who is focused, responsible and prepared to be 100% accountable to the stakeholders for the

implementation of a plan that is directed towards improved population health/cancer control outcomes? These are some of the considerations that underlie the choice of "steward and stewardship".

Preparedness and readiness requires being able to demonstrate, step by step, the feasibility of the developments that are imperative for implementing a NCCP. The strategic plan (the "why" and the "what") must become a business plan ("how", "how funded", "by whom"); the business plan must align to the financial plan; implementation must align with an annual operating budget ("what activity will we be doing tomorrow and how is it being paid for?"). Interestingly, this is more readily apparent for countries with one national policy and budget, rather than for "federated" countries, for whom implementation requires the determination of "added value for all without competition with any."

In addition, two fundamental and critical issues – culture and leadership – require an "up-front" consideration. Is there a culture of collaboration between science, medicine, public health, health services and the institutions/enterprises whose engagement is necessary to achieve improved population health outcomes? Why would the NCCP be more implementable and effective now than may have hitherto been the case to date? Globally, government indifference and/or change of political leadership represents a major impediment to national efforts to control cancer/NCDs. The public expression of support, including policy and funding is necessary. What might leadership look like at a national, state or municipal level?

Leadership can be demonstrated by other players besides elected politicians; such as by:

- NGOs: aligning organizational priorities (organizational well-being, competitive advantage and fundraising imperatives) and societal priorities attained through integrated and collaborative solution(s)?
- Academia: aligning academic and health service needs, particularly health human resource needs, training and mentorship, curriculum development, and fostering the changes in health practice underlying good, progressive change in healthcare universities, faculties of medicine, schools of public health, schools for health professional disciplines, and professional societies.
- Health sector authorities and institutions/hospitals/ community services: enacting the necessary shifts from acute, tertiary, facility-based, high-tech, high professional resource-based care to more sustainable models appropriate for chronic and non-communicable diseases in an ageing population, including the reallocation of resources within operating budgets.
- Patients, advocates and advocacy: mobilizing advocacy for cancer control, rather than reactively for single diseases, with patients and advocates becoming "owners" of the problem and its solution, rather than "arms-length" observers?
- Public/civil society: shifting the balance from an illness-focus to a health, wellness and illness management perspective, in which personal choices, behaviours and actions are integral components of necessary change.
- Private sector/health industry: engaging and harnessing the value, expertise and influence of the private sector whilst honouring the principles and practices of universal healthcare systems and balancing principles with the practical realities of sustainable healthcare.

If we define collaboration as "the pursuit by multiple, independent organizations, of a common vision and purpose to achieve a shared greater goal" then "true collaboration", would be ideal, but unlikely. Independent organizations have distinct governance, proscribed purposes, funding mechanisms and obligations to stakeholders/shareholders/funders. "True collaboration" would require the subjugation of individual mandates to a common "higher" and shared purpose.

Short of this ideal, but more realistic in practice, are lesser levels of collaboration; e.g., "sharing" – providing information with, or without, any necessary expectation of attention or action; "co-ordinating" – determining where mutual agendas can come together, in person or remotely, to exchange information that is relevant to purpose; or "cooperating" – working together on defined areas of mutual activity to the greater gain of all parties.

In principle, host nations and collaborating partners may expect benefit through any level of collaboration, but in practice, the increasing commitment through sharing, coordinating, cooperating and truly collaborating is the investment that host and partner(s) make in trust and mutual respect, time, and reconciling individual goals to a shared common purpose (sharing common "turf") (7).

Coherence and constructive collaboration between the "owners of the plan" – not just the steward (the person or organization with responsibility and accountability to oversee the implementation of the NCCP), but rather those whose leadership, influence, support and visible profile provide the impetus for a societal plan to be effective. The role of the steward is to foster and nurture this culture, environment and relationship, to enable the plan to be implemented in a contextually-appropriate manner, and report and demonstrate the results of collective action for control cancer at a population level.

We know which countries have NCCPs and we know which global organizations are taking the lead with assistance or

technical development on components of NCCPs. What we do not have is a ready source of knowing "who is doing what, how and where"?

There will be others, of whom we are unaware:

- pursuing the same purpose, within the same country, with a different set of partners, but without knowledge of others' activities;
- pursuing the same purpose, in countries with different contexts and cultures;
- pursuing different aspects of cancer control, unaware of "how the whole could be of greater value and relevance than the sum of the parts" to the host country.

Irrespective of country, or aspect of cancer control, the key opportunity is to learn why, under what circumstances (contexts), and through what relationships and understandings (collaboration) are cancer control interventions implemented successfully, or not. What determines success, or failure, when content (NCCPs) is similar?

Could we achieve greater gain more effectively and quickly through collective knowledge than by individual endeavour? Who could/would serve this role for global cancer control – the source of information regarding 'who is doing what, where and with whom' – the resource to facilitate collaborations to strengthen, rationalize and reduce duplication within aspects of cancer control, within and between countries? Who could be the "honest broker" of information that would benefit all parties, expedite partnerships and foster collective action? Who might, should or could assume the role of steward to advance the many initiatives to advance global cancer control?

Conclusions

Controlling cancer, or any NCD, is not solely a medical issue – it is a societal issue where the solutions come from the informed actions of multiple, relevant constituencies, each of which has a role and a level of influence through which the goals of improved population-based cancer (NCD) control can be reached. Proving that implementation of NCCPs causes improved outcomes of cancer control will be challenging inasmuch as there is no control group and no ability to rigorously compare the value of the interventions within a contemporaneous non-intervention population. Furthermore, population cancer/NCD control outcomes will continue to improve without an NCCP so long as social determinants of health continue to improve. Notwithstanding, the implementation of NCCPs is associated with improved cancer/NCD outcomes. To that end, NCCPs represent a direction that is consistent with where we want to get to. Knowing the destination is essential for the journey. However, to arrive at the right destination requires not only the map (content), but also knowledge of what one must be prepared for (context), and the level of readiness to optimize the likelihood of arrival (collaborations). Determining how we collaborate is our decision to make. ■

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