The Outcome Report of the London Global Cancer Week Round Table Discussion on building resilience in cancer systems in low- and middle-income countries

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In a Round Table discussion convened as part of the 2023 London Global Cancer Week programme an international panel of representatives from intergovernmental agencies, civil society and industry were asked to explore ideas on how best to build (or rebuild) more resilient and sustainable healthcare systems in low- and middle-income countries. The following report summarizes the notes that were made at the time and includes further reflections submitted by the participants post-meeting.

Globally, cancer represents a significant health burden with an expected increase of 51% in new cases between 2022–2045 *(1)* and is a leading cause of death worldwide. The majority of new cases of cancer and cancer deaths occur in low- and middle-income countries (LMICs). The prevention, early detection, diagnosis, and treatment of cancers results in substantial returns on investment in saved healthcare costs. A global analysis published in 2021 reported that a comprehensive scale-up approach combining imaging, treatment, and quality of care would produce a return of US$ 12.43 for every dollar invested *(2)*. To prevent or reduce future cancer incidence, the groundwork needs to have been laid decades in advance, offering no immediate reputational benefit or political advantage to government actors. If cancer cannot be prevented, cancer is best treated when it's at an early stage, and so speed of diagnosis and treatment is key to saving lives. However, since the COVID-19 pandemic of 2020–2022 many advances in public healthcare have stalled; even rolling backwards in some LMICs. Added to this has been the accelerating effects of climate change and the widening spread of military and civil conflict that together have caused the displacement of large populations around the world.

Preparing for cancer

Drawing up and implementing a comprehensive National Cancer Control Plan (NCCP) as the essential prerequisite for addressing cancer at a population level is a political decision that needs to be taken at the highest level of government. NCCPs should be population-based plans, designed to reduce the burden of cancer and enshrining principles that reflect the aspirations of patients and populations for the reduction of the national cancer burden. While each country's NCCP will be designed to meet the present and predicted needs specific to its own population, it should share the following key characteristics with other NCCPs:

- Evidence that the process of drawing up and implementing the NCCP has involved multisectoral stakeholders.
- A strong governance structure, where "governance" relates to the designated responsibility and accountability for the cancer plan on behalf of the public.
- A clear implementation plan, that is sustainable, costed, and linked to economic outcomes for society and the country.
- Linkage with other issues, e.g. NCDs, viral and parasitical infections, antimicrobial resistance, poor diet, climate change, pollution, obesity, financial and gender inequity, showing how action on cancer control can contribute towards their resolution or amelioration.
- A section addressing crisis management and resilience.
- The outline of a contextually relevant evidence-based national cancer research agenda.

It is important, from the outset, to bring all sectors to the table including the private sector, academia, NGOs, patient groups, and all areas of government (especially the Ministries of Finance, Education, Public Works, and Science and

Technology). Populations are best served by NCCPs that are the result of a systematic identification by all stakeholders of the existing gaps in the healthcare system and social infrastructure that can affect cancer care. Informed by this needs assessment, NCCPs should adopt a comprehensive approach to establish, maintain and increase system capacity based on predicted patient needs, rather than the level of currently available resources or politically favoured projects.

Fortunately, there are now several sources from which NCCP authors can draw to compare their proposed plan with other NCCPs and identify examples of interventions that will be useful in addressing their own cancer burdens at national, provincial, or local levels. Copies of many NCCPs are available through the International Cancer Control Partnership (ICCP) portal at https://www.iccp-portal.org/. WHO, IARC, and IAEA produce fact sheets, toolkits, monographs and a list of essential medicines. City Cancer Challenge *(3)* publishes examples of how strategic multisectoral partnerships in urban settings have improved patient access to cancer care in LMICs.

Substantial resources, underpinned by sustained political will, are needed to transform a NCCP into action. In the Round Table discussion workforce deficit was identified as a major challenge. principally due to the historic under-investment in education and training of health workers and the chronic mismatch between education and employment strategies in relation to health systems and population needs. Authors of NCCPs need to scope the scale of the investment involved, taking into consideration the educational and training needs for multidisciplinary working and the level of staff retention required. While investing in technology should decrease funding needs in the long term and reduce pressure on the workforce, it will not necessarily reduce existing inequities or guarantee increased patient access, nor will it be as meaningful in poorer resourced settings that lack the necessary supporting infrastructure.

Many LMICs have either not drawn up NCCPs, or have completed but not yet implemented them because either they are unaffordable due to indebtedness or because cancer was not yet perceived as a political priority (particularly in those countries with health burdens still transitioning from communicable diseases to NCDs); or possibly both. Since the equivalent of The Global Fund to Fight AIDS, Tuberculosis and Malaria does not yet exist in the NCD space, building the business case for investment is likely to be the biggest challenge facing the authors of NCCPs; making their constructive engagement with the Ministry of Finance, the private sector and NGOs throughout the drafting process of significant value.

The NCCP business case can be elevated by showing how investment in cancer can have a spillover effect, leading to health systems strengthening in other areas of healthcare. Cost efficiencies may also be achieved by combining new cancer initiatives with pre-existing public health programmes, e.g. in sexual and reproductive health, community vaccination or tobacco control. Alternatively, supported by the testimony of patient groups and evidence from academic research, attention can be drawn to the costs to the national economy of *inaction*, in terms of lost productivity and revenue due to the late presentation of cancers that is characteristic of under-resourced settings. Out-of-country referral, with its attendant diversion of revenue from the health system, represents an additional hidden cost.

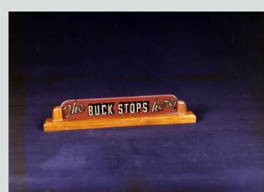
The Round Table recognized that "out-of-pocket" health expenses remain huge for many patients in LMICs with a diagnosis of cancer having a catastrophic impact on family budgets and financial futures. To be effective, all health systems require enduring funding and long-term vision and in recent years the goal of establishing Universal Health Care (UHC) – an important target of SDG 3 – has been regarded as the preferred solution. As a result of the COVID-19 pandemic the march towards UHC has slowed to a crawl ("stagnated" according to GAVI) *(4)*. The experience of COVID-19 showed that health (or rather ill health) has economic value and that the world's health systems are dangerously fragile due to perennial under-resourcing. Health system strengthening is a political choice.

The argument that health expenditure should be regarded as an investment rather than a cost has not yet landed with many minsters of finance in those LMICs transitioning from a health burden of communicable diseases to NCDs. For LMICs shackled by chronic indebtedness one strategy is to "debt swap"; i.e. to negotiate with creditors to turn one's debts into development investments. LMICs need their own resources outside of neo-colonial grants and "debt-for-development" swaps offer promise, especially if they catalyse additional capital infusions from the World Bank *(5,6)*.

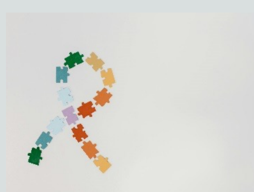
Many of the drivers affecting the success of cancer control measures originate from outside the health sector. Its reliance on the performance and compliance of many different ministries makes cancer control an all-of-government issue that requires leadership and oversight at the top. While it is advisable that a named individual is given the job of executing the NCCP and the resources with which to accomplish this task, it is equally important that overall political responsibility for the national status of cancer control rests with the highest office, i.e. at prime minister or president level, and that NCCPs be subject to the approval of the national legislature and granted legal status. Giving the NCCP the force of law will help embed the cancer control mission in successive governments and strengthen the multi-sectoral, all-of society consensus that will be necessary to address future goals beyond political term limits.

In addition to creating multisectoral collaborations,

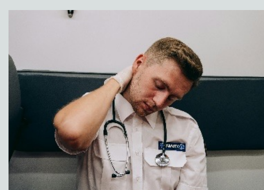
Figure 1: Take away points: Building resilience of cancer systems in low- and middle-income countries



Cancer control is an all-government issue and should sit within the purview of the president or prime minister of a country

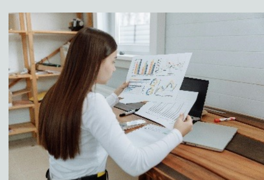


Ensure NCCPs include regulations for governance, monitoring and evaluation and costed, funded/, time-dependent plans for implementation include responses to crises

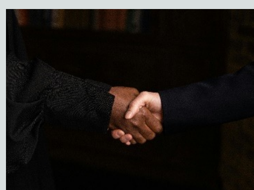


Address the shortfall in trained workforces and encourage the use of technologies that genuinely reduce inequities

Through legislation elevate the NCCP to the status of a law to ensure the continuity of commitment by successive governments to its implementation



Make cancer a notifiable disease and establish mandatory cancer surveillance through population-based cancer registration to inform government on cancer incidence, prevalence, survival, and mortality.



Pursue the goal of Universal Health Coverage that ensures populations cost-free access to evidence-based cancer prevention, diagnostic and treatment interventions that are known to be effective .

Prepare for crises by thinking the unthinkable and game planning

Reduce the siloing within different "issue" communities, e.g. AMR, tobacco, sugar, climate, pollution, etc. as these are all inter-linked with cancer control

Encourage regulated engagement between public and private sectors for all areas of cancer care

Work with civil society to educate populations about cancer, reduce cancer stigma and delegitimize the online communication of misinformation, and the suppression of evidence

Establish a multi-sectoral, all-society consensus to formulate and sustain NCCPs that set goals beyond political term limits.

Inter-country collaboration is vital in promoting workforce training and sharing examples of good practice. Expand the role of regional actors e.g. African Union, The Commonwealth, CARICOM, ASEAN, and professional networks.

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mitigating inequities in access to care, and fostering political will, the Round Table discussion identified three knowledge gaps that still exist in most LMICs.

Cancer registration

There has been insufficient investment in cancer surveillance and the establishment of population-based cancer registries in LMICs. The collection of cancer incidence, mortality, prevalence, and survival data, and, where possible, data on stage and on treatment outcomes, enable governments and health managers to determine whether their cancer strategies have been successful, to identify areas of care where further capacity is needed and to direct their limited resources accordingly.

Research

Proper investment in research infrastructure within LMICs is crucial to end the dependence on high-income country research agendas. Specifically, training in the conduct of high-quality implementation research will help inform key knowledge areas of cancer prevention, detection, diagnosis, treatment, and palliative care that have previously relied on research carried out in the different contexts of higher income country settings. Extending LMIC research ecosystems to include knowledge sharing networks and databases would

further encourage productive research collaborations.

Knowledge, attitude, beliefs and behaviour

There is much work to be done in educating LMIC populations about cancer, beginning with the language used by health professional in countries where the term "cancer" is not widely recognized *(7)*. The level of health literacy and engagement with the public needs to be raised in order for cancer control strategies to be successful; especially in the area of prevention. Social stigma, superstition, planted misinformation and a belief that cancer is inevitably terminal persists in many LMIC communities, contributing to delay and late presentation.

Cancer's impact extends across all of society; it requires a corresponding all-of-society response, particularly from commercial, financial, and media actors in the private sector, and an awareness of changing circumstances. Experience has shown that workable NCCPs cannot be created within an unchanging healthcare silo; they need to consider the impact of often violent external emergencies such as global economic crises, major risks to health security (e.g. a global pandemic), natural disasters such as earthquakes, tsunamis, and volcanic eruptions, the accelerating effects of climate change, military and civilian conflict and the resulting mass displacement of populations.

The outcomes of the Round Table discussion have been summarised in Figure 1. Financially cancer represents a double blow to national economies: it costs society to treat it, and society loses revenue through lost productivity. Yet cancer experts, in common with climate change experts, have largely been ignored by governments unwilling to initiate the changes and make the investments necessary to control cancer through prevention, early detection and diagnosis and treatment.

Cancer should no longer be regarded solely a medical problem: it is a development issue involving all of society and cannot be controlled effectively without addressing many other shortfalls in society including the inability to afford out of pocket expenses, low levels of literacy, gender inequities, workforce shortages, lack of infrastructure, and inadequate capital investment. The cancer incidence, prevalence and mortality data collected by population-based registries provide compelling metrics for assessing national socio-economic development, especially in those countries transitioning from communicable disease to NCD health burdens. Many of the measures and resources requiring infrastructural investment for cancer's prevention and treatment are also of benefit when tackling other major health and social issues. International initiatives that address the universality of the cancer burden can serve as a catalyst for elevating the economic, technological, academic, infrastructure and overall health benefits of the global community.

The full text of the report on the Round Table discussion is published on the London Global Cancer Week website (8). ■

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References

1 Predictions of the future cancer incidence and mortality burden worldwide up until 2050. International Agency for Research on Cancer, Lyon 2024 https://gco.iarc.fr/tomorrow/en/

2 Hricak H, Ward ZJ, Atun R, Abdel-Wahab M, Muellner A, Scott AM. Increasing Access to Imaging for Addressing the Global Cancer Epidemic *Radiology* 2021 301(3):543-546. doi: 10.1148/radiol.2021211351

3 City Cancer Challenge https://citycancerchallenge.org/

4 Progress has slowed on universal health coverage: Here's what needs to happen. GAVI https://www.gavi.org/vaccineswork/progress-has-slowed-universal-health-coverage-heres-what-needs-happen

5 A new-wave-of debt-swaps-climate-or-nature. https://www.undp.org/future-development/signals-spotlight

6 Spellman JD Opinion: Debt deals must become part of a country's economic plan. *South China Morning Post* 24 January 2024 https://www.scmp.com/comment/opinion/article/3249476/debt-deals-must-become-part-countrys-economic-plan

7 Simba H, McCormack V, Mutebi The language of cancer communication in Africa Cancer Control 2023 2023 pp49-51 https://www.cancercontrol.info/wp-content/uploads/2023/12/49-51-Simba.pd

8 Lodge M. Price P, Stanway S, Stevens S, Sutcliffe S. Building resilience of cancer systems in low and middle-income countries: *Outcome of the Round Table discussion held in London UK on Wednesday 16th November 2023.* Publ. London Global Cancer Week 2023