THE *CANCER CONTROL* CONSULTATION

Is there an appetite for a healthier, more just and equitable world?

"If international organizations seem ineffective, it is because their structure no longer reflects the current reality... The solution to the multilateralism crisis is not to abandon it, but to rebuild it on fairer and more inclusive foundations."
Luiz Inácio Lula da Silva, Brazilian President, *The Guardian*, 10 July 2026

"Today I will talk about a rupture in the world order, the end of a pleasant fiction and the beginning of a harsh reality … the Old Order is not coming back…we need to see "the world as it is", not "as we might wish it to be".
Mark Carney, Prime Minister of Canada, World Economic Forum, Davos, January 2026

Health is deeply interconnected with equity, social justice, clinical innovation, and environmental stewardship – a resource for living, equipping a resilient society through awareness, information, choice and opportunity. Health and well-being flourish with peace, security, social stability, resilience and sustainability. They are an expectation in high resource countries, but commonly about endurance, resilience against adversity, or suffering in low- and middle-income countries (LMICs). War, insurgency, forcible displacement, persecution, generalized violence and natural or man-made disasters currently impact more than 120 million people, the majority in LMICs facing protracted adversity, uncertain legal status, compromised food, shelter, healthcare, education, and social protection.

Geopolitical uncertainty, financial contraction, eroding multilateralism, rising nationalism, transactional politics, and the shifting world order have changed traditional concepts of development assistance and "foreign" aid. Global health governance, formerly rooted in the wealthy assisting the poor through financial aid (charity) needs re-vitalization to generate collaborative leadership, health system capacity-building, and technology development (molecular medicine, AI, population data with sovereignty, etc.) in concert with national investment and "ownership" of the population's health, well-being, and disease control. The true strength of a nation is the health, well-being and productivity of its people, yet public spending is decreasing for almost half of all LMICs. Debt repayment deprives poorer nations of funds to improve population health, limiting choices, and encouraging behaviours and lifestyles leading to poor health, loss of well-being, disability and premature death.

Overcoming inequalities of health outcomes resulting from limited access to available, affordable, good quality health services requires new legal and organizational frameworks to address health, illness control and well-being in the emerging context of the politics, economics, medicine and environment in the new world order – the greatest good for the greatest number through the best use of available resources.

Can an increasingly knowledgeable, longer-lived, technology-enriched and wealthy society generate "social good"? Could a new multilateralism harness the power of collaborative, co-invested relationships to:

- build trust and confidence through information rather than disinformation;
- replace external debt repayment in exchange for improved social determinants of health;
- replace repeated cycles of emergency and disaster relief leading to dependency, indignity and social unrest through building resilient infrastructure and sustainable development;
- align external financial support with improvements in population health, more complete universal health coverage, social protections and stronger, more resilient societies;
- forge open and inclusive collaborations based upon knowledge transfer and shared purpose rather than financial assistance/aid – collaboration rather than transactions?

Globally, the world is "cash-rich", but "social-good poor". Time is running out for indifference, inattention or complacency. Is there an appetite for a healthier, more just and equitable world? "Nostalgia is not a strategy" (Carney, 2026).

RESPONSES

HRH Princess Dina Mired *of the Hashemite Kingdom of Jordan, Past-President of the Union for International Cancer Control*

Absolutely. People everywhere want the same fundamentals: to live healthy lives, to protect their children, and to know that if illness strikes, they will receive the care they need. The appetite is there. The real question is whether our political and economic systems share it.

Nowhere is this disconnect clearer than in cancer. We are living through an extraordinary era of scientific progress, with immunotherapies, targeted treatments and personalized medicine transforming what is possible. Yet we have not even closed the old equity gap, and already a new one is opening.

Millions of people still lack access to basic diagnostics, surgery, radiotherapy, essential medicines and palliative care. Now we risk creating two worlds of cancer care: one benefiting from genomic testing, precision oncology, immunotherapy and the latest therapies, and another still waiting for the basics. What does scientific progress mean if your chances of benefiting from it still depends on where you were born or what you can afford?

We must ask whether our systems are truly designed around health. Governments operate within short political cycles, while prevention demands sustained investment over decades. Markets reward innovation, but not necessarily affordability, prevention or equitable access. The result is a fundamental mismatch between what our systems incentivise and what healthier societies actually need.

And then comes the more difficult question: is there a serious appetite not simply to aspire to healthier and more equitable societies, but to advocate and fight for them when it really matters?

Nowhere is that question more painfully tested than in the genocide in Gaza, where these contradictions reach their most unbearable extreme. What does "health equity" mean when hospitals and ambulances are targeted and attacked, healthcare workers are killed or detained, and cancer patients are left without diagnosis or treatment – or even the most basic right to die free from pain?

This is where our commitment to equity is truly tested. It is easy to advocate for health equity in declarations, conferences and strategies. It is far harder to defend it when doing so is uncomfortable, politically difficult or controversial. Yet surely that is precisely when our voices matter most.

For me, what has made this even more shocking and deeply disappointing has been the loud silence from much of the global cancer community. We are a community that speaks passionately about equity, universal health coverage and leaving no cancer patient behind. But these principles cannot apply only when they are easy or politically comfortable to defend. They must matter most when they are hardest to uphold.

If we cannot raise our voices for cancer patients when their very access to care is being destroyed, then we must ask ourselves what our commitment to equity truly means. And if the right to health disappears in war, can we truly call it a right?

So yes, the appetite for a healthier, more just and equitable world exists. We have unprecedented scientific knowledge, extraordinary innovation and resources that previous generations could scarcely have imagined.

What we lack is the collective courage to align our political and economic priorities with what people actually value: life, dignity and wellbeing – and to make health and equity non-negotiable, everywhere.

RESPONSES

David Reddy, *Director General, The International Federation of Pharmaceutical Manufacturers and Associations (IFPMA)*

The future of health globally will be shaped by how effectively we can translate scientific progress into better health outcomes. This cannot be done by one institution or sector, but will be built through partnerships that strengthen health systems and ensure that innovation reaches the people who need it most.

Today, we have unprecedented tools to prevent, detect, treat, and even cure disease. In cancer alone, advances in vaccines, diagnostics, precision medicine, immuno-oncology, and cell and gene therapies are transforming outcomes, with more than 4,700 potential cancer medicines in development. Every €1 invested in cancer medicines is estimated to return €6.80 in societal and economic value. Similar breakthroughs are reshaping our response across non-communicable diseases, which today account for nearly three-quarters of global deaths and increasingly define the health and prosperity of nations.

Innovation can only fulfill the potential of science when people can access it. It also requires stronger health systems, sustainable financing, and effective collaboration across governments, industry, healthcare professionals, patients, and civil society.

Modern multilateralism should enable countries to build healthier societies through investment, knowledge sharing, and long-term partnerships. When innovation, access, and collective action work together, health becomes not only a development outcome, but an investment in societal resilience and economic growth.

RESPONSES

HE Dr Leslie Ramsammy, *Ambassador and Permanent Representative of the Cooperative Republic of Guyana to Switzerland*

Global solidarity-based multilateralism has been weakened by fragmentation, inefficiency, misaligned mandates, development assistance contraction and the emergence of transactional multilateralism, resulting in threats to decade-long gains and impeded progress towards a healthier, more just and equitable world.

A reimagined, fit-for-purpose multilateralism for a healthier, more just and equitable world, without transactional geopolitical limitations, respecting national and regional voices, and based on human rights, must facilitate global resources for strengthening and transforming health systems by building adequate national capacities for biosecurity, health emergency responses, reduced child and maternal mortality, comprehensive capacity for critical care and surgical interventions, access to technology, including digital and AI technologies, a fair supply chain, health human resource, and to combat other challenges so that every country has a life expectancy of at least 80 by 2050 (80 x 50).

The remodeled health architecture must adopt country-led approaches to respond to poly-crises, such as non-communicable diseases, achieve the SDGs and its successor and the WHO's cervical cancer goals, build Universal Health Coverage, implement the principles of the Lusaka Agenda, the Accra Reset and the Pandemic Agreement and transform vertical Global Health Initiatives such as GAVI, Global Fund, Pandemic Fund, UNITAID and Global Financing Facility to align with country-based integrated approaches.

RESPONSES

Dr Dingle Spence, *Clinical Oncology and Palliative Care Honorary Consultant, University of the West Indies, Kingston, Jamaica*

Cancer control is an increasing global problem, we know what needs to be done, but are we willing to implement what we already know, so that everyone can benefit?

The 2026 WHO Global Cancer report reminds us that the global cancer story is one of profound inequity, and that gap is widening between HICs and LMICs. A shift in educational approaches to understanding the spectrum of cancer care can help us close this gap.

The report calls for three shifts. Better capabilities, better protections, better value. We cannot address these without supporting better broad-based cancer education. Greater cancer literacy is mandatory for healthcare professionals and the public alike.

The demystification of cancer is a high priority. Policy implementation requires a wide spectrum of educated professionals to carry it out. Time to shift from a place where oncology education is siloed in specialism, is narrow and vertical in approach, to a wider, more horizontal-based approach, particularly in LMICs where cancer control needs to be focused more on prevention and early detection.

Can we view oncology education as a pyramid with a wide flat base, where all are included, tapering to a point where super specialization dwells? In a healthier, more just and equitable world oncology education for all must be prioritized.

RESPONSES

Dr Lorna Renner, *Associate Professor at the Department of Child Health, University of Ghana School of Medicine and Dentistry and the Head of the Paediatric Oncology Unit, Korle Bu Teaching Hospital, Accra, Ghana*

The 21st century is an age of design and calls for a healthier world, but there should also be a greater hunger, particularly in LMICs, for a more just and equitable world, not just an appetite. The maldistribution of healthcare, using childhood cancer from my standpoint, as a typical example, with 80% of cases occurring in LMICs, over 80% survival in HICs and less than 30% in LMICs paints a picture of the skewed distribution of the burden, resources, treatments and outcomes. This maldistribution which is evident not only from HICs to LMICs but also in-country, is the consequence of poor social policies and programmes, unfair economic arrangements, and lack of political will and champions.

The inequalities we see in health are linked to inequalities in society and reducing them is a matter of fairness and social justice. This is based on the ideology by Marmot and colleagues (2010) in England entitled "Fair society, healthy lives," commissioned by the United Kingdom's

Department of Health. Taking action to reduce these inequalities in health does not require a separate health agenda, but action across the whole of society, social determinants of health.

With current geopolitical disruptions, the priority is on increasing defence budgets and "traditional" donor funding to the health sector has dwindled – a misalignment of our desires and actions. The commitment of the UN agencies such as the WHO is evidence of an appetite for social justice. It may seem as though nothing is being done but there exist frameworks to get us there. Post the Millennium Development Goals (MDGs), lessons learned ushered us into Sustainable Development Goals (SDGs). The SDGs recognize that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are inextricably linked, not only to each other, but also to population health. Back to Childhood Cancer, the WHO launched the Global Initiative for Childhood Cancer in 2018 with its CUREALL framework, promoting domestic efforts and collaborative partnerships with health sovereignty in mind, to address health inequities.

We have the appetite to transform our world, exemplified by all the frameworks; however, what we need today is hunger for implementation, and better redesigning of our current efforts.

RESPONSES

Karen Canfell, *Lead, Cancer Elimination Collaboration, Sydney School of Public Health, The University of Sydney, Australia*

The global burden of cancer is enormous. In 2024, an estimated 20 million people were diagnosed with cancer, and the number of people dying from cancer approached 10 million. Underpinned by population health and ageing, and fuelled via the current inequitable access to evidence-based interventions at global and within-country levels, this burden is set to increase to 35 million diagnosed and 18 million dying from cancer by 2050 *(1)*.

The challenges in cancer control loom even more acutely in the context of the major shifts since 2025 in the global health funding landscape, and the consequent adjustments and re-prioritization processes that are now occurring.

The traditional development models, involving donor-funded and time-limited programmes, can only be the first part of the solution. The aim must continue to be that country- and community-led initiatives are embedded into health systems and that these are associated with enduring political commitment. Key to this must be the provision of high-quality, flexible technical assistance in cancer control policy and in the implementation of evidence-based strategies.

WHO's Cervical Cancer Elimination Initiative (CCEI) and the Global Breast Cancer Initiative (GBCI) are evidence-informed approaches to reducing the burden of cancer in women, especially in LMICs. These initiatives have enormous potential to provide a backbone for health systems strengthening, from primary care to oncology, and their momentum should be harnessed accordingly.

1. Data from IARC Global Cancer Observatory, 2024. https://www.who.int/news/item/01-02-2024-global-cancer-burden-growing--amidst-mounting-need-for-services