CLOSING THE GAPS IN CANCER PREVENTION AND CONTROL: IS A NATIONAL CANCER ACT THE SOLUTION FOR SOUTH AFRICA?

POLICY BRIEF
**Summary**

South Africa is facing an impending crisis as regards cancer prevention and control. The *Percept Report* predicts that with escalating cancer incidence in South Africa, an additional R50 billion will be needed by 2030 to mount an effective public health response. However, given inadequate state funding to meet these demands together with poor coordination of services, geographic disparities and public vs private inequities, it is highly unlikely that the country will be able to fulfil its human rights obligations to cancer patients. It is against this backdrop of burgeoning need, that we investigated legal responses to similar challenges in six countries with national cancer acts (NCAs). Although there are differences between these NCAs, the United Kingdom (UK), the United States of America (USA), Japan, Kenya, the Philippines and Chile share similar approaches to: developing a national cancer plan; establishing a national cancer prevention and control coordinating body; financing cancer care and research; ensuring social protections; achieving equitable services; improving cancer surveillance; and, instituting accountability mechanisms. Given the urgency to solve South Africa’s current health policy deficits regarding cancer, we suggest key lessons that could be leveraged to generate legislative reform.

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**Policy conclusions**

- To address cancer prevention, control, care, palliation and research in a comprehensive manner, countries around the world have successfully implemented NCAs to coordinate resources and ensure accountability;

- Options for South Africa would be to follow suit, and develop our own dedicated NCA, or to amend existing legislation to achieve more equitable outcomes for cancer diagnosis and treatment, as well as institute social protections for people living with cancer;

- While a systematic review of levers and gaps in existing legal frameworks is required, obvious legislation open to such amendments are: the *National Health Insurance Bill* [B11-2019] and the *Basic Conditions of Employment Act*;

- Key stakeholders from government, health professionals, civil society and the private sector are called upon to initiate a national debate on how best to address the legislative and policy gaps in our current cancer frameworks.

**Introduction**

The purpose of this policy brief is to share considerations for an NCA in South Africa, as well as guide decision makers and stakeholders on requirements for goal setting, funding and accountability mechanisms. These outcomes are crucial to ensuring equitable access to comprehensive population-based cancer care for all in South Africa, particularly as the country is facing a growing cancer burden.

Drawing lessons from a desktop review of six NCAs, we contrast South Africa’s current cancer legislative and policy frameworks to derive key elements that could be incorporated into new legislation for South Africa.

**Scope of cancer care**

As South Africa recovers from the COVID-19 pandemic, and manages other competing health crises, the state must rethink how it prioritises public health resources for cancer. This is even more critical with the recent passage of the *National Health Insurance Bill*. While NHI intends to improve access to health care services, it only describes a financing mechanism at present. There is no mention of the minimum benefits to be covered, nor is there a definition of quality standards for health care services. In particular, and despite high treatment costs, there is no clarity on standards, processes and outcomes measures for cancer management under the NHI.

The NHI is particularly challenging given that the health needs of South Africans far exceed the current capacity of the health sector. This places immense pressure on an already severely constrained public health system, which serves 84% of the population. In terms of human resources as well, 80% of health care professionals work in the private sector. Of the country’s 200 specialist radiation oncologists, only 20% are employed in public facilities. Therefore, the issue is not simply the lack of resources, but also the inequitable and inefficient distribution of those resources.

Cancer requires coordinated interventions at all levels of care (primary, secondary, tertiary and quaternary) and across the entire continuum of care, including education, prevention, screening, diagnosis, treatment, support, rehabilitation, survivorship, and palliative care through to the end of life. Contemporary evidence-based cancer care further necessitates
investment in costly machinery, technology, medicines and personnel to diagnose, treat and otherwise intervene in the disease process. While these activities are expensive, there are proven priority interventions identified by the World Health Organization based on cost-effectiveness and other considerations aimed at driving down costs, especially with a shift to prevention and early detection programmes.

Why should cancer prevention and control be singled out for special consideration?

Factors, including the prevalence, progression and complexity of cancer prevention and treatment may alone justify privileging cancer for special consideration. In addition, the burden on patients, their families and caregivers to finance treatment as well as the emotional impact and stigma often result in patients delaying, discontinuing or foregoing treatment altogether. Furthermore, the current inequities between public vs private cancer care exacerbate these challenges and support the demand for a dedicated funding stream.

Given the complexity of integrated cancer care, a dedicated focus on cancer will contribute to health systems strengthening, which would then benefit the prevention, early detection, diagnosis, treatment monitoring and palliative care of other diseases and conditions.

- Policies, as opposed to legislation, are often dictated by the political agenda of the government in power, and subject to reprioritisation. Legislation, such as an NCA, would guarantee that cancer remains a priority even with a change in government.

- Regulations are useful but are not always appropriate for cancer which demands a multisectoral and whole of government approach, extending beyond the Department of Health. An NCA, or a considered approach to bolstering existing legislation, would provide coordination over the current fragmentation characteristic of cancer prevention and control.

- Finally, as evidenced in other countries, an NCA would provide leveragability for coordination and coherence as well as accountability for the delivery of cancer prevention and control mechanisms across all nine provinces of South Africa.

South Africa's commitment to provide equitable cancer care services

South Africa has a duty to uphold certain legal obligations having ratified both international and regional instruments that compel the country to respect, protect, promote and fulfil the human right to health. South Africa has ratified the African Charter on Human and Peoples’ Rights and is a signatory to the International Covenant on Economic, Social and Cultural Rights (ICESCR). Both frameworks recognise the ‘right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ and place a duty on states parties to realise that right progressively. The CESCR Committee further defined the right to health in General Comment No. 14 (GC 14) in 2000, which is used globally to assess and guide governments’ legal obligations to attain the right to health. Currently, South Africa is also striving to meet the Sustainable Development Goals (SDGs) by the year 2030, notably SDG 3.4 which aims to ‘reduce premature mortality from NCDs by one-third through prevention and treatment as well as promote mental health and well-being’; and SDG 3.8 which seeks to ‘achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.’

In 2017, many countries including South Africa made a commitment to invest further in cancer control as a public health priority, through the adoption of the World Health Assembly (WHA) Resolution 70.12 on Cancer Prevention and Control, by adopting an integrated approach. This requires states to monitor and address inequalities that impact access to safe, affordable and high-quality cancer-related health services by responding to six priority areas: ‘governance; prevention; early detection; management; palliative care; surveillance and research.’
Current gaps across six priority areas in South Africa

1. Cancer policy framework and governance

South Africa lacks a national cancer prevention and control plan, as well as a coordinating body to set, implement and finance strategic decisions. The National Cancer Strategic Framework for South Africa 2017 - 2022 remains largely unimplemented and has been extended by one year. The Cervical Cancer Prevention and Control Policy 2017 (updated from the previous 1998 policy) continues to experience challenges, as cytology-based screening programmes at primary care level and subsequent referral pathways for treatment at higher levels of care are still being implemented across the different provinces. The Breast Cancer Prevention and Control Policy of 2017 is ineffective due to the lack of implementation at the provincial level. Importantly, these policies were developed to set minimum standards of care with little or no attention to eliminating health care inequities. The National Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2022-2027 prioritises the prevention and early initiation of treatment for diabetes and hypertension, but not cancer. Broader frameworks like the National Development Plan and the Medium-Term Strategic Framework (2019-2024) provide limited attention to non-communicable diseases (NCDs) compared to communicable diseases, like HIV, AIDS and TB.

2. Cancer prevention

Similar to other NCDs, cancer risk factors include tobacco use, alcohol consumption, physical inactivity, unhealthy diets (linked to overweight and obesity) and exposures to environmental and occupational hazards. South Africa has taken steps in this regard through legislation and regulations on tobacco, alcohol and obesogenic diets. However, these measures have been insufficient in tackling the NCD crisis and adequately mitigating cancer risks, due to weak provisions and poor implementation.

3. Early detection

Appendix 3 of the WHO Global Action Plan on NCDs 2013-2030 identifies early detection programmes linked with timely diagnostic work-up and comprehensive cancer treatment for cancers of the breast, cervix, colorectum, prostate, head and neck (including oral cancers) and childhood cancers. There are also associated global initiatives adopted through WHA mandates for childhood cancer (2019), cervical cancer elimination (2020) and breast cancer (2021). South Africa is lagging behind peers across Africa in responding to these highly cost-effective priorities in terms of policy and implementation.

4. Cancer management

The intended cooperative but decentralised health system created by the National Health Act No. 63 of 2003, as amended, has not been able to achieve uniformity or equity in the delivery of cancer health services. The Medical Schemes Act 131 of 1998 offers little benefit. As a Cancer Alliance report has shown, even those who can afford private medical aid are often not guaranteed quality cancer treatment due to imposed limits on cost and/or invoking Prescribed Minimum Benefits (PMBs) that outline what medical aid schemes will cover. Despite the existence of the Medicines and Related Substance Control Amendment Act No. 90 of 1997 and the Patents Act 57 of 1978, as amended, the affordability of cancer medicines remains out of reach for most patients. The 24 Medicine Case study report has shown that the cost of some cancer medicines in South Africa are more than double the price of, for example, the same in India. This is due to our country's weak patent systems, including: poor patentability criteria, easy granting of patents, unnecessary issuance of secondary licences, and limited mechanisms to challenge patents before they are granted.

In addition to state-of-the-art cancer prevention and treatment, social and employment protections for patients and their families/caregivers are essential. The Employment Equity Act 55 of 1998 and Labour Relations Act 66 of 1995 delineate these protections for patients who are unable to work due to their disease and its treatment. However, unlike in many other countries, cancer patients do not meet the criteria for persons with recognised disabilities, and hence do not receive the same protections.
5. Palliative care

The management of advanced and terminal cancer diagnoses necessitates cross-cutting palliative care for all South Africans. Home-based and hospital care with multi-disciplinary teams and access to opiates and other pain management modalities are essential. Supportive medicines are also part of Appendix 3 of the Global Action Plan on NCDs and embedded in the 2014 resolution ‘Strengthening of palliative care as a component of comprehensive care throughout the life course’ (WHA67.19). The National Policy Framework and Strategy on Palliative Care remains unimplemented across the provinces.

6. Research

Despite budgetary constraints, a recent bibliometric analysis of cancer research outputs across Africa identified the high research output of South Africa compared to most other African countries. These research investments should be harnessed further to improve the evidence base for local cancer prevention and control mechanisms. Implementation research could include studies on health outcomes, quality of life and cost-effectiveness as defined in the 2017 resolution, ‘Cancer prevention and control in the context of an integrated approach’ (WHA 70.12) and should be a key component of a national cancer control plan.
National Cancer Acts: six country lessons

Table 1 presents a comparison of how the UK, the USA, Japan, Kenya, the Philippines and Chile have each dealt with standard setting for prevention, treatment and control as well as expanded social, financial and employment protections through their NCAs. These experiences offer critical lessons for

Table 1: Summary and impact of national cancer acts in six selected countries

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<thead>
<tr>
<th></th>
<th>United Kingdom</th>
<th>United States</th>
<th>Japan</th>
<th>Kenya</th>
<th>Philippines</th>
<th>Chile</th>
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**Key provisions contained in the acts**

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<th>United Kingdom</th>
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<th>Kenya</th>
<th>Philippines</th>
<th>Chile</th>
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<tbody>
<tr>
<td><strong>Dedicated national cancer control body</strong></td>
<td>None¹</td>
<td>National Cancer Institute</td>
<td>Cancer Control Promotion Council</td>
<td>National Cancer Institute</td>
<td>National Integrated Cancer Control Council (NICCC)</td>
<td>National Cancer Commission</td>
</tr>
<tr>
<td><strong>National cancer plan / programme</strong></td>
<td>National Health Service (NHS) Long-Term Plan; UK 10-Year Plan 2022</td>
<td>National Cancer Program: State Comprehensive Cancer Control Programmes</td>
<td>The Basic Plan to Promote Cancer Control</td>
<td>National Guidelines for Cancer Management</td>
<td>NICCC mandated to formulate relevant plans or programmes to combat cancer</td>
<td>National Cancer Plan</td>
</tr>
<tr>
<td><strong>Cancer prevention efforts</strong></td>
<td>Identifies prevention as a key priority area</td>
<td>Funds research on cancer prevention</td>
<td>Promotes prevention efforts</td>
<td>Establishes County Cancer Prevention Control Committees</td>
<td>Mandates key preventive measures</td>
<td>Links to National Cancer Plan</td>
</tr>
<tr>
<td><strong>Equitable access to care</strong></td>
<td>Establishes the National Institute for Health and Care Excellence (NICE) 1999</td>
<td>Mandates establishment of state cancer control programmes</td>
<td>Promotes even distribution of cancer treatment and care</td>
<td>Focuses on the most vulnerable populations. Ensures equitable access to full range of cancer prevention and control services.</td>
<td>Prioritises equitable access to cancer care especially for the poor and marginalised.</td>
<td>No specific measures</td>
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¹While the NHS is a national financing scheme for health care services, it is not a coordinating body dedicated to cancer prevention and control activities.
<table>
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<tr>
<th><strong>Funding for cancer research, treatment and innovation</strong></th>
<th>Establishes the Innovative Medicines Fund for the acquisition of new cancer drugs and treatments</th>
<th>Prioritises cancer research through the National Cancer Program</th>
<th>Promotes cancer research for the early approval of drugs and medical devices</th>
<th>None</th>
<th>Funds cancer treatment and research</th>
<th>Establishes cancer fund for research</th>
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</thead>
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<tr>
<td><strong>Patient protection and human rights</strong></td>
<td>Protects the public against fraudulent cancer treatments, cures or quackery. Human rights language is not included explicitly</td>
<td>Health rights are not included in US Constitution and do not feature here</td>
<td>Health is recognised as a human right in the Constitution</td>
<td>Supports the right to health in the Constitution, together with a National Health Insurance program</td>
<td>Protects the rights of cancer patients. The right to health is enshrined in the Constitution</td>
<td>Incorporates the law that protects rights of patients receiving health care. The right to the protection of health was enshrined in Chile’s first Constitution (1925)</td>
</tr>
<tr>
<td><strong>Social protection</strong></td>
<td>NHS provides general free access to health care and some at home support</td>
<td>None</td>
<td>None</td>
<td>Patients protected against discriminatory practices</td>
<td>Social and financial protection for cancer patients and families</td>
<td>Dedicated Cancer Fund; however, this is not linked to individuals</td>
</tr>
<tr>
<td><strong>Minimum standards/quality of care</strong></td>
<td>Regulated by the NHS Long-Term Plan to improve diagnostic, therapeutic and screening capacity, quality and personalised care. NICE also evaluates cost benefit/value of expenditure</td>
<td>National Cancer Centres deliver quality cancer treatments</td>
<td>Early care, maintenance and palliative care are prioritised according to specific conditions of each patient</td>
<td>Sets general standards and guidelines for delivering cancer care services for more than 20 types of cancer.</td>
<td>Provides care standards across the cancer continuum and access to medicines</td>
<td>Clinical guidelines reviewed every two years to accommodate new advances and technologies</td>
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<td><strong>Palliative Care</strong></td>
<td>Regulated by the NHS Long-Term Plan and NICE (not within the National Cancer Act)</td>
<td>Linked to National Cancer Centres that provide cancer care</td>
<td>Focuses on palliative and end of life care, extending to at home training for caregivers</td>
<td>Sets out National Palliative Care Guidelines</td>
<td>Enables access to palliative care and medicines</td>
<td>Linked to National Cancer Plan</td>
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<tr>
<td><strong>Public awareness/education</strong></td>
<td>Regulates the availability of information on cancer treatments and cures</td>
<td>Cancer Centres provide public education especially to underserved populations</td>
<td>Regulates public institutions to collect and provide information</td>
<td>Regulates consumer information.</td>
<td>Establishes detailed requirements for cancer education and awareness</td>
<td>Linked to National Cancer Plan</td>
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<tr>
<td>Participation</td>
<td>Broad participation through a decentralised model and National Comprehensive Cancer Control Plan</td>
<td>Encourages public participation from all concerned parties</td>
<td>Encourages multisectoral participation</td>
<td>Requires participation of various stakeholders within and outside government</td>
<td>Participation is a guiding principle of the Act</td>
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<tr>
<td><strong>Cancer surveillance</strong></td>
<td>Establishes the National Cancer Registration and Analysis Service</td>
<td>Regulates population-based and hospital-based cancer registries; Cancer Registry Promotion Act 2016</td>
<td>National Cancer Registry</td>
<td>Makes cancer a notifiable disease, with both population and hospital-based registries</td>
<td>Makes cancer a notifiable disease, and requires mandatory notification</td>
<td></td>
</tr>
<tr>
<td><strong>Accountability mechanisms</strong></td>
<td>None</td>
<td>Annual report by the Director of the NCI</td>
<td>Monitoring and evaluation framework linked to Strategic Plan</td>
<td>Annual report by the Secretary of Health</td>
<td>Annual report by the Ministry of Health</td>
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<tr>
<td><strong>Overall impact on access to care</strong></td>
<td>- Improves access to effective treatment - Invest in research and funding - Establishes a culture of patient protection</td>
<td>Increases funding for research on cancer prevention and treatment</td>
<td>Improves quality of care, especially patient-centred care and palliative care</td>
<td>Improves priority setting</td>
<td>Establishes the National Cancer Plan 2022-2027 - Increases expenditure for cancer care</td>
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Recommended elements for an NCA in South Africa

To provide overarching coordination of existing legal, policy, budgetary and regulatory frameworks and/or accountability mechanisms, any legislative response to expand health care access for cancer should include:

- **Tasking of a national cancer prevention and control coordinating body**
  To steer cancer priorities through policies, programmes and reforms and align stakeholders to ensure implementation of national cancer plans across all nine provinces as well as establish mechanisms for monitoring, evaluation and revision.

- **Cancer programme/plan**
  To establish clear and measurable objectives as well as monitoring and evaluation to inform investment in and budgeting for cancer.

- **Cancer financing**
  To guarantee funding for cancer treatment and care as well as cancer research and innovation.

- **Strengthen the availability, quality and equitable distribution of cancer care**
  To use evidence-based research for setting common cancer standards of care for both public and private sectors as well as ensuring patient-centredness.

- **Social protections**
  To provide cancer patients and their families financial assistance that might include coverage for cancer related absences from work, support for caregivers, etc.

- **Cancer surveillance**
  To enhance data collection and population-based reporting on cancer.

- **Accountability mechanisms**
  To ensure oversight, compliance, monitoring and evaluation in relation to implementation of the

**Conclusion and way forward**

We call upon legal experts to come together with public health practitioners in the cancer field, cancer treatment specialists, cancer survivors and advocates from across the spectrum of prevention and control, to address the urgent gaps in the South African legislative approach to achieving equitable cancer care.
References for further reading and additional information


30. World Health Assembly: Strengthening of palliative care as a component of comprehensive care throughout the life course. Available from: http://tinyurl.com/mpdb2h4v
Authors

This study was conducted as a research collaboration between Cancer Alliance (Salomé Meyer), Cancer Association of South Africa (CANSA) (Jane Harries), the Institute of Cancer Policy, King’s College, London (Julie Torode) and the Department of Family Medicine, School of Clinical Medicine, Faculty of Health Sciences, Wits University (Laurel Baldwin-Ragaven), with contracted research support from the Dullah Omar Institute for Constitutional Law, Governance and Human Rights, University of the Western Cape (Ebenezer Durojaye, Paula Knipe and Aisosa Jennifer Omoruyi).