The Facts

The concept of providing person-centred care to improve patient outcomes has been applied to many areas of health but is often not seen as central to cancer planning due to the misconception that cancer is a disease that can only be diagnosed and treated in specialist care facilities.

Primary care has a role in all stages of the cancer control and care continuum. Early detection of cancer, preventive care to reduce the incidence of poor health, health promotion to reduce exposure to cancer risk factors and provision of survivorship and palliative care can be delivered in an efficient, sustainable and equitable manner as part of primary health care services.

A Global Solution

The development and implementation of an essential primary care benefits package for cancer as part of comprehensive national cancer control plans is critical to providing an effective, sustainable and equitable response to national cancer burdens.

Practical evidence-based interventions can be delivered by primary care professionals and community health workers that are feasible and cost-effective for prevention, early detection of cancer signs and symptoms and delivery of survivorship and palliative care services. This core set of interventions can be expanded over time based on local requirements and the level of available resources.

Of equal importance is the development of a skilled primary care workforce and making the public, policy makers and health professionals aware of the benefits for both the health system and patients when cancer services are fully integrated into primary care.

Non-specialized human resources and primary and secondary levels of care can be used to deliver several components of cancer care and control and this can help to partially overcome the shortage of specialty services.

Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries

Supporting Evidence

There is a considerable evidence base showing that strong primary care contributes to overall health system performance (quality, efficiency and equity) and to improved health outcomes.

A person-centred, comprehensive and integrated approach to cancer that provides continuity of care with a regular point of entry into the health system - some of the key aspects that differentiate conventional health care from primary care - is cost-effective and feasible for cancer prevention, early detection and management of care in all settings.

- **Education and awareness**: Although awareness in developing countries remains low, even among health professionals, levels of concern about cancer are high, and the public pays attention to messaging about cancer. Awareness and education programmes targeted at communities, health professionals and policy makers can improve knowledge of cancer and cancer prevention and early detection strategies; dispel common misconceptions about cancer; and prevent stigma by the community, especially for women. Cancer outcomes cannot improve unless patients and the health care community understand the benefits of early detection and are willing to support timely diagnosis and treatment.

- **Prevention**: Primary care professionals and community health workers should be a major source of health and lifestyle advice for primary prevention focused on reducing exposure to the major modifiable causes of cancer, including tobacco, harmful alcohol use, inactivity and unhealthy eating. Due to the large burden of cancer from infectious agents, cancer prevention through vaccination should be delivered in the primary care setting including the provision of HPV and HBV vaccines through national immunisation programmes to address cancer-related infections to reduce the future burden of cervical and liver cancers.
Supporting Evidence

- **Early Detection and Treatment:** Early detection accessed through primary care can improve uptake and public awareness of cancer screening programmes. Raising awareness about early cancer diagnosis to health professionals in primary care is a critical component to achieving reductions in cancer mortality. Early recognition is particularly relevant in the context of primary care in low-resource settings — it is cost-effective and in some cases does not require any specialist diagnostic technologies as is the case with clinical breast examination and inspection for oral cancers. For cervical cancer, the screen and treat approach that combines VIA or HPV DNA testing with cryotherapy for early detection for women 35 to 42 years is currently recommended as part of the WHO package of essential core noncommunicable (PEN) disease interventions for primary health care in low-resource settings.

- **Survivorship Care:** Greater access to cancer control and care in low- and middle-income countries, and consequently, to reduce mortality and morbidity from cancer, will make it increasingly important to incorporate survivorship as part of care. There are currently more than 28 million cancer survivors worldwide, and people now diagnosed with cancer are increasingly likely to survive at least five years. The most effective way to expand survivorship care in low-resource settings is through a diagonal approach that involves the primary care network as well as community-based programmes. This approach will also help to reduce stigma and discrimination.

- **Palliative Care:** Countries must invest in the policies and procedures that enable access, effective and safe prescribing, dispensing and administering of key medications, especially opioids including morphine which is included on the WHO core list of medicines required for implementing essential NCD interventions in primary care. For a terminally ill patient, the ability to meet their specific needs including enabling a patient to die in the place of their choice, which for some will mean at home, is an important part of quality palliative care.

Meeting the Challenge

**Addressing the funding and policy gap:** The evidence that primary care can deliver better health outcomes at lower cost is strong. Despite this, investment in per capita health expenditure in many countries is low, making it difficult to integrate cancer interventions into primary care in a comprehensive manner. The trend for donor funding in the last decade to focus on vertical, disease-specific outcomes has resulted in an under-investment in health systems that are critical to supporting the primary care transition to offering cancer care. There is an urgent need to shift the balance of investment to health systems, to improve resource coverage and focus on integrated care management at the primary level and fail-safe access to care. Involving health systems in diagonal healthcare approaches that focus on the integration of health services, including integrating cancer prevention and management into primary health care will tackle cancer-specific priorities while addressing the gaps within the health system, optimising the use of resources and improving coverage for many diseases and population groups. Adoption of a national policy framework across all sectors of government that includes investment in education, training, health service provision, and research as well as comprehensive tobacco control measures, approaches and strategies to support individuals to lead healthy lifestyles and reduce consumption of salt and alcohol, and communities to engage in managing their health, must work in parallel to ensure that primary care interventions have the greatest impact on disability, morbidity and mortality from cancer.

**Addressing the skills gap:** A significant challenge is providing the workforce required to manage cancer with most developing countries facing a severe shortage of oncologists, and other specialists including pathologists and personnel to operate radiotherapy services. While access to some specialty care is essential, this can be complemented in many ways to build capacity in a skilled workforce at the primary care level. Optimal tasking whereby tasks are both shared among health workers with differing levels of training combined with the shifting of some tasks from specialist health workers to newly trained or less qualified health workers, has proven an effective way to engage expert patients, community health workers, clinical health assistants, nurses and physicians working in primary care level facilities to provide more and better access to cancer control and care services.

**Addressing the infrastructure gap:** The provision of care closer to patients and removing geographical barriers to access can be assisted through greater use of telecommunications to better connect patients, care givers and health providers through technology. At the primary level, training for a range of staff can be enhanced by distance learning through structured courses. This is being undertaken in Mexico, for example, for health promoters, nurses, physicians, and outreach workers around breast cancer early detection through the National Institute of Public Health. In addition, telecommunications can be used to provide access to diagnosis and specialised care in remote primary care facilities through partnerships and linkages with distant oncology specialists, as well as to facilitate exchange of information for decision-making and awareness-building.

**Summary:** Greater emphasis on primary care not only has cost benefits but increases access, improves continuity of care and brings care closer to the home and community. Existing programmes are most often small-scale and under-resourced so that programmes now require evaluation, and lessons learned adapted and incorporated into large-scale programmes.
Building capacity for breast cancer control and care

Using breast cancer as an example, many opportunities exist for optimal tasking and infrastructure shifting to expand access at each stage of the cancer control and care (CCC) continuum.

In terms of health promotion and primary prevention, all players at the primary care level, including community members and community health workers (CHWs), should be trained and engaged in promoting healthy lifestyles and physical activity, and in preventing obesity. This should be part of any anti-poverty, empowerment of women, maternal and child health, or sexual and reproductive health initiatives.

In early detection, CHWs should be trained to identify risk factors related to family history, teach women about breast health and assist them in recognizing warning signs, and help women seek a diagnosis. CHWs can also be trained to perform effective breast clinical exams, especially where the objective is to reduce the number of very late cases that are easily detected with visual inspection. This does not require sophisticated technology such as mammography. During treatment, the CHW can play an active role by supporting the patient, and, in survivorship, by educating the community to prevent stigma.

Well-trained technicians and radiologists at the primary or secondary level of care can undertake mammography, ultrasound, and biopsy, if appropriate medical devices are available. Images and samples can be shared with experts in the remote, specialty facility, via either electronic or physical transfer of files. This can facilitate the diagnosis that must take place at the specialty level.

Much of the adjunct therapy for breast cancer is repetitive (multiple doses of the same agent over weeks, months, or years) and can be provided at the secondary or primary care level, or even at home, if support staff are trained (nurses), basic laboratory facilities are in place, hygiene is good, and effective communication is available to link-up to a specialist in case of a reaction or a needed adjustment in the treatment protocol. If initial doses are managed at a specialty center, the risk of later reactions is minimized.

Ongoing survivorship care, such as therapy for lymphodema, can also be undertaken locally with proper training. Opioid-based pain control can be managed at the primary or secondary level, if drugs are available in appropriate packaging, and if there is guidance and communication with a remote specialist.

Thus, while diagnosis, treatment management, surgery, radiation, and some adjunct treatment should take place in tertiary-level facilities, many components of CCC for breast cancer can be handled in primary- and secondary-level care facilities. All of these activities can be assisted by telemedicine and applications of ICT that increase access to knowledge and awareness.

References