What progress can we point to? In today's global health world, we do now understand that noncommunicable diseases [NCDs] are a priority, and within NCDs, that cancer is the highest priority. But are countries discussing this, and thinking about strategies?

I think we have some important and specific country examples, and some very interesting platforms for financing cancer care that are novel and new, and I talk about "the economics of hope". This includes the incredible initiative in India where, by pooling procurement for 40 specific cancer drugs, they managed to drop the price by about 85% in terms of the reserve price. New initiatives like this, that learned from the GAVI Alliance, and the Global Fund for AIDS TB and Malaria, can go a long way in enabling us to finance global access to essential cancer care.

Another example is what St Jude's children's hospital is doing with WHO and UNICEF, putting US$200 million into a fund to finance essential paediatric oncology medicines around the world. This will allow countries to work together to get a much better price, but it also includes a whole health system strengthening component, and options to be able to help countries bring their health systems around cancer.

In a world where we often say the resources aren't there, it shows that they can come from many different places. These kinds of global and national collaborations can lead us to the kinds of answers that we need, to be able to stop cancer now and in the future.

Where are we failing? One area where I think we've fallen off tremendously is the global pain pandemic, which affects the entire world, but particularly poorer countries. Despite marginal improvements in access over the past 30 years, the 50% poorest in our world still have access to only 1% of the opioid medications. The current opioid epidemic, which is a crisis mainly in the high-income countries of north America, is further obscuring the need to do something about the untreated pain and suffering of poorer countries and communities.

The problem is not cost. It would take around US$ 145mn a year – roughly the annual budget for a mid-sized hospital in the US – to close the global pain divide in palliative care. The problem is politics and policies.

We also need to find ways to guard the progress that we do make from being wiped away by political upheaval or natural disasters. This was a very hard lesson we learned from the experience of the Seguro Popular programme in Mexico, which extended access to healthcare, including certain cancer treatments, to around 54 million people, but was ended with a change in the political leadership.

What should we be advocating for today? The standard answer we get from global health is that we can do a lot of prevention with good public health policies, some vaccination, some screening, and then with access to the basics of treatment, we can save many lives in ways that are not very expensive.

I think we can think bigger. In this post-Covid world we have the opportunity to harness technology in ways that we have never seen before. It would have taken us decades to convince companies, insurances or social security programmes to cover telemedicine. Today that is virtually a given.

What does that mean for cancer? It means that we can bridge distances to the poor in ways that we could never have done in the past – for detection, understanding need, survivorship, and palliative care. I am incredibly hopeful that, if we think in this 'economics of hope' framework, we can achieve a kind of access that defies geographic boundaries. Instead of thinking about these small essential packages, we need to think about new ways of achieving global access. We're never going to have it

all – but we can think way out of the box and do so much more in the world that we are in.

This was one of eight interviews with participants of the World Oncology Forum that were conducted by Cancerworld. *Click on the links below to see what the others had to say.*

> Advocating for accessible cancer care in the global South: are we doing this all wrong?

Nirmala Bhoo Pathy, **Public health physician, University Malaya, Kuala Lumpur**

> "What is not being discussed is how do we improve wellbeing?"

See interview summary | See video

Miriam Mutebe, **Breast cancer surgeon, Agha Khan University, Nairobi, and President Elect of AORTIC, the African Organisation for Research and Training in Cancer**

"We need to think critically about how our healthcare system can deliver the best for patients"

See interview summary | See video

Srinath Reddy, **Founder and Past President of the Public Health Foundation of India**

 "We need to make care affordable and strengthen our health workforce so we have people who can deliver the wide range of services that are needed"

See interview summary | See video

Bente Mikkelsen, **WHO Director for Non-Communicable Diseases**

 "We should think through what is needed to

ensure we have accountability, and simplify the metrics on what success looks like”

See interview summary | See video

Franco Cavalli, **Founder & organiser of the World Oncology Forum, past Chair of the Scientific Committee of the European School of Oncology, past President of the UICC**

“We need another approach, where governments, public spending, taxes, together with development banks play the overarching role in financing the global fight against cancer”

See interview summary | See video

Ben Anderson, **Breast Cancer Surgeon, WHO Global Breast Cancer Initiative lead**


“Our role is not to tell everybody what to do; it’s to create tools so they can do this in the way that is most effective in their environment”

See interview summary | See video

Mary Gospodarowicz, **Radiation oncologist at Princess Margaret Cancer Centre, University of Toronto, co-chair of the Lancet Commission on Cancer and Health, Past President of the UICC**

"We've been talking to decision makers for 20–30 years. It hasn't worked. I think we now have to engage better with the public"

See interview summary | See video