Australian aid and cancer control:
medium-term regional priorities

Options for AusAID consideration in the context of Australia’s regional aid White Paper

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Key recommendations

The Cancer Council Australia makes the following key recommendations in the context of the Federal Government's regional aid White Paper development process.

- That cancer control be recognised as a regional aid priority.
- That AusAID engage with Australian and international cancer control agencies to set measurable goals and scope specific priorities for the Asia-Pacific.
- That AusAID consider forming a partnership with The Cancer Council Australia, WHO Western Pacific Regional Office and other cancer control agencies in both government and non-government sectors, aimed at extending regional networks and maximising aid resources to support cancer control in the Asia-Pacific.
- That cancer control in the Asia-Pacific be identified as an opportunity to achieve broader medium- and long-term regional aid goals.
- That cancer control be recognised as a common challenge in the Asia-Pacific and that consideration be given to collective regional responses, particularly in tobacco control (see below), measures to reduce the incidence of precancerous disease, and building environmentally safer working and living areas.
- That tobacco control in the Asia-Pacific be identified as a key regional health priority in the context of Australia’s aid program and the implementation of our treaty obligations under the WHO Framework Convention for Tobacco Control.
- That AusAID take an active role in facilitating and supporting tobacco control networks involving Australian and international health promotion agencies.
- That AusAID, The Cancer Council Australia and health promotion allies collaborate to scope measures to build early diagnosis and treatment capacity for cancer in the Asia-Pacific.
- That AusAID, The Cancer Council Australia and health promotion allies collaborate to scope ways in which Australian capacity in cancer registration and data management can be shared with developing nations in the Asia-Pacific.
- That AusAID explore options to substantially subsidise the provision and distribution of palliative medicines to developing Asia-Pacific nations, to alleviate pain and improve symptom control in people with incurable cancer.
Overview

Australia has one of the world’s best cancer survival rates,\(^1\) reflecting the quality of early detection, treatment and support services available in this country. The situation among all of our regional neighbours, except New Zealand, is in stark contrast.

According to available data, people younger than 55 throughout the Asia-Pacific region are around 40% more likely to die from cancer than Australians in the same age range.\(^2\) This substantial excess premature mortality does not extend to older age groups, since the majority of people in developing nations die before reaching 65.\(^3\) The markedly higher prevalence of cancer in younger people throughout much of the Asia-Pacific region reduces productivity and adds to the burden of poverty, as well as representing the loss of many potential life years.

The pattern is not uniform. In specific nations and for some specific cancers, the mortality differential is far greater than 40%. Women in Melanesia, for example, are around 25 times more likely to die of cervical cancer than Australian women at any age.\(^2\) Oral cancer death rates in men across Melanesia are more than 12 times those in Australia.\(^2\)

It is important to note that the available data (summarised in Appendix 1, *Cancer mortality comparisons by site and region*) is imprecise due to inadequate diagnosis and incomplete case registration. The real burden of cancer in developing countries is likely to be substantially greater than the official figures indicate.

A moderate investment in the prevention, early detection, treatment and management of cancer in developing Asia-Pacific countries has the potential to deliver enormous returns in terms of health and economic outcomes and the reduction of poverty.

Supporting improved regional cancer control

Cancer incidence, prevalence and mortality impose a major health burden,\(^4\) particularly on developing nations. Trends indicate that the real burden of cancer will grow comparatively higher than the global average in the Asia-Pacific over the next decade.\(^2\)

Given the proven capacity of Australia to manage cancer domestically, there is an obligation on this country to consider ways in which foreign aid could be invested in improved regional cancer control.

Analyses of the impact of cancer in the Asia-Pacific indicate that the four areas where coordinated Australian involvement would produce the best medium-term results in terms of human and economic gain and ongoing capacity building are:

- primary prevention (particularly tobacco control);
- early diagnosis and treatment;
- cancer registration; and
- the provision of palliative medicine.

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\(^1\) Australian Institute of Health and Welfare, Cancer in Australia 2001, 2004
\(^2\) Analysis of GLOBOCAN database, IARC 2005
\(^3\) WHO Healthy Life Expectancy Table, 2005
\(^4\) WHO cancer control programme
Focusing on these four priorities, this document sets out to apply considerations in AusAID’s White Paper Guide for the Core Group (April 2005) to scoping cancer control measures that will ultimately help to facilitate improved duration and quality of life in the Asia-Pacific.

It highlights some of the salient regional cancer challenges and indicates, in general terms, how a moderate Australian investment in skills-sharing and resources could alleviate cancer-related sickness, death and poverty in the Asia-Pacific.

Cancer: a global epidemic

The World Health Organisation recognises cancer as a major global epidemic and has drafted a resolution outlining a policy for its coordinated control. Cancer causes an estimated 7 million deaths worldwide each year, more than 2.4 million of them in the Asia-Pacific. The cost of cancer in developing countries is immeasurable: not only does the limited or non-existent patient data understate the extent of the problem in epidemiological terms, but the death and sickness of people at productive ages also has a far-reaching impact on families and communities.

Cancer incidence is increasing throughout the world, with the burden expected to grow relatively higher in developing countries over the next decade. Tobacco smoking is the greatest single cause of cancer worldwide. Australia’s smoking rates are declining and among the world’s lowest; in contrast smoking rates are on the rise in many neighbouring nations, which will thereby experience significant increases in incidence of many of the most lethal and debilitating cancers over the next decade.

A number of other morbidity, environmental and behavioural factors contribute to higher rates of preventable cancers, particularly among relatively younger age groups, in developing countries. These include significantly higher prevalence of communicable diseases such as hepatitis B (a precursor to liver cancer), HIV (Kaposi’s sarcoma) and human papilloma virus (cervical cancer), and unsafe industrial and domestic practices no longer common in developed countries.

About The Cancer Council Australia

The Cancer Council Australia is Australia’s peak non-government cancer control organisation, representing the eight state and territory Cancer Councils on national and international issues. We have a number of formal partnerships with the Federal Government.

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8 Analysis of GLOBOCAN database, IARC 2005
9 International Agency for Research on Cancer (IARC), www-depdb.iarc.fr/globocan/GLOBOframe.htm
10 Stewart B, Coates A, Cancer prevention, a global perspective, Journal of Clinical Oncology, 2005
As a member of the International Union Against Cancer (UICC), The Cancer Council Australia has a responsibility to contribute to improved cancer control globally, particularly in the Asia-Pacific. To focus our efforts, we have formed a Regional Affairs Working Group (see Appendix 3, page 26), which draws on the expertise of a number of Australia’s leading medical, healthcare and public policy administrators with experience in infrastructure development in the Asia-Pacific.
Cancer control and AusAID’s ‘key considerations’

Three out of every five cancer deaths worldwide is expected to occur in developing countries by the year 2020.11 The capacity to prevent cancer and to significantly improve the lives of people with cancer through medical intervention present an opportunity for Australia to facilitate measurable, self-perpetuating improvements in living standards across the Asia-Pacific region over the next decade.

The nature of cancer, its incidence, prevalence, mortality and projected burden, and Australia’s achievements in cancer control domestically, combine to make a strong case for cancer to be a recognised element of Australia’s regional aid framework.

Cancer control and related public health initiatives in Australia have provided a substantial return on public investment over the past 30 years. For example, a 1997 Australian tobacco control campaign was shown to provide a three-to-one financial return on investment in healthcare costs within a year, with substantially higher gains expected over the medium and long term.12

The following section outlines how Australia could support cancer control in the Asia-Pacific in the context of the key considerations in AusAID’s White Paper Guide for the Core Group (April 2005).

Strategic partnership

The recognition of cancer as a major regional health issue and the development of networks involving AusAID, The Cancer Council Australia and health promotion allies would be pivotal to facilitating improved regional cancer control and, as a result, contribute to a number of broader regional aid goals.

Given Australia’s strong domestic record in cancer control and its cross-sectoral capacity, there are important opportunities to forge international networks to foster information exchange and build ongoing regional capacity to reduce the impact of cancer.

Cancer Council capacity

The Guide for the Core Group reports that AusAID launched a $5 million partnership program in 2004-05 to fund Australian professional and peak organisations to conduct capacity building work with partners in the region. Such an approach to the regional cancer epidemic, on an appropriate scale, would be effective in reducing the financial and human cost of cancer in the Asia-Pacific and would also help facilitate efforts to reduce the impact of other chronic disease in the region.

The Cancer Council Australia and its non-government health promotion allies are well-placed to provide advice and assistance to improve cancer control throughout the Asia-Pacific. We are active through a number of initiatives, such as the Asia-Pacific Cancer Society Training Grants*, and are represented on the Council of the International Union

12 Priorities for action in cancer control 2001-02, Department of Health and Ageing, 2003
* A regional training fellowship, funded through a Cancer Council trust and administered by the UICC.
Against Cancer (UICC). We also have links with the International Atomic Energy Agency and WHO, which have formed the Programme of Action for Cancer Therapy (PACT), designed to build cancer treatment capacity in developing countries.

The Cancer Council Australia has a proven record in working constructively with the Federal Government, with a formal business partnership since 1997 in the form of the National Cancer Control Initiative (www.ncci.org.au) and participation in a number of committees.

We have recently formed a Regional Affairs Working Group (RAWG) in order to take a structured approach to our regional obligations as a UICC member and leading cancer control peak body in the Asia-Pacific. RAWG members (membership list on page…) have international experience and professorial skills in clinical medicine, epidemiology, health promotion and healthcare infrastructure development, and hands-on experience in international trade and politics. The group includes New Zealand representation, to help foster relations and better understand cancer-control issues in developing South Pacific countries.

Academic, institutional and community links

The Guide for the Core Group asks how institutional, academic and community links can facilitate and enhance the effectiveness of Australia’s aid program. The Cancer Council Australia’s and its non-government allies have strong links throughout all three sectors, with representation on our national policy committees from Australia’s leading healthcare and scientific institutes, universities and peak community-based bodies.

We are well placed to bring together common interests across these sectors through a proposed partnership with AusAID aimed at improving cancer control in the Asia-Pacific.

Recommendations:

- That cancer control be recognised as a regional aid priority.
- That AusAID engage with Australian and international cancer control agencies to set measurable goals and scope specific priorities for the Asia-Pacific.
- That AusAID consider forming a partnership with The Cancer Council Australia, WHO Western Pacific Regional Office and other cancer control agencies in both government and non-government sectors, aimed at extending regional networks and maximising aid resources to support cancer control in the Asia-Pacific.

Strategic directions

It is understood that optimal value for Australia’s aid dollar is a key program priority; potential returns, in terms of economic and humanitarian gain and in regional capacity building, would make addressing the growing burden of cancer in the Asia-Pacific a key objective to factor into medium-term strategic planning.
The identification of cancer control as a regional health priority would be the first step. As set out in the following four sections, a moderate Australian investment and improved information-sharing networks, drawing on our domestic experience in areas such as tobacco control, cancer education programs, treatment guidelines and data administration, has the potential to yield substantial medium-term returns.

Regional challenges over the next 10 years

Projections based on available epidemiological evidence and demographic trends\textsuperscript{13} show that developing countries will bear a greater overall cancer burden than developed countries over the next decade. This paper summarises how cost-effective interventions to prevent cancers in the region and to build capacity to manage the expected increase in cancer prevalence will help to meet regional challenges over the next 10 years.

Sustaining growth, building human capacity

As observed throughout AusAID’s policy documentation, economic growth and global participation are essential to building the capacity of developing countries and fragile states to reduce poverty, develop rigorous governance and become self-sufficient.

Developing healthcare capacity, particularly in the prevention and management of chronic disease, is a key to overall national viability. Modest (when measured against potential returns) Federal Government assistance and nurturing of international networks would facilitate the exchange of cancer control ideas and ensure support is well-targeted.

Recommendations:

- That cancer control in the Asia-Pacific be identified as an opportunity to achieve broader medium- and long-term regional aid goals.

Common challenges

While the burden of cancer is projected to grow disproportionately higher for Australia’s neighbours, cancer remains the largest cause of preventable and premature death in Australia and is expected to increase in prevalence here by more than 30% as our population ages over the next 10 years.\textsuperscript{14}

A more unified regional response to the cancer epidemic would benefit Australia as well as our Asia-Pacific neighbours. Although Australia is a recognised world leader in cancer control, we cannot assume to take an exclusive or superior approach to cancer control in the region; Australia can learn from the experiences of developing countries as we move forward to address common challenges. Networks, relationships and joint protocols established as a result may also facilitate a more unified approach to other common health threats, such as those posed by communicable diseases.

\textsuperscript{13} Analysis of IARC Globocan data, 2002
\textsuperscript{14} Cancer incidence and mortality in Australia: projections, Australian Institute of Health and Welfare, 2005
Framework Convention for Tobacco Control

Tobacco is the second-largest cause of death in the world and the largest cause of cancer death. As tobacco control in developed countries improves, the tobacco industry looks increasingly for revenue at developing countries, which are incurring higher rates of preventable chronic disease and death as a result.

In 2003 the WHO’s World Health Assembly developed the Framework Convention for Tobacco Control (FCTC) and urged all countries to sign and ratify the treaty. The treaty requires countries to impose restrictions on tobacco advertising, sponsorship and promotion; establish new packaging and labelling of tobacco products; establish clean indoor air controls; and strengthen legislation to clamp down on tobacco smuggling.

The Australian Government showed regional leadership by signing and ratifying the FCTC in 2004, helping to facilitate its entering into force in February 2005.

Much of the treaty’s effectiveness will depend on its ability to work across international borders. Australia, with the Asia-Pacific’s lowest smoking rates, has a unique opportunity to encourage neighbouring countries to ratify the FCTC and to support the development of cross-border mechanisms to facilitate its effectiveness.

In August 2005, The Cancer Council Australia convened a meeting of Western Pacific tobacco control stakeholders, including representatives of the WHO Tobacco Free Initiative, the Secretariat to the Pacific Community, the Australian Council for International Development, the National Heart Foundation and the Commonwealth Department of Health and Ageing. The group committed to seek collective ways to use the Framework Convention for Tobacco Control to reduce smoking-caused death and disease in the region and to scope ways in which Australian Government agencies could play a facilitative role. A proposal was drafted to offer Australian expertise in areas such as policy development pro bono to neighbouring countries – an example of how skills and experience could be shared and exchanged cost-neutrally by willing partners.

(See Core priority – tobacco control, page 13)

Industrial, domestic risk factors

Millions of people in the Asia-Pacific are at significantly higher risk of cancer, particularly in earlier life, due to exposure to a wide range of risks that are either controlled or no longer common in developed countries.

Prevalent precancerous diseases such as hepatitis B, HIV and human papilloma virus, and unsafe working and living conditions that expose employees and communities to environmental carcinogens, lead to high levels of avoidable cancers.
Recommendation:

- That cancer control be recognised as a common challenge in the Asia-Pacific and that consideration be given to collective regional responses, particularly in tobacco control (see following), measures to reduce the incidence of precancerous disease, and building environmentally safer working and living areas.

Business opportunities

The key priority in regional cancer control is reducing death, disease and suffering. Spin-off effects would include reduced poverty, greater workforce participation due to prevented or delayed onset of disease and the eventual emergence of offshore markets.

While we believe that Australia has a moral obligation to improve cancer control in the Asia-Pacific without any entrepreneurial motive, goodwill and the development of new alliances associated with Australian interventions to reduce the impact of cancer, and a greater Australian understanding of local needs, may provide business opportunities for a range of Australian export interests.

Australian assistance in building infrastructure that reduces environmental cancer risks factors – such as improvements in industrial and domestic food storage facilities, healthier and safer workplaces (eliminating residential and occupational exposure to carcinogens, which are common in newly industrialised centres) – has the potential to open new markets to Australian interests over the next 10 years.

Australian healthcare technology also presents a key export opportunity, particularly if Australia clearly demonstrates an interest in the health and welfare of its neighbours and in building capacity for self-sufficiency.

Medium-term priorities: rationale

The disparity in cancer outcomes between Australia and most Asia-Pacific countries is enormous, but Australia’s capacity to assist is limited. It is therefore imperative to target our assistance where it will provide the best results in terms of humanitarian and economic gains in the context of Australia’s aid program over the next 10 years.

On this basis, and according to epidemiological and empirical evidence, The Cancer Council Australia recommends that Government-supported efforts to reduce the impact of cancer in the Asia-Pacific be focused on primary prevention (including tobacco control, which will be addressed separately due to its extraordinary potential to reduce poverty); early diagnosis and treatment; cancer registration; and palliative medicine.
Primary prevention is by far the most efficient, effective and humane way to reduce the impact of chronic disease, particularly cancer, which is often caused by avoidable environmental factors. Modest, affordable interventions, particularly improvements to infrastructure, can permanently prevent or significantly delay the onset of cancer.

Tobacco control represents the greatest single return for investment in terms of reducing the human and financial cost not only of cancer but of other major chronic disease. It has been identified as a major health priority in developing countries by WHO, the World Bank and the Organisation for Economic Co-operation and Development.

Capacities for early diagnosis and treatment of cancer vary widely throughout the Asia-Pacific. The sharing of Australian expertise could help build capacity in countries which already have rudimentary services, and lay the foundations for longer-term development of treatment infrastructure in areas that have poor or non-existent services.

Cancer registration is inadequately administered in many Asia-Pacific countries. A modest investment in infrastructure and skills transfer would foster permanent improvement in the notification of cancer cases and data management. Cancer control cannot be significantly improved unless epidemiological data is adequately recorded.

Palliative medicine: It will take more than 10 years for cancer control in most of the Asia-Pacific to be at the level we expect in Australia. In that time, up to 3 million people are expected to die of cancer, many in unnecessarily severe pain. The provision of palliative medicine would significantly reduce their suffering.

**Recommendations:**

- That tobacco control in the Asia-Pacific be identified as a key regional health priority in the context of Australia’s aid program and the implementation of our treaty obligations under the WHO Framework Convention for Tobacco Control.

- That AusAID take an active role in facilitating and supporting tobacco control networks involving Australian and international health promotion agencies.

- That AusAID, The Cancer Council Australia and health promotion allies collaborate to scope measures to build early diagnosis and treatment capacity for cancer in the Asia-Pacific.

- That AusAID, The Cancer Council Australia and health promotion allies collaborate to scope ways in which Australian capacity in cancer registration and data management can be shared with developing nations in the Asia-Pacific.

- That AusAID explore options to substantially subsidise the provision and distribution of palliative medicines to developing Asia-Pacific nations, to alleviate pain and improve symptom control in people with incurable cancer.
Core priority – primary prevention (non-tobacco)

Investing in the prevention of cancer has not only been shown to be the most cost-effective\(^{21}\) way to manage the disease in terms of healthcare costs, it also enables more individuals to contribute towards economic and community prosperity and thereby reduces overall poverty.

This section summaries important environmental cancer causes and recommendations for their reduction or elimination; tobacco, the major cause of cancer in the Asia-Pacific, is examined separately in the following section.

Hepatitis B

Hepatitis B is a precursor to liver cancer and is significantly more prevalent in developing countries, particularly among children, in the Asia-Pacific than in Australia (excluding Australian Indigenous communities); cancers of the liver are markedly higher in these developing countries as a result.

It is recommended that AusAID explore, facilitate, or expedite any existing planning to develop a childhood hepatitis B vaccination program in high-need Asia-Pacific countries within the next three to five years.

Food storage

Incidence of cancers of the stomach and gastrointestinal tract has fallen dramatically in developed countries over the past 70 years,\(^{22}\) largely through advancements in food storage technology, most notably refrigeration. This is because major causes of cancer include excessive dietary salt – still widely employed in many developing countries as a food preservative – and carcinogens in fungi that form in inefficiently stored food.

It is recommended that improvements in food storage technology be identified as a regional aid priority in high-need Asia-Pacific countries.

Environmental carcinogens

An important cause of increasing cancer incidence in developing countries is the presence of environmental carcinogens, both in the workplace and home.\(^{23}\) The high speed at which industry is developing in poor- and middle-income nations can lead to unsafe industrial and urban planning practices on a large scale.

Australia is well placed to work with countries in the Asia-Pacific to develop occupational health and safety guidelines and advise on processes and structures for their implementation. Measures could be scoped aimed at discouraging Australian businesses from investing in commercial operations in developing countries that place employees and local residents at unacceptable environmental risk of developing chronic disease.

\(^{21}\) Cancer Strategies Group, Priorities for action in cancer control, Commonwealth of Australia, 2003
\(^{22}\) Australian Institute of Health and Welfare, cancer statistics clearing house
\(^{23}\) WHO, World Health Assembly, Cancer prevention and control, report to the Secretariat, 2005
Core priority – tobacco control

Measures to reduce smoking rates present the best return on investment in alleviating the human and economic burden of preventable chronic disease.\(^24\)

But as smoking rates fall in wealthy nations, the tobacco industry increasingly builds markets in developing countries, adding to the cycle of poverty and to disparities in age-adjusted cancer morbidity and mortality.\(^25\)

The World Bank, WHO and the Organisation for Economic Co-operation and Development (OECD) have all published extensively on the link between tobacco use and poverty, and expressed clear support for tobacco control as a vital strategy in the fight against poverty.

Regional smoking burden

Extensive study on the compound effects of smoking on the health and economies of nations, communities, families and individuals shows that tobacco and poverty form a "vicious circle".\(^26\) Tobacco use disadvantages developing nations in terms of trade balance,\(^27\) productivity and healthcare costs; addiction to tobacco products causes individuals to spend very limited funds on a product that has more than a 50% probability of causing their death, often at the expense of necessities such as food, clothing and shelter, and education programs that could help families escape extreme poverty.\(^1\)

The cycle of tobacco and poverty is exacerbated by markedly higher smoking rates in the Asia-Pacific (see Appendix 2, Smoking prevalence: Western Pacific, South-East Asia, page 25):

- Of the 4.9 million reported global deaths attributed to tobacco use each year, 1.1 million occur in South-East Asia.\(^29\)
- 36% of the world’s smokers live in the World Bank East Asia and Pacific region, which comprises Cambodia, China, Indonesia, Japan, Korea, Lao PDR, Malaysia, Mongolia, Myanmar, Pacific Islands, Papua New Guinea, Philippines, Singapore, Thailand, East Timor, Vietnam.\(^29\)
- In the World Bank East Asia and Pacific region (see above) in 1995, 61% of males and 4% of females aged 15 years and over were smokers.\(^3\) (In stark contrast with Australia’s current rate of around 18.6% of males and 16.3% of females.)
- In China, it was estimated that, on current patterns, about 100 million of China’s 300 million males aged 0-29 in 2002 would die from smoking.\(^3\)

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\(^{24}\) National Centre For Chronic Disease Prevention and Health Promotion, Health Impacts 2002
\(^{25}\) WHO, Tobacco Free Initiative, Tobacco Atlas, 2003
\(^{26}\) WHO, Tobacco and poverty, a vicious circle (2004)
\(^{27}\) FAO Statistical Database, Value of total exports by country for 2002, UNCTAD Handbook of Statistics 2003
\(^{28}\) WHO Regional Office for South-East Asia, Tobacco Free Initiative 2005
\(^{29}\) C K Gajalakshmi, Prabhat Jha, Kent Ranson and Son Nguyen, Global patterns of smoking and smoking-attributable mortality’, Tobacco Control in Developing Countries, The World Bank, 2000
Similar preliminary estimates for India suggested that about 30% of male deaths in middle age were attributable to smoking, and that about 80 million Indian males aged 0-34 years in 2002 would die from smoking.\(^3\)

The WHO Western Pacific Regional Office reports that “Western Pacific Region Member States bear a disproportionate burden of tobacco-related mortality, as the region accounts for 20% of [global] deaths” and that “tobacco consumption causes or aggravates several chronic diseases that together comprise up to 18% of the total disability adjusted life-years (DALYs) lost.”\(^30\)

Projections based on current trends indicate that the burden of smoking will rise significantly over the next decade unless effective tobacco control measures are introduced now.\(^4\)

**Productivity losses**

The WHO estimates that if current trends persist, about 650 million people alive today – roughly one-tenth of the world population - will be killed by tobacco, half of them in productive middle age, each losing 20 to 25 years of life.\(^31\) In 1998, the premature deaths from smoking-related illnesses of an estimated 514,100 people in China alone resulted in a productivity loss of 1.146 million person years.\(^32\)

**Tobacco trade deficits in developing countries**

In 2002, 19 countries had a negative balance of trade in tobacco products of US$100 million or more, including Cambodia, Malaysia, the Republic of Korea and Vietnam.\(^33\)

**Tobacco control and Australian aid and trade policy**

An AusAID-commissioned report published in 2000, which studied the impact of the Asian economic crisis on health in Laos, Vietnam, the Philippines, Thailand and Indonesia, made the following recommendation in relation to health promotion in those countries:

“Provide support to expanding health promotion programs, especially those aimed at preventing non-communicable diseases and injuries.

The leading causes of morbidity and mortality in the countries reviewed in this study (with the probable exception of the Lao PDR) are shifting rapidly to what WHO and the World Bank refer to as Group 2 and 3 conditions. These diseases are related to changes in nutrition, lifestyle, drug, alcohol and tobacco use, environmental and occupational factors, and rapid urbanisation.

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\(^{31}\) World Bank, Curbing the Epidemic: governments and the economics of tobacco control, 1999

\(^{32}\) Jiang Y, Jin S. Social economic burden attributed to smoking in China, 1998

\(^{33}\) WHO, Tobacco facts: Tobacco increases the poverty of countries 2005
As a result of stagnating government revenue, public investment in programs that address these issues is unlikely to increase in the short-to-medium term. This support should initially be in the form of applied health research, especially intervention research studies that develop appropriate strategies to promote good health in the context of the national health profile, culture, risk behaviours and available resources.  

This rationale, applied across the Asia-Pacific and in the context of data and recommendations provided throughout this document, makes a strong case for Australian assistance in tobacco control (See Options for Australian support, page...).

Globalisation and economic growth: the special case of tobacco

In “Australian Aid: An Integrated Approach”, the Government places a high premium on tackling poverty in the Asia-Pacific by “assisting countries to maximise the benefits of globalisation and regional integration”. The Government’s 2005 Statement to Parliament on Australia’s Aid Program states that “economic growth has been the main driver of poverty reduction”, and that “growth drives poverty reduction, and openness to trade and investment is critical”.

One of the Australian aid program’s five “guiding themes” is “assisting developing countries to access and maximise the benefits from trade and new information technologies”.  

The evidence in a 25-year, 42-country study shows that the advantages of trade liberalisation do not apply to the removal of tobacco trade barriers, because increased tobacco demand and consumption, and with them a more costly smoking burden, are the result.

Proven Australian capacity in tobacco control

Over the past three decades, Australia has introduced strong domestic measures aimed at reducing the harm caused by tobacco. These include tightened regulation, restricted advertising, mandatory health warnings, public health campaigns, outlawing sales to minors, taxation and restrictions on smoking in public places. The result is a decline in smoking rates from more than 45% of males and 29% of females in 1977 to around 18.6% of males and 16.3% of females in 2004.

These measures, employed by Australia to demonstrably good effect in health and economic outcomes, are among the requirements of the Framework Convention for Tobacco Control (FCTC), which Australia signed and ratified in 2004 and which entered into force in February 2005.

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34 Macfarlane Burnet Centre for Medical Research, Impact of the Asian Financial Crisis on Health, 2000  
36 Taylor A, Chaloupka FJ, Guindon E, Corbett M., Impact of trade liberalisation on tobacco consumption, 2000  
37 Australian Bureau of Statistics, Health Trends, 2000  
38 National Drug Strategy report, licit drug use, 2005
Options for Australia to support Asia-Pacific tobacco control

FCTC

As a proven leader in tobacco control, Australia is ideally placed to assist Asia-Pacific countries in adopting measures set out in the FCTC to help reverse their increasing smoking prevalence rates.

In August 2005, The Cancer Council Australia convened a meeting of Western Pacific tobacco control stakeholders, including representatives of the WHO Tobacco Free Initiative, the Secretariat to the Pacific Community, the Australian Council for International Development, the National Heart Foundation and the Commonwealth Department of Health and Ageing.

The group committed to seek collective ways to use the Framework Convention for Tobacco Control to reduce smoking-caused death, disease and poverty in the region and to scope ways in which Australian Government agencies could play a facilitative role. A proposal was drafted to offer Australian expertise in areas such as policy development pro bono to neighbouring countries – an example of how skills and experience could be shared and exchanged cost-neutrally by willing partners.

It is our view that there is great potential for AusAID to contribute as an additional partner in the development and implementation of strategies to ensure that the FCTC becomes an effective instrument in reducing death, disease and poverty in the Asia-Pacific.

Trade liberalisation and health promotion

It is imperative that any efforts to reduce poverty through trade liberalisation and regional trade agreements do not have a counter effect by subsequently increasing smoking prevalence.

It is therefore recommended that tobacco products be excluded from the terms of any regional trade agreements between Australia and countries in the Asia-Pacific, unless those countries have signed and ratified the FCTC and demonstrated a capacity to introduce measures that will make it effective, and Australia is prepared to provide such countries with assistance in implementing appropriate FCTC measures to counter the increase in consumption levels that is known to result from trade liberalisation.

WHO has recommended that government trade and aid agencies establish links to this end; on that basis, there is a clear opportunity for AusAID and Austrade to work together to ensure that the breaking down of trade barriers does not inadvertently add to an already enormous smoking burden borne by developing countries in the Asia-Pacific.

39 [http://www.who.int/entity/tobacco/en/](http://www.who.int/entity/tobacco/en/)
General capacity building

In 2000, the World Bank published a series of research findings on tobacco control in developing countries, including a discussion of strategic priorities for international agencies contemplating greater involvement in the area. Suggested capacity building priorities included:

- Improving capacity in counter-advertising, mass information, smuggling control and nicotine replacement therapy (NRT) regulation; analysis of possible subsidies for NRTs for the poor
- Analytic units within public sectors (e.g. investing in finance ministries to build tobacco taxation policies)
- Economic and health policy research within countries to inform and guide control programs

It was suggested that “beyond program implementation, all agencies could adopt policies to strengthen capacity within countries in service delivery, policy analysis, and research, often using existing loans and grants”. The authors considered it likely “that the optimal mix of strategic priorities for tobacco control [would] differ for different countries, depending on their economic, cultural, and political circumstances”. Presently, epidemiological and behavioural research is comparatively limited in developing countries and needs to be expanded, as research findings relating to developed countries may not be applicable.

On this basis, there are a number of potential opportunities for Australia to support research projects in developing countries over the next decade. Reciprocal study and student exchange arrangements, and the sharing of skills and experience, could be explored to help build a rigorous evidence base that would help to ensure relevant health promotion measures are well-targeted and evaluated.

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40 ‘Strategic priorities in tobacco control for governments and international agencies’ in Prabhat Jha and Frank Chaloupka (eds), *Tobacco Control in Developing Countries*, The World Bank, 2000
Core priority – early diagnosis and treatment

Australian input into the development and support of sustainable cancer treatment services in the Asia-Pacific presents a key medium-term opportunity for Australia's aid program.

Cost-effective assistance, much of which could be built around the exchange of knowledge and expertise, has the potential to provide mutually beneficial development opportunities.

Early diagnosis

“Cancer” describes a wide range of diseases affecting most parts of the body. A common feature of all cancers is that treatment is usually more successful and cost-effective the earlier the cancer is diagnosed.

Cervical cancer

The most acute large-scale disparity in cancer mortality rates between Australia and the rest of the Asia-Pacific applies to cervical cancer. Australia has by far the lowest mortality rates in the region; elsewhere, rates vary widely, but at best are 2½ times Australian rates and at worst more than 25 times Australian rates.

It has been estimated that Pap test screening for human papilloma virus, the main cause of cervical cancer, has the potential to reduce squamous cell carcinoma of the cervix by up to 90%. However, the efficiency of screening and follow-up programs varies widely across the Asia-Pacific; in some areas, programs are non-existent.

There is considerable scope for Australian expertise and experience in the early detection of HPV to be applied in the Asia-Pacific and tailored according to existing regional capacity.

The emergence of a vaccine to prevent HPV, currently being developed in Australia, also has great potential to reduce the disparity in cervical cancer mortality between Australia and its neighbours.

Breast cancer

Women in developing countries in the Asia-Pacific aged under 55 die from breast cancer at higher rates than Australian women, resulting in the loss of many potential life years and often depriving poverty-affected families of mothers, relatively young grandmothers and women in other important and productive community roles.

While breast cancer mortality rates in women aged 55 and over are generally lower in developing countries than in Australia (due in part to the differential in overall life expectancy), survival rates are lower outside Australia. 

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41 Australian Institute of Health and Welfare, BreastScreen and National Cervical Screening Program, 1999
42 Analysis of GLOBOCAN database, IARC
Australian advances in the early detection and treatment of breast cancer over the past 20 years have contributed to a steady decline in mortality, despite an increase in incidence due in part to population ageing (and the effect of breast cancer screening). Australia therefore has a lot to offer in improving regional breast cancer outcomes, particularly for relatively younger women who are essential to community viability.

Appropriate interventions would vary according to regional capacity and environmental factors. For example, the application of Australian protocols and expertise could improve outcomes where screening and detection services are being developed. Where screening programs are unlikely to be available in the medium term, women in target groups could be reached by building on basic medical services provided to other community women, for example via ante and postnatal care for which all countries have some capacity.

Australia’s experience in reaching Indigenous women domestically with public health messages – albeit with mixed results – may also be applicable to some communities in neighbouring nations.

General cancers

Innovative, cost-effective approaches aimed at achieving measurable results in the context of Australia’s aid program should be considered for improving the early-stage diagnosis of all cancers in the Asia-Pacific.

The many variations and wide-ranging considerations to this end cannot be documented in a brief overview. However, evidence-based advice on specific details could be provided in response to an in-principle Government commitment to explore options.

Treatment

It is self-evident that screening and early diagnosis are of very limited value where there is no capacity to treat identified cases of cancer or precancerous conditions. Effective cancer control is a multifaceted process, from primary prevention through to supporting people (and their families) at the end of life.

Treatment capacity varies widely across the Asia-Pacific. Approaches need to be tailored accordingly and in full consultation with client/partner nations.

For example, in countries that have some tertiary services but cannot meet demand due to population density, the sharing and coordinated development of treatment protocols could improve patient throughput. In countries where there is no prospect of treatment capacity to meet demand within the medium term due to infrastructure limitations, Australian assistance could contribute to the management of severe cases (see Core priority – palliative medicine) and initial efforts to build capacity over the long term.

44 Australian Institute of Health and Welfare, Cancer in Australia 2001, 2004
45 Principles of practice, standards and guidelines for providers of cervical screening services for Indigenous women, Commonwealth of Australia, 2004
Building capacity

The key evidence-based cancer treatment modalities are surgery, radiotherapy and systemic therapy (including chemotherapy), supported by care from a range of other disciplines. There are a number of areas where Australia could facilitate efficient and cost-effective delivery of these modalities in low- and middle-income countries, including:

- Service planning
- Treatment protocols
- Needs assessment
- Staff training
- Technology transfer
- Facilities development/enhancement.

As well as increasing patient throughput and overall cure rates, improved efficiencies reduce costs and facilitate sustainable infrastructure development. Benefits can also be applied to clinical services targeting health issues other than cancer.

While Australia’s capacity to assist is limited, considerable preliminary work is already underway in analysing the region’s basic requirements and proposing possible solutions for discussion with established and prospective partners, including Australian aid agencies.

A number of organisations are taking the lead in addressing cancer treatment challenges in developing countries. The International Atomic Energy Agency, in collaboration with WHO has developed the Programme for Action for Cancer Therapy (PACT), which is currently scoping ways of building regional capacity. Other entities of WHO and the UICC, along with the Institutes of Medicine and the Collaboration for Cancer Outcomes, Research and Evaluation (CCORE), are also working towards sustainable solutions.

Their efforts could be better coordinated and resourced, and thereby markedly more effective, if formally supported by the Australian Government.

Radiotherapy

Radiotherapy is an effective modality for curing cancer (alone or in conjunction with other modalities), prolonging life and reducing symptoms in palliation. It is of comparatively greater benefit to people in developing countries, who are diagnosed with cancer at comparatively late stages, when radiotherapy is often the most effective treatment.

The challenge, however, is that radiotherapy requires hi-tech, medium- to high-maintenance and largely immobile equipment. Exploring innovative ways to overcome such barriers to make radiotherapy more accessible is essential to reducing overall inequities in health outcomes.

Detailed work, including cost-benefit analyses and the tailoring of proposal to suit existing capacities in varying target countries, is currently being undertaken through PACT, CCORE and other collaborations. The involvement of AusAID would add considerable impact to their self-motivated efforts.
Core priority – cancer registration

If the incidence, prevalence, mortality and epidemiological trends relating to a disease cannot be measured in specific environments, efforts to reduce the burden it poses will be inadequately informed and poorly targeted.

The registration of cancer and the development of cancer epidemiological data therefore play a central part in its medium- and long-term control. However, up-to-date data on cancer in a number of countries in the Asia-Pacific is either inadequate or non-existent.46

Evidence-based medicine

The Cancer Council Australia and its health promotion allies promote the principles of evidence-based medicine, which are based on rigorous scientific study to demonstrate the effectiveness of all interventions from primary prevention through to palliation and which underpin all major treatment advances over the past 50 years.

Developing an evidence base includes identifying cancer trends in particular environments and among specific population groups, a process that relies on the efficient registration and monitoring of cancer incidence, prevalence and mortality.

Australian capacity

Australia is acknowledged as a world leader in cancer epidemiology and is one of a small group of nations with universal cancer registration – a requirement that cancer registries be notified of all diagnosed cases and patient histology.

Australia’s success in treating cancer is dependent of our application of cancer registry data for planning, implementing and evaluating preventive, screening, therapeutic and palliative services.

WHO has identified cancer registration as a key priority in developing nations and already engages Australian epidemiologists as expert advisers on the establishment and operation of registries in a number of Asia-Pacific countries; Australian Government support would benefit all parties.

Options

WHO is currently surveying shortfalls in cancer registration capacity in all developing countries; moderate Australian Government assistance in response to the current position in the Asia-Pacific would facilitate Australian efforts to address the problem and cement our role as a regional leader in cancer control and a proponent of reducing regional disparities in living standards.

The International Association of Cancer Registries (IARC) has developed two-week training courses on cancer registration, often run from its headquarters in Lyon, France.

46 IARC Globocan program.
Opportunities may exist for Australia to run similar courses here, where they would be more accessible to our neighbours. Australian aid could potentially subsidise the attendance of students from high-need countries to training sites overseas and possibly in Australia, thereby investing in a major and lasting improvement in capacity building that would enhance all elements of cancer control in a client/partner nation.

Australia is also ideally placed to support "twinning" arrangements – the modelling of registries in developing countries with ongoing support and advisory input from established registries in Australia.
Core priority – palliative medicine

Up to 40 million people in the Asia-Pacific are expected to die of cancer over the next 10 years. Yet little is known about the final stages of life for those in the most disadvantaged countries.

Healthcare for the dying is given a low priority in developing countries. Coupled with the reported limited availability of effective analgesia using oral morphine, this indicates that a large number of people with incurable cancers suffer unnecessary severe pain and distress as they wait, in some cases for many months, to die.

Options for intervention

Support for general cancer treatment capacity building, particularly if coordinated care is introduced, has the potential to significantly reduce the pain and suffering of advanced and incurable cancer. However, as such an outcome is not a realistic medium-term prospect in a number of key aid-client countries, it is a harsh truth that many thousands of people will die in severe pain and distress without access to palliative medicine.

Opioid medications are relatively cost-effective and widely available in Australia. Given the demonstrated efficacy of morphine in alleviating pain, there is a strong case to explore options to subsidise the provision of morphine to developing nations in the Asia-Pacific and develop protocols and networks to help ensure that it is administered directly to people most in need.

AusAID is well-placed to foster such networks and leverage existing channels to oversee the delivery of medication to appropriately diagnosed and staged patients.

Innovative approaches could be explored to extend domestic subsidising of morphine products through the Pharmaceutical Benefits Scheme to high-need aid-client nations.

Palliative care through radiotherapy

Radiotherapy is an effective treatment modality for controlling cancer symptoms in later-stage patients, such as the majority of those who present for diagnosis in developing countries.

The focus of radiotherapy services in countries with limited capacity operating in population-dense centres is largely on cure. Australian support in the co-development of treatment protocols could boost patient throughput in some centres to a level where radiotherapy could more widely be used as a palliative measure as well as a cure.

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47 Analysis of GLOBOCAN database, IARC 2005
48 Quality care at the end of life, Singer, Bowman, British Medical Journal 2002
49 Dying from cancer in developed and developing countries: lessons from two qualitative interview studies, Murray, Grant, Grant and Kendall, BMJ, 2003
50 Terminal Cancer, duration and prediction of survival time, European Journal of Cancer, 2000
## Appendix 1

All-cancer mortality rates, Australia compared with Asia-Pacific regions (New Zealand excluded)

*Source: International Association of Cancer Registries; Globocan data 2002*

### Male

<table>
<thead>
<tr>
<th>Age</th>
<th>Aust.</th>
<th>Melanesia</th>
<th>Micronesia</th>
<th>Polynesia</th>
<th>East Asia</th>
<th>South-East Asia</th>
<th>South-Cent. Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>3.533</td>
<td>5.704</td>
<td>7.974</td>
<td>3.455</td>
<td>5.045</td>
<td>6.871</td>
<td>4.299</td>
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<tr>
<td>45-54</td>
<td>108.892</td>
<td>152.597</td>
<td>128.456</td>
<td>203.461</td>
<td>229.809</td>
<td>147.178</td>
<td>113.694</td>
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<tr>
<td>55-64</td>
<td>369.274</td>
<td>358.935</td>
<td>323.523</td>
<td>529.580</td>
<td>471.030</td>
<td>339.233</td>
<td>283.137</td>
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</table>

### Female

<table>
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<tr>
<th>Age</th>
<th>Aust.</th>
<th>Melanesia</th>
<th>Micronesia</th>
<th>Polynesia</th>
<th>East Asia</th>
<th>South-East Asia</th>
<th>South-Cent. Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>2.460</td>
<td>3.836</td>
<td>4.118</td>
<td>4.806</td>
<td>3.737</td>
<td>5.465</td>
<td>2.794</td>
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<tr>
<td>15-44</td>
<td>18.005</td>
<td>37.056</td>
<td>29.333</td>
<td>48.826</td>
<td>20.794</td>
<td>24.984</td>
<td>22.322</td>
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<tr>
<td>45-54</td>
<td>109.960</td>
<td>233.530</td>
<td>175.505</td>
<td>268.404</td>
<td>134.743</td>
<td>156.436</td>
<td>151.700</td>
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<tr>
<td>55-64</td>
<td>266.152</td>
<td>400.914</td>
<td>261.517</td>
<td>247.036</td>
<td>250.448</td>
<td>244.172</td>
<td>265.769</td>
</tr>
</tbody>
</table>
Appendix 2

Smoking prevalence in the Western Pacific and South-East Asia regions

Source: WHO Tobacco Atlas

**WHO Western Pacific Region**

<table>
<thead>
<tr>
<th>Male Adult Smoking Prevalence (aged 15 or above)</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 60%</td>
<td>Cambodia, China, Republic of Korea, Mongolia, Nauru, and Tonga.</td>
</tr>
<tr>
<td>50-60%</td>
<td>Japan, Kiribati, Niue and the Philippines</td>
</tr>
<tr>
<td>40-50%</td>
<td>Brunei Darussalam, the Cook Islands, Lao PDR, Malaysia and Papua New Guinea</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female Adult Smoking Prevalence (aged 15 or above)</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>Nauru</td>
</tr>
<tr>
<td>32.3%</td>
<td>Kiribati</td>
</tr>
<tr>
<td>20-30%</td>
<td>Papua New Guinea, Mongolia, New Zealand</td>
</tr>
<tr>
<td>10-20%</td>
<td>Australia, Brunei Darussalam, Cook Islands, Fiji, Japan, Lao PDR, Niue, Philippines</td>
</tr>
</tbody>
</table>

**WHO South-East Asian region**

<table>
<thead>
<tr>
<th>Male Adult Smoking Prevalence (aged 15 or above)</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 50%</td>
<td>Bangladesh, Indonesia</td>
</tr>
<tr>
<td>40-50%</td>
<td>Myanmar, Nepal, Thailand</td>
</tr>
<tr>
<td>30-40%</td>
<td>Maldives</td>
</tr>
<tr>
<td>20-30%</td>
<td>India, Sri Lanka</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female Adult Smoking Prevalence (aged 15 or above)</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30%</td>
<td>Bangladesh, Myanmar, Nepal</td>
</tr>
<tr>
<td>Below 5%</td>
<td>India, Indonesia, Sri Lanka, Thailand</td>
</tr>
</tbody>
</table>
Appendix 3

The Cancer Council Australia’s Regional Affairs Working Group

Membership

Chair: Professor Carol Gaston. Also Chair of The Cancer Council South Australia. Worked in health programs in Bangladesh, Nigeria, Mauritius, Brunei, Laos et al and with remote Australian Aboriginal communities; consultant to WHO in Western Pacific Region. Particular expertise in health workforce planning.

Associate Professor Michael Barton. Research Director, Collaboration for Cancer Outcomes Research and Evaluation. Radiation oncologist; studied Papua New Guinea’s radiotherapy needs; conducts science program for International Atomic Energy Agency. Ex-Chair of the International Society of Radiation Oncologists’ education committee; former Chair of Cancer Council/COSA education committee.

Professor Alan Coates AM. CEO, The Cancer Council Australia; trustee of the William Rudder fund (education fund for developing regional capacity in cancer control). Represents the interests of fellow Union of International Cancer Control members in Fiji; leads and participates in Asia-Pacific region clinical conferences.

Dr Aileen Connon. Retired academic and gynaecologist; extensive experience in global health promotion, particularly in women’s health and medical workforce. Maintains links with American Cancer Society’s regional interests in Asian/Oceanic group; was involved in Australian gynaecological faculty activities in the Asia-Pacific region.

The Hon Hendy Cowan. Chair, Western Australian Cancer Council. Former Deputy Premier of Western Australia; eight years as WA trade minister, active in Indian Ocean/ASEAN rim countries; extensive experience in processes for international engagement.

Mrs Judith Roberts AO. President of The Cancer Council Australia, former Chair of The Cancer Council South Australia; involved in a number of international projects, particularly around women’s health. Active in cross-border projects as former ACOSS Vice President. Trustee of William Rudder fund.

Professor David Roder. Epidemiologist, The Cancer Council South Australia; representative of Oceania region on International Board of Cancer Registries, works for WHO as consultant to Indonesia and Malaysia.

Professor Richard Taylor. Head, International Health Division, School of Population Health at Queensland University; epidemiologist, physician, active in professional consultant role in Pacific community; former head of NSW cancer registry.

Terms of reference
Australian aid and cancer control: medium-term regional priorities

Mission

To contribute to continuous improvements in cancer prevention, early detection and patient care throughout Australia, South East Asia and the South-West Pacific Region, respecting the cultural, political, geographical and economic differences.

Aims

- Contribute to improved cancer prevention, treatment and care outcomes across neighbouring regions;
- Share and exchange cancer control knowledge, resources and expertise;
- Support the application of research throughout different cultural, political, geographical and economic environments.

Purpose

- Develop networks with key Australian and international stakeholders with a focus in the region, including government and non-government agencies and individuals;
- Develop networks with relevant agencies and individuals based in neighbouring nations;
- Build mechanisms to transfer knowledge and best practice in cancer control in a culturally appropriate way.