cost of significant financial strain, inadequate palliative care, and unmanaged existential suffering, it would seem so.

The question arises as to how physicians can better manage the care of patients with advanced cancer in an age of unlimited access to knowledge. It is crucial that from the very outset hope is balanced against realism. In this, physicians, patient advocates, the media, government agencies, and the pharmaceutical industry all have parts to play in the provision of honest, measured information for patients and their families. Realistically, we need to accept that many of our patients will seek a second opinion (if not more) online, and be prepared to engage with them in interpreting the results of their enquiries.

And yes, we should celebrate the victories with our patients. But we should also temper their expectations. As we inform our patients that their time may be limited, we should ask—“Is there anything you want or need to do that you haven’t yet done? In order for me to best look after you, I need to know what matters to you.” Confronting yes, but it is questions such as these that can profoundly refocus the therapeutic relationship in a way that acknowledges not only the limits of our ability to defy death, but the intrinsic value of the life that has been lived.

In the post-truth age our obligations as physicians remain the same. We should use information with precision and wisdom, much as a surgeon uses a scalpel. As we strive to provide compassionate care, it is up to us to ensure not only a steady hand, but that the knife is not wrested from our grasp.

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**Advancing access and equity: the vision of a new generation in cancer control**

As the next generation of cancer advocates and leaders, we inherit a legacy that is in many ways, remarkable. The past few decades have seen rapid and unparalleled progress in cancer control. Investigative breakthroughs, such as those in cancer genomics and immunology, have transformed our understanding of the disease. New discoveries in cancer prevention have mitigated risk factors, and improvements in surgical techniques, radiotherapy technologies, and systemic agents have led to substantial improvements in cancer cure rates—a substantial survival rate of roughly 20% during the past three decades.¹

This progress has been impressive, but its distribution has not been equitable. Significant disparities in cancer outcomes persist between and within countries resulting in a so-called cancer divide, a deplorable situation compounded by the fact that the greatest burden of cancer affects low-and-middle-income countries (LMICs).² It is the call of our generation to close this cancer divide, especially in view of the rapid acceleration of the global burden of cancer and its consequent strain on social, economic, and health systems.

The challenges are many. Inadequate prioritisation of effective prevention strategies exacerbates the global burden. Early detection is complicated by limited primary care and pathology capacity; in many LMICs, even the most basic diagnostic and treatment services are inaccessible or unaffordable. Supportive and palliative care is absent in most of the world, a startling inequity that permits the needless suffering.
of millions. Fragmented and weak systems tend to engage individuals in terms of their disease, rather than as people situated within a specific family and cultural context, further amplifying health disparities (table). We must dramatically alter the current trajectory of cancer care to ensure that improvements are accessible by all in the global community. We must bridge the gap between what is achievable and what is accessible. We must act with urgency and precision, recognising the tremendous social and economic costs of inaction.

In light of these issues the Union for International Cancer Control (UICC) Young Leaders, have been brought together at the World Cancer Leaders’ Summits during the past 3 years. We represent six continents, 12 countries, and six sectors (academia, civil society, government, health-care providers, finance, and international organisations). The Young Leaders emerge with a vision of transformative leadership in cancer control—one rooted in history, shaped by emerging social trends, guided by ethical reasoning and urgency, and focused on our commitment to achieve equitable and tangible progress. For decades, the cancer community has rightly prized access, people-centeredness, affordability, and prioritising patient safety and outcomes across borders and communities from LMICs; tobacco kills around 6 million people each year and nearly half its users over their lifetime; obesity is a signifi cant risk factor for cancer development; in 2014, more than 1.9 billion adults were overweight; the world’s population consumes just 6% of medicinal opioids; a patient with pain who dies from cancer or AIDS has access to an average of 200 mg of oral morphine (or equivalents) in the poorest 10% of countries, compared with 99 000 mg in the richest 10% of countries; and tobacco kills around 6 million people each year and nearly half its users over their lifetime. The Young Leaders group is a microcosm of this principle, representing varied health sectors and recognising our interdependencies.

As global citizens of the digital age, we see technology as an innovative way to improve wellbeing and link communities. With a third of the world’s population on social media, we can now use the online community to rapidly create global networks, raise awareness, and advocate for addressing inequities.

The digital age brings immense responsibilities along with its unique opportunities. Global inequity can be seen every day—the child with cancer in a remote rural village is no longer unknown to us. With a new global communications platform, we seek to harness the power of social media and respond effectively to calls for help. Successful projects like GlobalRT, Global Oncology Project Map, Breast Cancer Navigation & Palliative Programme (BCNPP) in Nigeria, GW Cancer Center’s Cancer Control Technical Assistance Portal, and Prepared Patient initiative have shown that online communities can promote active patient engagement and gives voices to those previously unheard.

It is not enough to rely on technology alone, and advocacy must also recognise the unique needs of communities. Locally contextualised grassroots outreach is needed, especially in regions where internet access is limited. The National Youth Service Corp (NYSC) Scheme in Nigeria, for example, offers young graduates the opportunity to reach vulnerable communities with tailored messages on cancer.

A new framework of cancer control is needed—one that prioritises access, people-centeredness, affordability, and integration. The first priority should be to reframe cancer care. The UN Sustainable Development Goals herald a new
era of aiming to attain universal health coverage in which cost, coverage, and service availability define the framework. Cancer control must be seen through the lens of access and equity, with an ethical framework that is based on social justice. Health systems must be people-centred, adopting the perspective of individuals, families, and communities and seeing them as participants and beneficiaries of this system that responds to their needs. Services must be integrated within health networks, founded on primary care, and must efficiently use the capacity of nurses, patient navigators, and community health workers to expand critical services to all populations. Attention to the mental health care and psychosocial needs of patients with cancer and their families are also crucial, especially in LMICs.

Second, we need to identify different measures of cancer outcomes. Cancer monitoring has historically focused on essential but limited outcome indicators such as mortality, disease-free survival, screening, and vaccination rates. Structured data are also needed to identify heterogeneity in patient outcomes and patient experiences to assist with planning and implementing evidence-based interventions. Patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs) are crucial to better understand the psychosocial implications of treatment and to emphasise patient values, concerns, and preferences.

Vulnerable populations have been invisible in cancer monitoring systems because of resource limitations and lack of political will. Only recently, for example, have lesbian, gay, bisexual, and transgender (LGBT) individuals started to be included in clinical and research databases that previously lacked sexual orientation and gender identity data. Similarly, indigenous populations are marginalised by data that are inadequate to improve access and establish best practices. A comprehensive, patient-inclusive framework to the monitoring of cancer care empowers patients, promotes accountability, and involves communities in a significant and meaningful way.

Third, we need to challenge extant priorities. We are all stewards of health resources and are increasingly required to answer difficult questions about costs, access, and goals of care. Novel targeted therapeutic agents, technologies, and diagnostic tools have revolutionised cancer care. Who should receive them? Who will fund and regulate them? Priorities should be based not only on cost-effectiveness analyses but, more importantly, on shared societal values and a guiding ethical framework. Decisions on cancer care priorities must involve all stakeholders and seek an accessible and sustainable cancer control system. Without inclusion, transparency, and clear blueprints for action, equitable progress cannot be achieved.

Finally, we need to consider the equal needs of cancer survivors and those requiring palliative care. Cancer treatment should not result in bankruptcy or financial catastrophe, and obstacles to accessing care must be addressed. No patient with cancer should die without basic supportive care services and pain relief. We must promote an open, truthful discussion about the potentially competing goals of cancer care for patients, caregivers, providers, private industry, economists, and politicians. We must balance the costs of innovation and health services delivery with the social, economic, and ethical imperatives for equitable, accessible cancer care. The UN Sustainable Development Goal of universal health care is founded on solidarity, in which everyone benefits from health services according to their needs and contributes according to their capacities. Disparities in outcomes are not inevitable and poverty as a result of health challenges is not acceptable.

Our generation has a moral obligation to advance health, with equity and social justice as global tenets. From different parts of the world, different spheres of influence, and different cultures, we make a unified, urgent call and commitment to action: we stand for inclusive and integrated cancer care founded on collaborative partnerships that value equity as the cornerstone of cancer control. We commit to working with cancer organisations globally, regionally, and nationally to invest our knowledge, experience, and passion to realise the vision of equity in cancer care.

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Comment
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