



Improving cancer care in the Philippines: The need for deliberate and careful implementation of the National Integrated Cancer Control Act

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In the Philippines, a Southeast Asian nation of over 110 million people, cancer is amongst the leading causes of death. In 2020 alone, cancer accounted for over 150,000 new diagnoses and over 90,000 deaths.¹ In February 2019, the Philippine National Integrated Cancer Control Act (NICCA) was signed into law. The NICCA includes wide-ranging provisions covering the development of national and regional cancer centers; educational initiatives for healthcare professionals and laypeople; psychosocial, supportive, and palliative services; the establishment of a national cancer registry; support for training in and conduct of cancer research ranging from basic science and clinical investigation to psychological and sociological research; and expanded financial support for patients under PhilHealth and the Cancer Assistance Fund.² The recent “Hope Matters: Lighting A Path for Better Cancer Care” event aimed to galvanize efforts to implement NICCA’s provisions.³ Although NICCA is an important step in the right direction, we advocate for careful implementation of the NICCA cognizant of stark disparities in healthcare access, social and cultural determinants of health, the need for Filipino-led research, and the value of multi-institutional and regional collaboration.

1. Implementation must consider deeply rooted health inequities in the country and prioritize communities most in need, particularly in geographically isolated and disadvantaged areas of the archipelago. As cancer care systems develop in cities, majority of which are private in nature, public institutions

severely lag, perpetuating healthcare disparities.⁴ The importance of developing public cancer care systems from primary to tertiary care across all regions of the country cannot be overstated; doing so has also been associated with reduced cancer mortality rates.⁵ Additionally, with most oncologists and cancer care providers centralized in the capital city of Manila, an organized referral system through nationwide telehealth programs and centralized electronic medical records may improve access in remote parts of the country. Importantly, efforts are needed to incentivize oncologists’ practice in underserved areas, coupled with training of general practitioners and local *barangay* health workers (BHWs) in the provision of basic oncology care. In partnership with the Department of Health, the Philippine Society of Medical Oncology has recently launched the “Abot Kamay Ako at ang PSMO” (AKAP) initiative, a cancer education program for BHWs designed to promote health literacy among local communities, to correct misinformation, and to promote screening and early detection. AKAP will prioritize areas in the country with very few practicing oncologists.

2. Social and cultural determinants of health must also be considered, given varying levels of socioeconomic development, diverse cultures, and heterogeneous belief systems. These significantly impact the Filipino patient’s ability and willingness to understand, seek, and accept healthcare and modern medicine, the frameworks of which are heavily based on Western cultures and populations, and often come at high out-of-pocket costs.⁶ From education initiatives and screening to survivorship, psycho-oncology care, and end-of-life care, cultural sensitivity must be ensured, financial toxicity must be mitigated,⁶ and interventions must be tailored to the needs and social contexts of patients and their

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families, especially among vulnerable populations including women, children, indigenous peoples, gender minorities, and those living below the poverty line.

3. Research that focuses on the needs of Filipino cancer patients is necessary given the nation's unique genetic ancestry, cancer epidemiology, social determinants of health, and healthcare access barriers.^{7,8} Such research should prioritize the perspectives of Filipino patients and providers who maintain experiential knowledge of cancer care in the country.⁷ Although the NICCA contains provisions supporting research at all levels of the cancer spectrum, deliberate resource allocation is needed to fund researchers' training, time, and equipment. Furthermore, collaboration amongst hospitals and academic centers in the country may galvanize multi-institutional prospective studies, resource sharing, and knowledge exchange.⁹ Importantly, implementation research is needed to generate evidence that should inform systems-level changes.
4. Finally, in addition to public-private partnerships in the procurement and development of cancer care infrastructure, multi-institutional exchange is necessary given the interdisciplinary nature of cancer care. Oncology societies in the Philippines must work together to create and update local clinical practice guidelines, and multi-institutional tumor boards and partnerships must be encouraged to expand access to expertise and treatment options. Much can be gained from collaborating with other cancer care systems in neighboring Southeast Asian countries, particularly those who have vastly improved cancer care systems despite similar resource availability. For example, the Thai National Cancer Control Program has achieved universal health care, the development of regional cancer centers, and a strong cancer surveillance system.¹⁰ Individuals tasked with designing cancer care delivery systems should be trained in evidence-based health policy and implementation science. Importantly, given the trans-disciplinary nature of cancer control and cancer care – ranging from education and prevention to access and treatment – systems-level thinking should inform the implementation of the NICCA.

The NICCA is indication that for governing bodies in the Philippines, providing hope for patients with cancer matters. Given limited resources, focused, time-bound expansion of investments supported by a committed government budget is needed such that the NICCA would not simply remain a paper tiger. It is in careful and equitable implementation of legislation that hope can be attained.

Contributors

ECD and MABE conceptualised and wrote the initial draft. CDUA, FILT, and EDT contributed supervision, writing - original draft (revision), writing - review & editing.

Declaration of interests

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