



**TACKLING  
THE BURDEN OF  
PROSTATE CANCER  
IN LATIN AMERICA**

The prospects for  
patient-centred care

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## ABOUT THIS REPORT

*Tackling the burden of prostate cancer in Latin America: The prospects for patient-centred care* is an Economist Intelligence Unit report, sponsored by Janssen, which examines how countries in the region are responding to prostate cancer in a patient-focused manner. The findings of this report are based on an analysis of the disease and economic burden of prostate cancer in the region conducted by The Economist Intelligence Unit in 2016 and ten interviews with experts, including oncologists, policymakers and non-governmental organisations carried out from December 2016 to January 2017. We questioned these experts on progress made in the area of, and the limits of, patient-centred prostate-cancer care in the region.

These experts work in a range of cancer-related areas in Brazil, Colombia, Costa Rica and Mexico. The Economist Intelligence Unit would like to thank them for sharing their insights and observations (they are listed alphabetically):

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- Leticia Aguiar Green, co-ordinator, Latin American Movement Against Prostate Cancer (MOLACAP), Mexico
- Luis Eduardo Bravo, director, associate professor, Cancer Registry of Cali, Department of Pathology, University of Valle, Colombia
- Gabriela Echeverría, director of patient care, Salvati, Mexico
- Mayra Galindo Leal, director-general, Mexican Association for the Fight Against Cancer, Mexico
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- Rafael Kaliks, oncologist, Albert Einstein Hospital; director of oncology, Instituto Oncoguia, Brazil
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## EXECUTIVE SUMMARY

Prostate cancer is placing an ever-growing burden on already strained Latin American healthcare systems, as both the incidence of the disease and mortality rates rise. For the purposes of this report, Latin America encompasses the territory from the northern border of Mexico to the southern tip of South America, including the Caribbean.

Prostate cancer is the leading cause of male cancer-related deaths in the region, and the disease and economic burden is set to rise in tandem with longevity and changes in lifestyle and diet.

Addressing this rapid growth is thus an urgent task, and one that higher-income countries around the world have addressed with some success through patient-centred healthcare. In the US, for example, integrated-care systems have been delivered through accountable care organisations that focus on patient needs.

The World Health Organisation (WHO) says that “integrated people-centred health services means putting the needs of people and communities, not diseases, at the centre of health systems, and empowering people to take charge of their own health”.<sup>1</sup> However, integrated and patient-centred healthcare has seen a slow rate of adoption in the Latin America region. This suggests that much work needs to be done to sharpen the focus on respecting and responding to patient needs.

This report draws on findings from an Economist Intelligence Unit study, *Assessing the burden of Prostate Cancer in Brazil*,<sup>2</sup> and in-depth interviews with ten experts on cancer care in the region. It assesses current prostate-cancer developments and provides real-world examples from Brazil, Colombia, Costa Rica and Mexico of how institutions are addressing, or failing to address, prostate cancer through a patient-centred approach.

### **Key findings**

#### **Prostate-cancer incidence, prevalence and mortality are rising rapidly in Latin America.**

Risk factors are highest in Brazil, which has a population that is ageing more rapidly than those elsewhere in Latin America and a greater proportion of males of African descent than in other countries in the region. Studies show that populations of African descent have the highest prostate-cancer incidence rates, for reasons that are still not fully understood. Other risk factors, such as unhealthy diets, are also becoming more prevalent in the region. The rates of incidence of prostate cancer and deaths from this disease are expected to double in the region by 2030, according to The Pan-American Health Organisation.

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**The economic burden of prostate cancer in the region is growing.** If the growing disease burden of prostate cancer is not brought under control, Latin American healthcare systems could come under intense pressure, given that they are already financially stretched. For example, our forecasts show that the economic costs of prostate cancer in Brazil could rise by 50% to US\$1.8bn per year by 2022, driven mainly by population dynamics and healthcare spending patterns. Policymakers have been at pains to deal with short-term budgetary constraints, while the potential long-term financial and health-outcome benefits of integrated care have not yet emerged as a priority on the political agenda.

**Despite its rising prevalence and economic burden, prostate cancer appears to be a low healthcare priority in the region.** Prostate cancer is sometimes considered a neglected disease in Latin America. Partly as a result, late diagnosis is a major problem in the region: a large proportion of patients (over one-half in Brazil and Mexico, according to non-governmental organisations) are diagnosed when prostate cancer is already at an advanced stage. New scientific evidence suggest that active monitoring, with prompt treatment if needed, may be a preferable alternative to radical surgery or radiotherapy for prostate-cancer patients if the disease is confined to the prostate gland.

**Latin American countries lack a common response to the threat of prostate cancer.** Awareness campaigns have been launched, although early-detection methods have remained controversial. While policymakers in some countries have in the past promoted systematic screening of the male population to detect the disease at an early stage, it has been demonstrated that population-wide screening leads to overdiagnosis and overtreatment and does more harm than good. Instead, policymakers are now encouraging ongoing dialogue between medical practitioners and patients based on symptoms.

**For cultural reasons prostate cancer is a taboo issue in many parts of Latin America, undermining early detection and integrated-care solutions.** Men are reluctant to go to the doctor and often refuse to talk about prostate-related issues. Their wives and partners have a role to play in encouraging them to address the issue. For example, a leading Mexican anti-cancer activist has suggested that women who go to test for breast cancer take their partners with them to test for prostate cancer.

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**The notion of patient-centred care is still in its early stages in many parts of Latin America.** This is primarily due to the fact that healthcare systems are unable to keep up with demand, given the limited resources currently available in some countries and the major differences in quality between public and private healthcare systems in other countries. Moreover, a lack of multidisciplinary teams and/or integration of these teams in many hospitals is also holding back a shift towards putting the patient at the centre of health decision-making. For example, in Brazil fewer than 20% of public hospitals and roughly one-half of private hospitals have capacity for multidisciplinary care. By contrast, Costa Rica is moving faster in the direction of integrated, patient-centred care. Patient advocacy groups have a role to play in demonstrating the merits of focusing more strongly on patient needs. Some of them have been calling for early detection, expansion of prostate-cancer registries and the adoption of integrated care across the region.

**Significant progress is needed in pain management and training in palliative care in order to improve the quality of life of prostate-cancer patients.** Oncologists need to be trained to deal with pain-related issues and provide better advice and guidance to patients (such as referring them to pain clinics where available). Efforts to train families to support patients can also contribute to better integration of care. Across the region, many families play the role of caregivers, although they are generally unprepared for the task; in practice, they have to learn by themselves.

## INTRODUCTION

Latin America is currently emerging from a protracted economic slowdown. In most countries, including Brazil and Mexico, efforts to improve the public health system have been thwarted by financial constraints, while others, such as Costa Rica, have tried to implement new health policies centred on patient needs.

Patient-centred care requires more integrated healthcare and a more collaborative and participatory relationship between patients and healthcare providers, including doctors and hospitals.<sup>3</sup> For doctors, it implies a change in the role of the physician, from being the source of expertise to acting as the interpreter of the often overwhelming amount of information available and the co-ordinator of the patient's interaction with the whole healthcare delivery ecosystem.<sup>4</sup> Thus, integration is a key element of patient-centred care, which also incorporates family involvement and pain management.

For the purposes of this report, integrated care is considered a crucial element of patient-centred care. According to the World Health Organisation (WHO), "integrated care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."<sup>5</sup> Indeed, the WHO considers integrated care and patient focus as two sides of the same coin: "Integrated people-centred health services means putting the needs of people and communities, not diseases, at the centre of health systems, and empowering people to take charge of their own health."<sup>6</sup>

From the perspective of service users, patient-centred, co-ordinated care means: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."<sup>7</sup>

An example of patient-centred systems in cancer care can be found in the UK. Driven by some of the lowest survival rates in western Europe, the first cancer plan of the UK's National Health Service (NHS) in 2000 focused on improving survival by boosting the co-ordination of care and communication between stakeholders, including patients.<sup>8</sup> Subsequently, health outcomes strengthened, with cancer mortality falling, survival rates rising for many cancers and patients' experience of care improving too.<sup>9</sup> More recently, NHS England has been working with a cancer charity, Macmillan Cancer Support, to roll out a "recovery package" that focuses on tailored support and services for patients.<sup>10</sup>

### ***Significant gaps***

In Latin America, private healthcare systems generally provide better-quality care than public schemes. A few private institutions in the region are introducing multidisciplinary approaches to put patients at the centre of their decision-making. Nevertheless, patient-centred care is far from being a reality in many parts of Latin America, even in private

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facilities. In Brazil, for example, only a handful of top hospitals have case managers who can deal with patients in an integrated fashion, according to Rafael Kaliks, an oncologist at the Albert Einstein Hospital and director of oncology at the Instituto Oncoguia, an advocacy organisation for improved cancer-patient care in São Paulo.

The struggle to shift towards a healthcare system that is better attuned to patient needs is perhaps most evident in the region's largest country by population, Brazil, where a severe two-year recession that began in 2015 is weighing heavily on the public healthcare system. In particular, an unemployment rate of 12.6% (as of January 2017) has pushed 2.5m Brazilians off private health-insurance plans and into already overburdened public healthcare schemes.<sup>11</sup> The struggle to meet patient needs is particularly evident in the field of cancer treatment, due in part to the largely centralised nature of cancer care. Although countries like Brazil and Mexico, for example, have good public cancer hospitals, these are usually located in capital cities, often far away from patients who may urgently require these services. In addition, the quality of private institutions is uneven.

Against this backdrop, it is not surprising that the notion of patient-centred care is still in its infancy in many parts of Latin America. This may be because, broadly speaking, simply providing access to care is the primary concern across the region.

Indeed, a recent survey of the general population exploring patient-centred primary care in the region has found significant gaps in the availability and delivery of services and in patients' communication with medical practitioners in public and private healthcare. Over one-fifth of respondents in the region note that they lack either a regular place of care or a primary-care doctor (36% of respondents in Brazil, 28% in Colombia and 22% in Mexico). More alarming is the fact that more than two-fifths of respondents point to difficulties in communicating with the primary-care clinic (45% in Mexico, 44% in Brazil and 41% in Colombia). Also noteworthy is the fact that large proportions of respondents cite a lack of co-ordination of care (78% in Brazil, 52% in Colombia and 48% in Mexico).<sup>20</sup>

### ***Financial incentives for integrated care***

Economic considerations are important. Budgets have been under pressure across the region. In Brazil, a fiscal crisis led the government to pass a constitutional amendment in late 2016 to cap overall public spending for 20 years. Although putting integrated-care concepts into practice may require some initial investment (for example, in systems and infrastructure geared towards patient-centricity), in the long term there could be substantial cost savings. Various studies, such as a 2014 study by the European Observatory on Health Systems and Policies, have found evidence of the cost-effectiveness of integrated-care approaches.<sup>13</sup> Thus, a shift to patient-centred care may not only be desirable from the point of view of patients and healthcare professionals (as it has the potential to boost the quality of healthcare) but could also achieve greater efficiency and cost savings for policymakers in the long term.



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However, even in developed countries data on the economic benefits of integrated care are scarce. As the UK Local Government Association's Integrated Care evidence review notes, the difficulty in assessing the economic benefits is partly due to the fact that "integrated care needs to be rolled out on a significant scale in order to support the reconfiguration of services and demonstrate significant cost savings".<sup>14</sup>

### ***A focus on prostate cancer***

This report strives to identify progress towards patient-centred prostate-cancer care in Latin America, with a particular focus on Brazil, Mexico and Colombia (the three most populous countries in the region) as well as Costa Rica (as an example of a smaller country in the region).

In terms of the framework for analytical comparison between the countries, The Economist Intelligence Unit Healthcare team developed a model to assess the costs associated with prostate cancer, using as inputs data on diagnosis stage, prevalence, incidence, mortality, treatment and employment.<sup>15</sup> We used incidence, prevalence and mortality figures reported by the Section of Cancer Surveillance of the International Agency for Research on Cancer, as they were consistent with data from the International Cancer Institute of Brazil (INCA) while providing consistency across all four countries. We complemented this quantitative research with additional desk research and qualitative insights from in-depth interviews with experts from the four countries in order to compare the countries in terms of how they address the challenge of prostate cancer, with a particular focus on integrated, patient-centred care.

Prostate cancer is of particular concern in Latin America because of its high prevalence among males in the region and its continuing upward trajectory. It is the leading cause of cancer-related deaths among Latin American males.

Against this backdrop, prostate cancer would appear to be an ideal candidate for patient-centred care in Latin America, given the existence in the region of an enduring culture that discourages men from discussing the disease, and also owing to the importance of early detection in order to prevent, diagnose, treat and cure the condition. A closer relationship between patients and primary-care physicians, constant communication involving families, and outreach efforts to monitor for prostate-cancer symptoms can pay dividends for communities, economies and healthcare systems.

The first chapter of this report will highlight the incidence of prostate cancer in the region and its economic impact. The second chapter will examine current government priorities for cancer care—and prostate-cancer care in particular—in selected countries in order to provide a sense of the current prevalence of patient-centred care and appropriate responses to patient needs in the region. The third chapter will examine the state of patient-centred care and the focus on patient needs in the region.

## CHAPTER I

# DISEASE BURDEN AND ECONOMIC IMPACT

In Latin America, cancer is a growing public-health concern due to its increasing incidence and mortality rates. For example, overall cancer mortality in Latin America is about twice that in more developed countries, according to *The Lancet Oncology*.<sup>16</sup>

Of all cancers, prostate cancer perhaps preoccupies medical practitioners most, due to its high and still growing rate of incidence. Although the incidence of all types of cancer has increased across the region, the rapid rise in the incidence of prostate cancer in Latin America is alarming. The Pan-American Health Organisation (PAHO) reported 150,000 new cases of prostate cancer and almost 50,000 prostate-cancer deaths in the region in 2012.<sup>17</sup> Among the male population, prostate cancer was the most frequently diagnosed cancer in Latin America in 2012.<sup>18</sup> (Worldwide, however, lung cancer was the most common cancer in men in 2012, ahead of prostate cancer.<sup>19</sup>) Prostate cancer was also the leading cause of male cancer deaths in Latin America, although in terms of mortality it trailed lung cancer in Brazil and stomach cancer in Colombia.<sup>20</sup>

Data reported by the Section of Cancer Surveillance of the International Agency for Research on Cancer (IARC) show that, of the four countries that we focus on in this report, Brazil is the leader not just in absolute levels of incidence, mortality and prevalence—unsurprisingly, since it is the largest country in the region—but also in terms of five-year prevalence per 100,000 population (see Table 1). However, there are caveats about data availability and quality: as there is no central data collection, the high numbers in Brazil may actually indicate that the country collects better data than its regional peers.

### **Rising disease burden**

High prevalence of prostate cancer is associated with rising life expectancy, which is the main risk factor for prostate cancer as the risk increases with age. Lifestyle factors, such as poor diet, a family history of the disease and ethnic background are additional risk factors. The risk increases significantly after the age of 50 in white men with no family history of the disease and after the age of 40 in black men and men with a close relative with prostate cancer.<sup>21</sup> Men of recent African descent have the highest prostate-cancer prevalence rates; the reason for this is not fully understood, but it may indicate differences in genetic susceptibility.<sup>22</sup>

Brazil is emblematic of this trend. In 2012 men over 65 accounted for a greater share of the male population in Brazil (at around 7%) than in Colombia (5.9%), Costa Rica (6.8%) or Mexico (6.6%).<sup>23</sup> Furthermore, the Brazilian population is ageing fast, and a larger

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proportion of Brazil's population is of African descent, at roughly one-half (including those of mixed ethnic background); Mexico's population, by contrast, is mainly American-Indian/Spanish (69%) and American-Indian (30%)—ethnic groups that have a lower risk of prostate cancer than African-American men.<sup>24</sup>

**Table 1: Prostate-cancer incidence, mortality and five-year prevalence**

Country	Incidence (total no.)	Mortality (total no.)	5-year prevalence (total no.)	Five-year prevalence per 100,000
Brazil	72,536	17,218	212,532	291.9
Colombia	9,564	2,934	28,076	169.3
Costa Rica	1,556	465	4,576	248.1
Mexico	14,016	6,367	41,088	101.3

Source: IARC, GLOBOCAN 2012: Estimated Cancer Incidence, Mortality and Prevalence Worldwide in 2012.

Despite Brazil's high figures, Caribbean countries dwarf Brazil in terms of their higher rates of prostate-cancer incidence and mortality per 100,000 population, for which these countries lead the region. This is particularly true of Trinidad and Tobago, Barbados and Guyana.<sup>25</sup>

Collectively, the already high rate of prevalence of prostate cancer in the region, coupled with longer lifespans and changing lifestyles and nutrition, will stretch Latin American healthcare systems in the years to come. PAHO has warned that the numbers of new prostate-cancer cases and deaths will almost double by 2030 in Latin America and the Caribbean if current upward trends continue.<sup>26</sup>

As a result, the costs incurred in diagnosing and treating prostate cancer in Latin America are expected to rise rapidly owing to increased diagnosis, diagnosis at an earlier stage and higher survival rates. This will substantially increase the economic burden of the disease and will put pressure on healthcare systems. In order to prevent advanced-stage prostate cancer and the high mortality rates associated with it, a patient-centred approach could include active monitoring, with prompt treatment if needed, for localised prostate cancer (see box: *Prostate-cancer awareness and prevention*), as well as improved palliative care (see Chapter 3). Both these approaches are more cost-effective alternatives to—and have fewer side effects than—radical surgery or radiotherapy, for example.

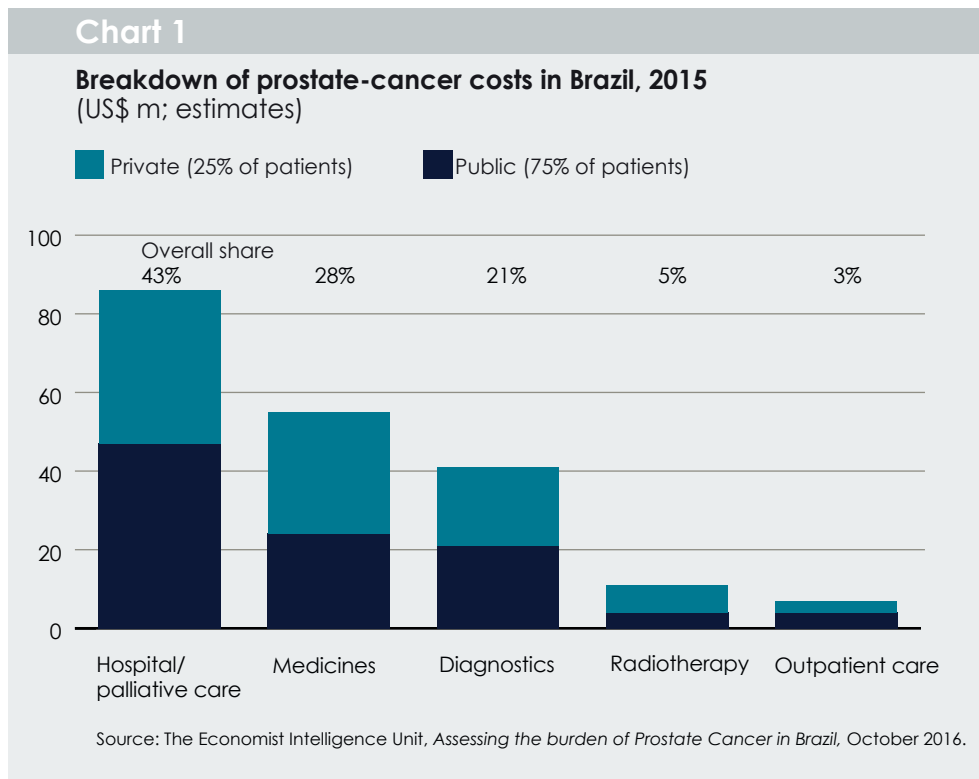
For an idea of the price tag, consider Brazil. The Economist Intelligence Unit's study of the economic impact of prostate cancer estimates the costs of prostate cancer in Brazil to be in the order of US\$1.2bn in 2015, and this figure is expected to rise to US\$1.8bn by 2022.<sup>27</sup> The direct costs make up 52% of the total, and are driven by the

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costs of hospitalisation (43%), medicines (28%), diagnosis (21%), radiotherapy (5%) and outpatient treatment (3%). Although 25% of the Brazilian population have private healthcare coverage, the private sector's share of total direct prostate-cancer costs is estimated to be slightly more than one-half, owing to higher unit costs for treatment and doctor consultations for those covered privately, as well as different—and more expensive—clinical practices in the private sector (see Chart 1).

Of the US\$580m in indirect costs in Brazil in 2015 the largest share (62%) is accounted for by early mortality. Early mortality also accounts for the largest share of indirect costs in Colombia, Costa Rica and Mexico (see Chart 2).

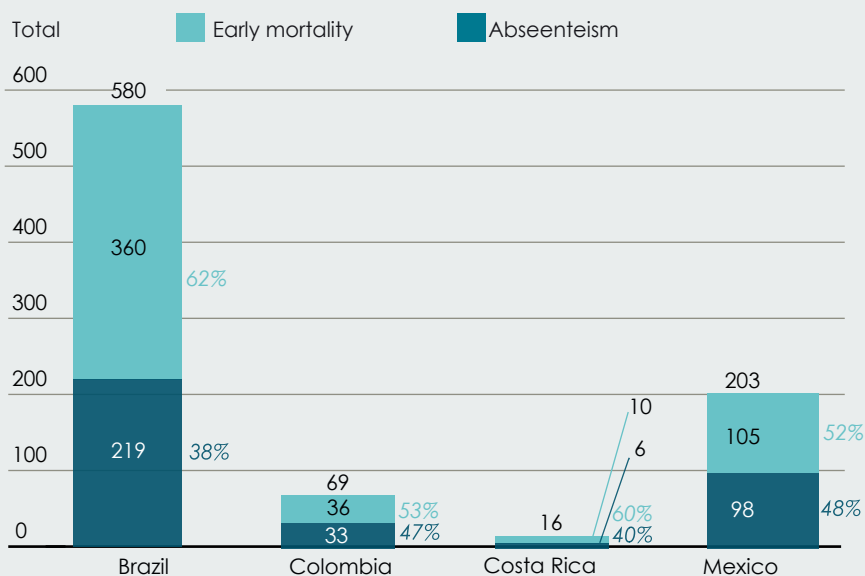


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Chart 2

Indirect costs of prostate cancer in four Latin American countries, 2015 (US\$ m; estimates)



Source: The Economist Intelligence Unit, *Assessing the burden of Prostate Cancer in Brazil*, October 2016.

### Prostate-cancer symptoms and survival rates

In its early stages, prostate cancer usually shows no symptoms. As the disease progresses, problems with urination are a common symptom.<sup>28</sup> Survival rates from localised prostate cancer are high if addressed appropriately; most men survive for ten years or more following diagnosis.<sup>29</sup>

However, in its advanced stage symptoms are more evident in pain in the hips, spine, ribs or other areas as the cancer spreads to the bones.<sup>30</sup> As for survival rates, about one in three men with advanced prostate cancer (30%) will live for at least five years after diagnosis.<sup>31</sup>

For early-stage prostate cancer the treatment options include the monitoring of the cancer within the prostate to see whether it is contained or is spreading (known as active surveillance or active monitoring); surgical removal of the prostate (prostatectomy); or radiotherapy by internal or external means.<sup>32</sup>

New scientific evidence from the so-called ProtecT trial suggests that active monitoring, with prompt treatment if needed, may be a preferable alternative to radical surgery or radiotherapy for prostate-cancer patients if the cancer is confined to the prostate gland.<sup>33</sup> In

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the trial, few men had died of prostate cancer after an average of ten years, and there was no difference in survival rates between men receiving active monitoring and those who had radical treatments, for example surgery (which caused incontinence and sexual-function problems in some men) or radiotherapy (which caused bowel problems, problems with sexual function and bladder emptying in some men). However, active monitoring was associated with an increased risk of the cancer progressing or spreading to other parts of the body.<sup>34</sup>

In the advanced stages of the disease, prostate-cancer treatment options include hormone therapy to stop the production of testosterone or prevent it from stimulating cellular growth; and chemotherapy, which can be used separately or concurrently.<sup>35</sup> Yet treatment often impacts patients' quality of life due to side effects or complications, such as urinary and erectile difficulties, that may be short- or long-term.<sup>36</sup> In Brazil, around one-tenth of prostate-cancer patients are diagnosed at the last stage (stage IV).<sup>37,38</sup>

Preventing prostate cancer from progressing to an advanced stage makes economic sense. In Mexico, the

number of prostate-cancer patients rose by 35% in the ten-year period from 2004 to 2013, according to the Mexican Association for the Fight Against Cancer, although at least part of this growth may have been due to population ageing and better data collection. Mayra Galindo Leal, director-general of the association, says that "the economic impact is obvious" in Mexico, as the cost of a late prostate-cancer case is almost three times that of a prostate cancer that is detected early. "With such a high number of deaths of men [who are] still productive, there is of course a strong economic impact," she adds.

However, population-wide screening to boost early detection is controversial. While policymakers in some countries have in the past promoted systematic screening of the male population to detect the disease at an early stage, it has been demonstrated that population-wide screening leads to overdiagnosis and overtreatment and does more harm than good. Instead, policymakers are now encouraging ongoing dialogue between medical practitioners and patients based on symptoms (see box: *Prostate cancer: awareness and prevention*).

## CHAPTER II

# CURRENT GOVERNMENT PRIORITIES

Despite rising awareness of prostate cancer as a significant public-health concern in Latin America, some experts argue that it has not been treated as such. This may in part be due to the fact that, for historical reasons, contagious and infectious diseases had earlier and prolonged attention and more resources devoted to them at the expense of a focus on chronic diseases.

According to Sandro Martins, chronic disease co-ordinator at the Ministry of Health in Brazil, “when the public healthcare system was set up, it had to respond to pressing challenges [such as] malaria or tuberculosis. Chronic diseases have not had such exposure until today.”

However, this is not the case in other parts of Latin America. In Colombia, for example, the fight against cancer in general is now a priority thanks to a policy transition, according to Luis Eduardo Bravo, an associate professor in pathology at the University of Valle in Cali. “Our country is simultaneously dealing with infectious and chronic diseases.”

Indeed, in recent years public policies aimed at addressing cancer have gained prominence in Latin America. Various governments, for example in Brazil and Colombia, have adopted official—and in some cases long-term—cancer plans; meanwhile, Brazil and Costa Rica have issued specific norms or protocols for prostate cancer, and Mexico is in the process of doing so.

### ***Pioneers and best practices***

Population-based cancer registries provide important information for planning, prevention and cancer management, but the data have to be comprehensive, valid and comparable.<sup>39</sup> Although *The Lancet Oncology* has noted some progress in the establishment of official cancer registries in the region since 2000, the WHO’s Global Initiative for Cancer Registry Development (GICR) has reported that high-quality, population-based cancer registries cover only 7.7% of Latin America’s population of 580m. In August 2016, therefore, the GICR launched the Regional Hub Co-ordinating Centre in Latin America in the Argentinian capital, Buenos Aires, to ensure further progress in registering those with cancer in the region by providing training on cancer registries.<sup>40</sup>

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The first cancer registry in the region was set up in the Colombian city of Cali in 1962 as the Cali Cancer Registry.<sup>41</sup> It is now a benchmark for regional authorities in planning their oncological services, says Professor Bravo, who is also director of the registry. Other Colombian cities, such as Medellín, have since set up their own cancer registries. Such registries provide detailed information that helps authorities to establish public-health strategies in the region.

The success of Cali's cancer registry has also helped to spawn registries for other conditions, such as HIV and haemophilia, since 2007, when Colombia's health ministry set up an autonomous fund, the Cuenta de Alto Costo (High-Cost Diseases Fund), to help to reduce inequalities of access for patients with cost-intensive diseases, including cancer.<sup>42</sup> "We have a nationwide registry for all types of cancer," says Lizbeth Acuña Merchán, executive director of the fund.

That said, there is no national Colombian cancer registry, and this limits coverage. A recent study of five major population-based cancer registries in Colombia (Barranquilla, Bucaramanga, Cali, Manizales and Pasto) showed that they covered only around 12% of the Colombian population.<sup>43</sup> An assessment of cancer-incidence data also showed global under-coverage of cancer registration at Bucaramanga and Manizales and more specific under-coverage for certain localities in Cali and Pasto.<sup>44</sup>

Costa Rica has taken inspiration from the success of the Cali registry by creating a nationwide population-based cancer registry, known as the Costa Rica National Tumour Registry. This was founded in 1976 to collect data on cancer incidence and prevalence across the entire country, and its data quality is generally good.<sup>45</sup> "Its data are published by the WHO's International Registry for Research on Cancer (IARC). [The registry is] very useful [for] health-services planning and decision-making at the technical and political levels", says Adolfo Ortiz Barboza, associate professor at the University of Costa Rica and a medical director at Costa Rica's Ministry of Health.

By contrast, Mexico's cancer registry is not population-based but rather hospital-based. Hence cancer surveillance is limited, with incidence data derived from national mortality estimates using modelled survival rates.<sup>46</sup>

Brazil's cancer registries are also fragmented. The Brazilian Population-Based Cancer Registries (PBCRs) were started in 1967, but there is no nationwide registry.<sup>47</sup> There are more than 20 PBCRs in Brazil, supported by around 300 cancer-hospital registers.<sup>48</sup> Support provided by the Brazilian government has strengthened the implementation of quality-control procedures and staff training since the 1990s, boosting the quality of data provided in PBCRs.<sup>49</sup> However, coverage is limited to around 20% of the population.<sup>50</sup> "In Brazil, we do not have the results of cancer care [on record]. We have not monitored the share of patients who have been cured and survived for 'x' years, for instance" because of the patchy coverage of cancer registries, says Mr Martins. "We are currently restructuring the system to monitor [and] to get these data in each hospital on a nationwide basis.



### ***Prostate cancer: a neglected disease?***

Against the backdrop of the growing prostate-cancer burden (see Chapter 1), several Latin American countries, including Mexico for example, have recently drawn up or are in the process of creating national cancer plans, and in particular norms for prostate cancer. In 2011 Costa Rica issued specific guidelines and policy recommendations for prostate cancer.<sup>51</sup> Meanwhile, in 2012 Colombia approved a ten-year plan to control cancer and issued official recommendations to address prostate cancer, from diagnosis and treatment to patient rehabilitation.<sup>52</sup>

More broadly, in 2009 Brazil adopted a set of policies on male health, the National Policy for Men's Health, and in 2015 it issued revised guidelines for prostate-cancer care.<sup>53</sup> But policies can be difficult to implement. "They have a written plan, but it is never put in practice," notes Rafael Kaliks, an oncologist at the Albert Einstein Hospital and director of oncology at the Instituto Oncoguia, an advocacy organisation for improved cancer-patient care in São Paulo, Brazil.

Despite this progress, addressing prostate cancer appears to be a low healthcare priority in the region. "Unfortunately, prostate cancer is not very popular in terms of advocacy or visibility. No one would admit that it is neglected, but it is," says Dr Kaliks. In Mexico, for example, more funds are channelled into combating breast, lung and ovarian cancers, although deaths from prostate cancer are more numerous than those from breast cancer, observes Mayra Galindo Leal, director-general of the Mexican Association for the Fight Against Cancer in Mexico.

In response, pressure groups across Latin America are organising through MOLACAP (the Latin American Movement Against Prostate Cancer), a regional network of non-governmental organisations (NGOs) that strives to raise awareness of prostate cancer among policymakers. "We are trying to put prostate cancer on the government's agenda," says Leticia Aguiar Green, co-ordinator of MOLACAP in Mexico.

The creation of national cancer registries all over Latin America is one of the main avenues through which MOLACAP is trying to help to mobilise budget allocations for prostate-cancer patients. "Money is always short in health departments. They need to know how much treatment costs and the probability of recovery. But we do not have data. [Governments] do not have the big picture, and they are not aware how big the problem is. And the government says we need the money for other diseases," explains Ms Aguiar Green.

### Prostate cancer: awareness and prevention

To diagnose and detect prostate cancer early, several Latin American non-governmental organisations have advocated patient screening. But addressing prostate cancer is a complex task in the region, due to the disease's taboo status in some contexts and also to scientific evidence that questions the usefulness of both population-wide screening and radical surgery or radiotherapy. Dialogue between doctors and patients on the merits and disadvantages of screening can be seen as a first step towards a valid patient-centred approach. While early detection is desirable, screening tests may in some cases lead to false positive results or generate side effects and incur unnecessary costs.

Despite a number of public-awareness campaigns, "a problem related to [the] macho culture in Latin America persists," says Leticia Aguiar Green, co-ordinator of MOLACAP (the Latin American Movement Against Prostate Cancer) in Mexico. "Men don't want to talk about it; it is a cultural problem," observes Gabriela Echeverría, director of patient care at Salvati, a Mexican foundation that strives to raise awareness of prostate cancer and to improve patients' quality of life after treatment or cancer surgery. According to Ms Echeverría, men's reluctance to discuss the issue has undermined Salvati's efforts to set up support groups for prostate-cancer patients.

"Prostate cancer [kills more people] than breast cancer in Mexico," says Mayra Galindo Leal, legal representative of the Mexican Association for the Fight Against Cancer in Mexico. "Men are not aware (of the problem). They do not want to go to the doctor. The ideal would be that [when] women take a breast-cancer test [they] take men along with them to test for prostate cancer." Such an approach, which does not require policy change, high-cost treatment or medical intervention, is but one example of a more integrated or patient-centred way of combating prostate cancer—an approach medical practitioners and policymakers in the region increasingly favour.

That said, broad screening has been questioned by scientists and many policymakers in the region on the grounds that screening often diagnoses prostate cancer at a stage that is too late for successful intervention. As a result, the prostate cancer diagnosed in more than half of patients is already at an advanced stage. In order to prevent advanced-stage prostate cancer and the high mortality rates associated with it, a patient-centred approach could include active monitoring, with prompt treatment if needed, for localised prostate cancer. Scientific evidence from the ProtecT trial suggests that such an approach may be a better option than radical surgery or radiotherapy for patients with localised prostate-cancer.<sup>54</sup>

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Scientific studies also highlight the questionable efficacy and return on investment of such tests. In many cases, results from the current screening method, which combines a prostate-specific antigen (PSA) test and rectal digital examination, have proved unreliable. More specifically, men may be incorrectly diagnosed with prostate cancer (“false positives”), causing them distress and leading to unnecessary tests, treatment and costs for health-service providers. In 2013 Brazil’s National Cancer Institute (INCA) warned that broad screening was a method that “may do more harm than good”.<sup>55</sup> Guidelines for prostate cancer in Brazil have been published by the Ministry of Health, and since 2014 they have recommended that screening should not take place at the level of the general population.<sup>56</sup> This is in line with practice in countries in Europe and elsewhere in which population-wide screening is not recommended.

“We are against population-wide screening,” says Sandro Martins, chronic disease coordinator at the Brazilian health ministry, which in 2015 issued a revised protocol on prostate-cancer diagnostics. “[We do not recommend] screening for patients without any symptoms, only for patients with urinary symptoms. Some high-risk groups, such as black men or those with first-degree relatives with the disease, are nevertheless advised to consider screening from the age of 45.”

In Mexico, the minutes of a new health ministry protocol to be issued in 2017 recommend screening for male patients from the age of 45, or even 40—that is, age groups that experts there now deem to be at high risk.<sup>57</sup> Similarly, 2016 saw the launch of an early-detection campaign against prostate cancer for men aged above 40 in Costa Rica.<sup>58</sup>

In all cases, it is the dialogue between doctors and patients that should prevail, Mr Martins emphasises. Patients must be informed about the risks and benefits of both screening and detection. Mr Martins highlights the fact that, because there is no certainty regarding screening, the relationship between the urologist or oncologist and the patient is all the more important.

“Physicians should be trained to recognise the symptoms,” says Rafael Kaliks, an oncologist at the Albert Einstein Hospital and director of oncology at the Instituto Oncoguia, an advocacy organisation for improved patient care in São Paulo, Brazil. “If a patient is proactive enough to ask me whether he should do the PSA screening or not, my answer is yes. But if you ask me whether the Brazilian government should pursue population-wide PSA testing and digital rectal examination, the answer is no. The money should be spent elsewhere, because it will not decrease prostate-cancer mortality.”

## CHAPTER III

# PATIENT-CENTRED CARE: FOCUS ON PATIENT NEEDS AND PATIENT CHOICE

Based on the evidence gathered in this report, among the four countries we examined patient-centred care is strongest in Costa Rica, while multidisciplinary care is restricted to a few institutions in Mexico and Brazil. As far as pain management and palliative care are concerned, Colombia and, especially, Costa Rica have registered most progress. Interviews conducted for this report highlight the fact that there is a will to move towards integrated care, but that policymakers tend to focus on pressing budgetary issues rather than taking a long-term view. Much work lies ahead in most countries to improve the response to patient needs and to place patients at the core of healthcare.

### ***Health structure***

Latin America has a variety of healthcare systems. This study will take a look in particular at the structures and policies in Brazil, Colombia, Costa Rica and Mexico. Brazil, Colombia and Costa Rica lean towards universal healthcare systems, although the challenges vary greatly between countries.

Costa Rica, with its population of just 4.5m and its relatively stable economy, has one of the best-performing universal healthcare systems in the region, while Brazil struggles to deliver good-quality care to its 200m-plus people. Around one-quarter of Brazilians also have private healthcare: Brazilians who can afford it tend to pay for private insurance in order to avoid the public health system.<sup>59</sup>

Colombia's healthcare system provides almost universal coverage, with 93.6% of the population covered.<sup>60</sup> Studies evaluating the impact of universal health insurance in Colombia highlight the fact that it has greatly increased access to and use of health services, including those services that are free to all users, and has reduced the incidence of catastrophic health spending.<sup>61</sup> Out-of-pocket expenditure as a share of total expenditure on health fell from 38.1% in 1995 to 15.4% by 2014 and is now much lower in Colombia than in Brazil (25.5%), Costa Rica (24.9%) or Mexico (44%).<sup>62</sup> In recent years the focus in Colombia has switched from providing universal coverage to issues around funding, quality and how extensive the benefit package should be. Since 2016 the country has instituted a reform to organise healthcare delivery into patient-focused units known as *Rutas Integrales de Atención en Salud* (co-ordinated care programmes).<sup>63</sup>

### **Cancer care**

In Mexico, which has a predominantly publicly funded healthcare system known as Seguro Popular, cancer treatment is available to the entire population. Although Seguro Popular has greatly enhanced access to health services across the country and has reduced out-of-pocket health expenditure, major challenges remain, including limited institutional capacity at the federal and state levels, tensions in federal-state relations, limited information systems, the influence of political interests and the use of financial resources for unauthorised expenditure at state level.<sup>64</sup> In addition, many employees in the private sector and civil servants can access better-quality services through private health insurance.

Despite their stretched public finances, large countries such as Brazil and Mexico boast high-quality public cancer hospitals in large cities. But outside these major urban centres patients often face long journeys to receive cancer care in state-run hospitals. "There are a few excellent hospitals in the federal district (DF) of Mexico, but none in the rest of the country, especially outside large cities. Outside the DF, some of them do not even have an oncology centre. So patients are being sent away from their families to be attended," says Mayra Galindo Leal of the Mexican Association for the Fight Against Cancer.

Across Latin America, few countries can cope with the growing number of cancer patients. This translates into long waiting lists—and the quality of patient care suffers accordingly.<sup>65</sup> Even in Costa Rica, patients face waiting lists for admission to public hospitals for examinations and radiotherapy, according to Adolfo Ortiz Barboza of the University of Costa Rica and the country's Ministry of Health; over 90% of the population are covered by the public health system in Costa Rica.

Similarly, in Brazil the quality of cancer-patient care provided can vary greatly between the private and public healthcare systems, as well as between different locations of care delivery.<sup>66</sup> "There is [cancer] treatment available to every patient that walks in the door," says Dr Kaliks. "But there is no homogeneity in terms of the quality of care delivered to patients throughout the country. Even within the state of São Paulo, there are better and worse hospitals in the public health system."

### **Lack of personalised care a key barrier to patient-centred cancer services**

"Any man who starts having urinary symptoms should be able to see a physician immediately," notes Dr Kaliks, referring to one of the first signs of prostate cancer. However, realising this goal appears to be a distant prospect across Latin America.

Indeed, media reports often feature cancer patients who must travel for several hours to reach hospitals in state capitals.<sup>67</sup> "In the north and north-east, the care is dismal in

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every sense of the word. It may take several months to get an appointment, and several months to do a test," explains Dr Kaliks.

This lack of personalised care is a big obstacle to patient-centred care. Many Brazilians do not have a personal physician, so they often see a different doctor on each hospital visit, according to Dr Kaliks. There is a high level of rotation among doctors in the public health system. Because doctors move around quickly, patients are unable to obtain personalised care. This also means that a patient's medical condition cannot be tracked closely, thus undermining continuity and integration of care. Hence, telehealth—remote diagnosis, treatment and monitoring, for example via video conferencing—has the potential to bridge some of the geographical challenges in terms of access to healthcare, including cancer care, in the country.<sup>68, 69, 70</sup>

Some countries in the region have included multidisciplinary care in their official policies, but it is seldom implemented. "In Brazil, there is a trend towards multidisciplinary care for cancer," notes Dr Kaliks. This involves a range of medical specialists from oncologists and psychologists to psychotherapists, nutritionists and nurses. But this has little practical effect yet. Such teams may exist, but there is little communication and interaction among their various members. "In theory, every cancer hospital should have a multidisciplinary chair, psychologists that help patients, a team," says Dr Kaliks. "But this is just something that is written on paper. In real life, it does not happen."

That said, the availability of training in multidisciplinary cancer care is improving. For example, the Sociedade Brasileira de Cirurgia Oncológica (SBCO; Brazilian Society of Surgical Oncology) promotes leadership and collaboration in multidisciplinary cancer care, while the American Society of Clinical Oncology (ASCO)—in partnership with the Sociedade Brasileira de Oncologia Clínica (SBOC)—has offered courses in multidisciplinary cancer management.<sup>71,72</sup>

A knowledge gap also constrains moves to make care more patient-centred. "In Brazil, we don't have nurse practitioners as they do in the US or Canada. The difference in knowledge between the nurse and the physician is much larger [in Brazil than in] the US or Canada. Here, nurses are less [well] trained and [their] interaction with physicians less intensive. Even in the private health system, there are different levels of quality," adds Dr Kaliks.

Indeed, multidisciplinary care appears to be the exception rather than the rule in the region. In Brazil, fewer than 20% of public hospitals and roughly one-half of private hospitals have capacity for multidisciplinary cancer care, says Dr Kaliks. Moreover, only a handful of hospitals in Brazil have case managers. "Patients have to sort themselves out on their own. The oncologist should help patients navigate through the system, but they often have to find out by themselves and look for psychological help or phytotherapy," adds Luciana Holtz de Camargo Barros, president and chief executive officer of Instituto Oncoguia. Physiotherapy may also help with rehabilitation but is seldom used, she says.

Mexico also lags in this area. "In Mexico, the national cancer hospital (INCAN) is the only hospital [that offers] this kind of multidisciplinary care," says Gabriela Echeverría, director of patient care at Salvati, a Mexican NGO that strives to improve quality of life for patients after cancer treatment and surgery. But multidisciplinary care is not widespread. "Oncologists have to figure out how important quality of life is. They just control the symptoms, they just control the physical problems, but it is also important for a patient to have good nutrition, pain control, to prevent other problems. They still don't get it."

When it comes to a multidisciplinary model in cancer care, Costa Rica may be the exception in the region. Mr Ortiz Barboza calls the country's approach a "comprehensive care model". "There is a comprehensive set of services, from psychology and nutrition to physical therapy," explains Cintia Solano Cantillo, founder of ANASOVI (Association for a Second Opportunity in Life).

### ***Pain management and palliative care***

Costa Rica also stands out in terms of pain management and palliative care. For cancer treatment, pain management and palliative care can play a pivotal role in a patient's quality of life, particularly when the disease has progressed. Costa Rica has a good network of pain clinics and palliative-care centres, according to Ms Solano Cantillo. Among countries in Central America and the Caribbean, Costa Rica has been singled out for praise in terms of integrating palliative cancer care activities with mainstream service providers.<sup>73</sup>

By contrast, research compiled by Human Rights Watch, an NGO, highlights major deficiencies in palliative-care services and pain clinics in Mexico, showing that seven of the country's 32 states, with a combined population of almost 16m people, do not have any known palliative-care services in the public healthcare system.<sup>74</sup> Mexico also suffers from limited access to painkillers because, as "controlled substances", they are subject to special regulations and few physicians are trained in using them.<sup>75</sup> "There is a lot to improve," notes Ms Galindo Leal.

Brazil also has major work to do to improve in this area. "Brazil...has one of the worst pain-management [systems] in the world," says Dr Kaliks.

Oncologists often lack the training and knowledge required to send patients to pain clinics. "[Pain clinics] are not really well known, and sometimes oncologists are reluctant to send patients there. Pain is not properly addressed. Often patients have to cope with pain. Oncologists [should be trained to address] patients' pain," says Ms Holtz de Camargo Barros. A 2016 cross-sectional study of resident nurses who were enrolled in the multi-professional oncology residency programme of a High Complexity Oncology Centre (CACON) in Rio de Janeiro in 2013 revealed that most of them had inadequate knowledge of the management of cancer pain.<sup>76</sup>

### **Family matters**

Families play a crucial role in Latin America in decisions involving end-of-life care and advanced care planning.<sup>77</sup> More broadly, training families in patient-centred care requires improvement. Across the region, many families play the role of caregivers but are woefully unprepared for the task. "Training for family members is still very primitive. We don't have a specialised service to train relatives to take care of [family members with cancer]. So people learn by themselves," observes Dr Kaliks.

In many Latin American societies, family members are often consulted about cancer diagnoses even before patients themselves.<sup>78</sup> But the family's role may start even before diagnosis. "They push the patient to go to the doctor. Sometimes men go to the doctor because their wives literally take them there," says Ms Aguiar Green of MOLACAP in Mexico, who insists that cancer is a family issue. "The disease affects all the family, it has an impact on the economy of the family, it has an effect on the relationship of the couple. At the beginning we wanted men to take responsibility for their health, but we found that this message did not work very well, so we got the women involved in our awareness campaign."

Governments and companies can ease the financial pressures on families that take care of prostate-cancer patients by increasing the levels of payments of employee benefits to cancer patients (see box: Employee benefits for cancer patients in the region).

### **Employee benefits for cancer patients in the region**

Employee benefits for those who are unable to work for health-related reasons vary widely across Latin America, and often depend on the extent of public healthcare coverage. In Brazil, individuals who pay into the social-security system are entitled to receive benefits (payouts) if they are temporarily incapacitated. Benefits are paid by the state from the third week of sick leave. The disease and the inability to work must be confirmed by a social security doctor.

In Brazil, cancer patients may retire early if they are permanently incapacitated. They are also granted income-tax and

mortgage exemptions, if applicable. In addition, some urban public transport is free to cancer patients. All elderly and disabled patients, and those with cancer, are entitled to benefits equivalent to one minimum salary if their family income is below 25% of the legal monthly minimum wage.

Colombia also grants pensions to cancer patients that are equivalent to a share of their income. "All types of cancers are covered by our benefit plans," says Lizbeth Acuña Merchán of Colombia's Cuenta de Alto Costo (High-Cost Diseases Fund).



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In Costa Rica, those patients who previously worked in the formal economy are entitled to a pension or subsidy if incapacitated by cancer, while those who were employed in the informal sector may apply for social-assistance benefits from the Department of Social Security, according to Adolfo Ortiz Barboza, associate professor at the University of Costa Rica and a medical director at Costa Rica's Ministry of Health.

In Mexico employee benefits are not as generous, due in part to the highly fragmented character of the country's

social-security system. Private-sector employees who depend on the Instituto Mexicano del Seguro Social receive social benefits for only six months (extended to one year in some cases), according to Mexican regulations. A large percentage of the population who are unemployed or excluded from the formal job market depend on the public health system, known as Seguro Popular. However, in such cases they are not entitled to any sickness benefits, according to Mayra Galindo Leal, director-general of the Mexican Association for the Fight Against Cancer.

### **Access to innovation**

Economic conditions and fiscal constraints also mean that access to more sophisticated treatment is often limited in the public health system. In Brazil "the standard [prostate-cancer] treatment offered and paid for by the government is exactly the same as it was ten years ago, although [since then] several improvements in prostate-cancer care have [come into effect] in the [Brazilian] private health system and [around] the world," says Dr Kaliks.

Access to innovative medicines and technology is an area where there is a wide differential. "In the private health system, patients may have access to more innovative treatment," says Ms Holtz de Camargo Barros. She notes that many new cancer drugs have been discovered in the past decade, "but these are not available in the public health system."

A shortage of equipment also impacts the quality of healthcare. "Radiation therapy is not available to everybody who may require it," says Dr Kaliks, noting Brazil's deficit of about 40% in the area of radiation-therapy equipment. "So 40% of all patients with an indication of radiation therapy are not receiving the treatment that they should, just because there are not enough machines. This is true in the public health system, which is very short of radiation machines, but also [to some extent] in the private system." Dr Kaliks also points out that there are no plans in the public healthcare system to introduce 3D technology for radiation therapy.

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There is even more room for improvement in other areas of technology, such as the use of electronic health records. Such records could support integrated care by collecting patient-level data and lead to cost savings and fewer medical errors.

In Costa Rica, Mr Ortiz points to a technological divide between the private and public sectors, with greater access to modern technology in private hospitals and clinics than in public ones.

Meanwhile, in Brazil, Mr Martins says that information gathering and information sharing depend on local authorities, but that these institutions do not perform well in this regard. "This is the Achilles' heel of the system. Our [integrated information] tools are of very poor quality. Some [in the south-eastern regions] have good systems, but the others are not improving." Information-gathering is managed at the local level, but "the great majority of towns have inefficient systems of care management because they don't use the tools to share that information. The fragmentation of the information chain is a great obstacle. Especially in the case of prostate cancer patients are not [treated] quickly because they are not part of the same integrated network."

It is difficult to build a patient-centred care system that focuses on patient outcomes and value-based healthcare in the absence of effective systems to assess the cost-effectiveness of new health technologies, for example through health technology assessment (HTA).<sup>79</sup> Since the late 1990s the strengthening of HTA and reimbursement regimes has been on the agenda in Latin America, with varying degrees of progress occurring.<sup>80</sup> In order to boost HTA in the region, in 2011 the Pan-American Health Organisation and its member countries launched a Regional Network of Health Technology Assessments for the Americas (RedETSA). This aims to promote and strengthen HTA through regional information exchanges "to support decision-making on regulation, use and replacement of technologies, improvements in the quality of care and rational use of technologies, and contribute to the sustainability and equity in access to health systems".<sup>81</sup>

In Mexico, HTA and economic evaluation have played a fundamental role in the acquisition of new health technologies for a number of years.<sup>82</sup> In Brazil, HTA as a requirement for decision-making processes in the public health system was defined in 2011 with the creation of the National Committee for Health Technology Incorporation (CONITEC). By 2015 new technologies made available within the public health system had already benefited more than 50m Brazilians, reflecting US\$1bn in public spending.<sup>83</sup> Similarly, Colombia has made progress in recent years in rationalising healthcare expenses and ensuring equitable and timely access to health technologies, as highlighted by the creation of the Institute of Health Technology Assessment (IETS) in 2012.<sup>84</sup>

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However, in contrast to the situation in other areas explored in this report (such as cancer registries, multidisciplinary care, pain management and palliative care), Costa Rica lags behind other countries in the institutionalisation of HTA. The OECD notes that HTA for the introduction of new drugs is performed only at the central level of the Costa Rican Social Security Fund (CCSS); for medical devices, no HTA institutional practice has yet been established, thus limiting evaluation to costs only.<sup>85</sup> That said, Costa Rica is currently exploring options for the design of HTA in the country.<sup>86</sup> Nonetheless, in the absence of an explicit, transparent and evidence-based approach—such as HTA—for rational priority-setting in the provision of access to care, the Costa Rican government (and other governments) has faced an increasing number of court cases relating to patients' rights to access medications.<sup>87,88</sup>

## CONCLUSION

Prostate cancer is the leading cause of male cancer-related deaths in Latin America. The disease increasingly preoccupies public-health officials in the region, as rates of prostate-cancer incidence and mortality alike will rise sharply in the coming years amid growth in risk factors (such as population ageing and unhealthy lifestyles).

Costs, both direct and indirect, are also set to rise. Worryingly, public health systems are already overwhelmed and are ill prepared to cope with the expected flood of new patients.

Outside large cities, access to prostate-cancer care is alarmingly weak. There is still considerable room for improvement in the implementation of multidisciplinary care, although private health institutions tend to fare better in this regard. Overall, progress towards putting patients at the centre of the healthcare system has so far been limited in the region.

Patient-advocacy groups in Latin America have only recently started to pool their efforts to raise awareness about prostate cancer. MOLACAP, a regional platform of NGOs that focus on the disease, was set up in 2013, years after breast-cancer advocacy groups had already started to mobilise public opinion regarding that form of cancer.

Cultural factors, and in particular men's reluctance to see a doctor, play a role too. Relatively cost-effective innovative solutions to this problem exist but are not yet in widespread use. A case in point is the idea that when women take a breast-cancer test they take men along with them to test for prostate cancer—an approach that does not require policy change, high-cost treatment or medical intervention. This is an example of the more integrated, patient-centred approach to combating prostate cancer that is increasingly favoured by medical practitioners and policymakers in the region.

The family environment plays an important role in Latin America. Hence, more support, guidance, advice and training for family members on how to become effective caregivers could be a crucial element of a more patient-centred approach to prostate-cancer care in the region.

Further efforts must be made to move towards patient-centred, integrated care that better co-ordinates communication and decision-making among various stakeholders in the patient journey. This entails multidisciplinary care that is overseen by a case manager or other medical professional who helps patients to navigate their way through the healthcare system. Pain management and palliative care are better in some countries (such as Costa Rica) than in others, but across the region there is room for improvement.

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This report has also identified deficiencies in the integration of technology—such as medical equipment and the use of electronic health records and care-management systems—into the healthcare system to support integrated prostate-cancer care. Across Latin America there are technological divides between the private and public healthcare sectors, as well as between regions within countries (for example in Brazil).

Many Latin American countries continue to struggle with fiscal pressures, following years of economic stagnation or even crises. But many countries, such as Colombia, are rethinking their social-security programmes; Brazil may do the same, amid a great deal of national debate about healthcare. This would seem to be an opportune moment to explore the benefits of patient-centred care with regard to its potential advantages in terms of cost savings, success rates, efficiency, and patient satisfaction.

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