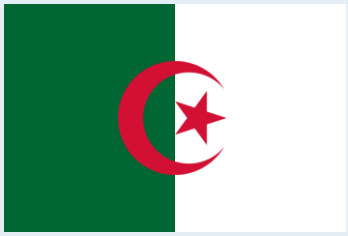
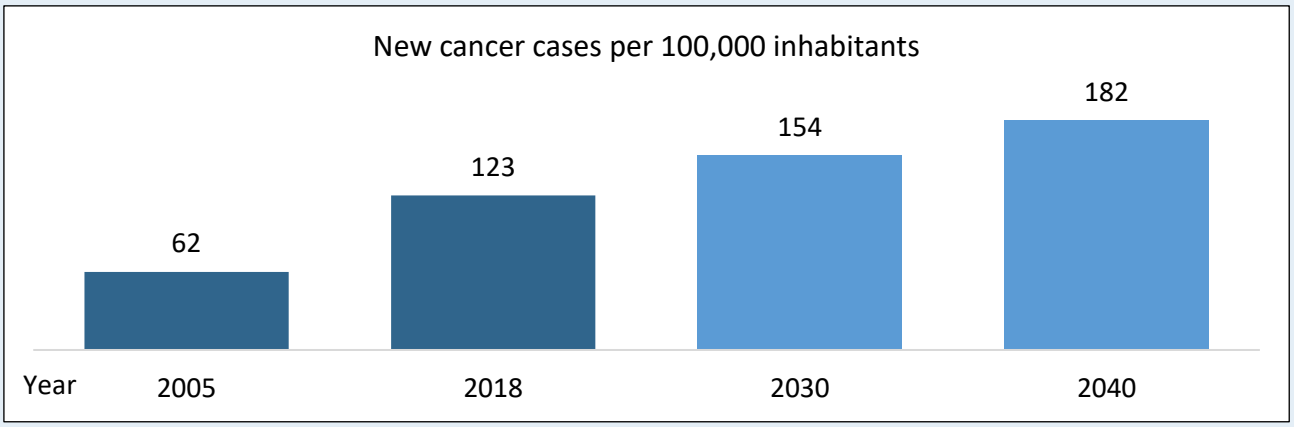


ALGERIA

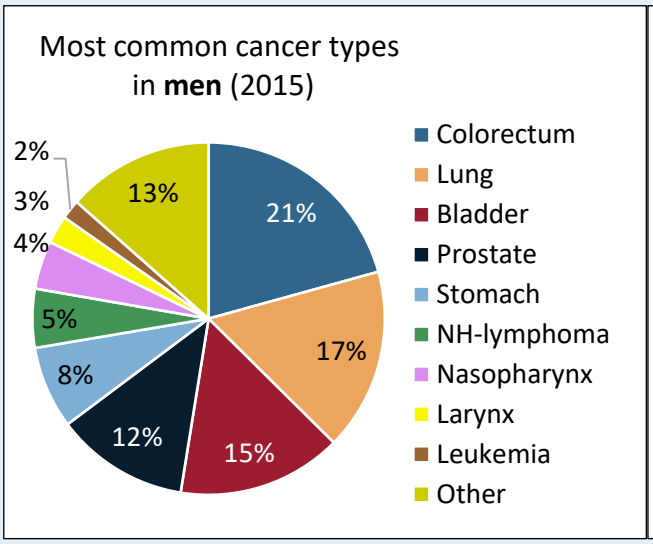
Population: 43.1 million
GDP per capita: USD 3,976
Life expectancy: 76.6 years
Total health expenditure: 6.2% of GDP
(in 2018)

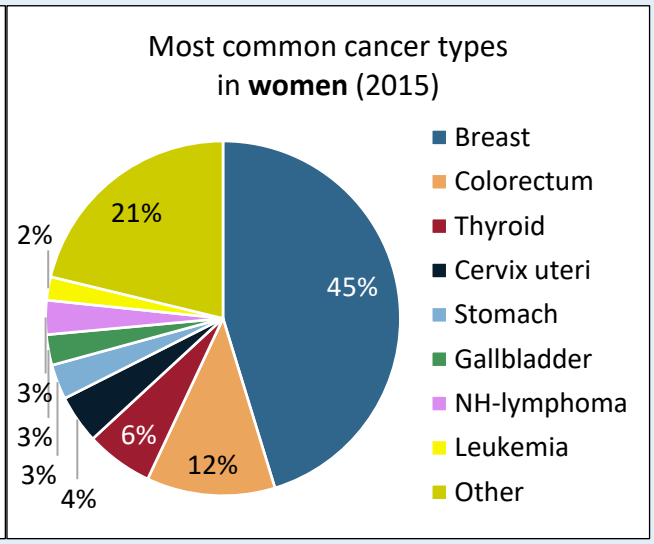
Cancer epidemiology

- The number of newly diagnosed cancer cases (incidence) has been increasing and is expected to increase further in the coming decades.

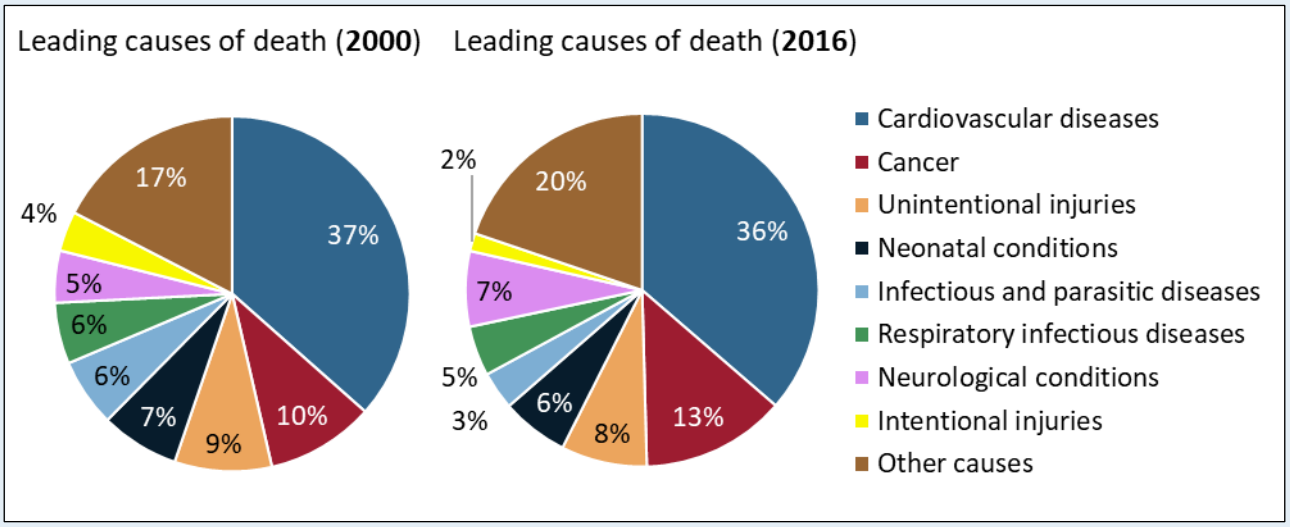


- There are many different cancer types diagnosed in men and women.





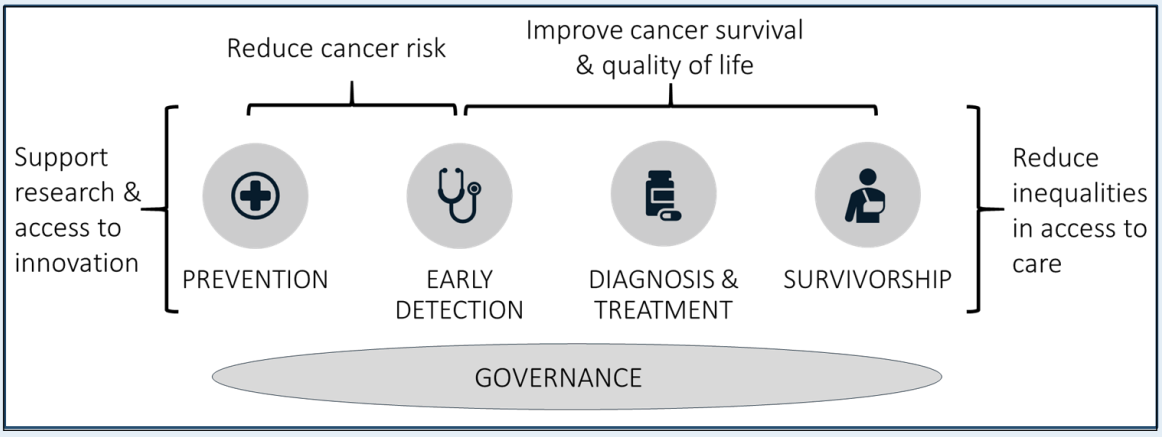
- Cancer is gradually becoming one of the leading causes of death.



Economic burden of cancer

- **Direct costs** within the health care system: USD 10 per capita in 2018 (≈3.7% of total health expenditure)
- **Indirect costs** of productivity losses (premature death, sick leave, early retirement): USD 4 per capita in 2018
- **Informal care costs**: not quantifiable

Areas of cancer control and overarching goals



Recommendations to improve cancer care

General steps to improve cancer care:

1. **Measure and understand** the magnitude and the development of the disease burden of cancer
2. **Plan, coordinate, and implement** – financial and non-financial – actions to address cancer
3. **Monitor and evaluate** actions on cancer control

Governance of cancer care

- The first cancer plan for 2015–2019 led to improvements in many different areas of cancer care and succeeded in achieving many of its objectives. This was facilitated by a dedicated funding plan for all actions. The planned evaluation of the first plan needs to be finished and then made publicly available. Based on the lessons drawn from the evaluation, the establishment of a second cancer plan needs to be a priority. The local research community and cancer patient representatives could also be involved in this process. The second plan needs a clear aim to reduce incidence and improve survival and also once again include a funding plan for all planned actions.
- Improving health system performance and monitoring of all actions is important. The current situation is that hospitals are allocated with a budget, but there is no follow-up of how the budget has been spent. The cancer registries could be developed further so that they can be utilized to analyze treatment patterns and efficient use of resources.
- Institutions such as the National Institute of Public Health (INSP) within the MSPRH could support local competence development in fields such as health economics, HTA, payment models, etc. to support the growing challenges of access and management of new cancer drugs.

Organization and financing of health care and cancer care

- Public spending on health care amounts to around 4% of GDP, which falls short of the informal WHO spending target of 5% of GDP. Additional spending to bring the country closer to the benchmark would be needed.
- Around 90% of the population are covered by two public insurance funds (CNAS and CASNOS). Ways to cover the remaining uninsured population need to be explored.
- CNAS/CASNOS only cover medical services at public health facilities. Many insured patients seek certain services in the private sector due to perceived lower quality of care in the public sector. This leads to high out-

of-pocket expenditure, as few patients have a private health insurance that covers services in the private sector. Expanding the role of private health insurance could be considered.

- CNAS/CASNOS could start covering certain medical services at private institutions. One suggestion is to perform all cancer screening activities in private health facilities and have public health facilities focus on cancer treatment instead.
- CNAS/CASNOS usually do not cover the full price of medical services at public health facilities. This leads to rather high out-of-pocket expenditure of patients. Higher reimbursement rates by CNAS/CASNOS for medical services could be considered.
- Patient referral needs to shift from a paper-based to an electronic system.

Cancer registration

- Continuing to improve cancer registration and its analysis is important. There is no nationwide population-based cancer registry, although the recent establishment of three networks covers now 70–90% of the population. Remaining regions need to be encouraged to establish registries.
- Only cancer incidence is captured in the cancer registries, while information on cancer mortality is missing. Linking information on mortality to the registries and assessing survival needs to be prioritized.

Prevention

- The fight against tobacco consumption needs to be stepped up. A special focus needs to be placed on children and young people and existing age limits need to be enforced. Existing smoking bans in public indoor places also need to be enforced. Cigarette smuggling also needs to be put a stop to. Excise taxes on cigarettes could be increased further.
- Obesity needs to be addressed. Measures need to be taken to encourage changing dietary habits back from a Western diet with fast food to a Mediterranean diet. Excise taxes on sugary drinks could be introduced. Ways to increase physical activity also need to be encouraged.
- A strategy to roll out a vaccination program against HPV in children could be considered, as cervical cancer is the fourth most common cancer type in women.

Early detection

- General physicians need to be better trained to recognize common early symptoms of cancer. Health literacy in the general population on early symptoms of cancer also needs to be improved.
- Screening has become a priority in recent years. The ongoing pilot projects for organized breast cancer screening and colorectal cancer screening need to be evaluated, before deciding on country-wide expansion.
- Steps to turn opportunistic cervical cancer screening into an organized program could be taken to improve participation.

Diagnosis and treatment

- Achieving a balanced workforce and a balance between infrastructure and workforce needs to be prioritized. While the number of medical oncologists has increased greatly, there are very few nurses. Many new cancer centers have been established in recent years, but adequate staffing with trained personnel is a challenge.
- There are few modern diagnostic imaging units, with the first two PET scanners becoming available only in 2021 in the public sector, which limits accurate diagnosis for the vast majority of patients. Investment in additional scanners could be considered to enable greater patient access.
- Molecular diagnostic laboratories need to be established to enable the administration of modern cancer drugs.
- Multi-disciplinary team meetings to find the best treatment decisions could be introduced.
- The treatment guidelines currently developed by the Special Cancer Committee need to be published and applied consistently to ensure more equitable care all over the country.
- The number of radiation therapy machines has improved and is now not too far below recommended standards, but the geographic distribution is inadequate. Waiting times of three to six months for treatment in

the eastern and southern parts of the country compared to only a few weeks in the rest of the country call for the installation of additional machines in these regions.

- The availability of modern cancer drugs (targeted therapies and immunotherapies) is very limited. The Special Cancer Committee is tasked to review cancer drug access and improve the situation. The criteria applied in this review are unclear. Previous drug assessments were focused on the price of drugs instead of also taking into account the value that they provide to patients. A shift towards a more value-based assessment – as part of a transparent process – could help in the prioritization of introducing modern cancer drugs.
- Clinical trial activity could be promoted to create another route for patients to access modern cancer drugs. The current clinical trial regulation hampers clinical trial activities. The regulation would need to be revised to make it less bureaucratic.
- The regulatory approval of drugs could be accelerated – at least for those with high clinical benefits. This would make them at least available in the private sector and would stop wealthy patients from traveling abroad to receive modern cancer drugs.
- The drug management systems need to be improved. The current systems of the Ministry of Pharmaceutical Industry responsible for purchase of retail drugs and the PCH responsible for hospital drugs are not functioning well. Cancer patients face breaks in their drug treatment or cannot finish it all, because the supply of even old drugs with generic availability is not working properly.
- The first positive experiences with biosimilars should be built on and greater use of biosimilars and generics could be encouraged. Local production of generics/biosimilar could stimulate competition and reduce prices further to create budget headroom for new drugs.

Survivorship

- The few existing psycho-oncology services could be extended to more facilities and offered to more patients.
- Informal caregivers with regular jobs could be better supported, such as through a right to flexible working arrangements and paid leave.
- The reintegration in the labor market of cancer survivors could be supported by flexible working arrangements.
- Cancer survivors could be protected from discrimination in the acquisition of certain services (e.g., health insurance, life insurance, loans, mortgages), by imposing time limits up to which a previous cancer diagnosis needs to be disclosed.