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Sociodemographic, political, and policy contexts of cancer care: A comparative analysis of countries with the highest survival rates

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ABSTRACT

Introduction: Cancer remains a leading cause of mortality, with 20 million new cases and 10 million deaths in 2022 (WHO). Despite advances in detection and treatment, structural inequalities affect exposure to risk factors and healthcare access. This study compares the cancer care policy contexts of five countries with the highest five-year survival rates.

Methods: This qualitative review examines cancer care policies in Australia, Canada, Costa Rica, Belgium, and Japan countries through a critical comparative approach. Data was gathered from official and international documents, focusing on four domains: socio-demographic characteristics, socio-political traditions, health systems, and cancer policies.

Results: The countries share high life expectancy, and education, while face similar population challenges. Australia and Canada have implemented telemedicine and mobile services to address the needs of dispersed rural populations, while Belgium and Japan ensure equitable access in dense areas. All countries integrate public-private partnerships, and adapt governance structures to contexts, under a strong welfare state with universal health coverage. Cancer policies are characterised by participatory processes that emphasise equity, accessibility, and innovation

Policy summary: The study identifies consistent patterns in cancer care policies, highlighting contributing factors to high survival rates. Participatory and bottom-up policy design enables responses to complex contexts. Strategies focus on financial sustainability, equity, cultural relevance, and territorial adaptation. An innovative framework for assessing cancer care policy contexts is introduced.

1. Introduction

Cancer remains one of the leading causes of mortality worldwide, significantly impacting public health and healthcare systems. According to the World Health Organisation (WHO), approximately 20 million new cancer cases were recorded globally in 2022, resulting in around 10 million deaths [1]. Although mortality rates have declined in many countries due to advances in early detection and treatment, these improvements are not consistent between regions. Deep structural inequities between and within countries influence exposure to risk factors and access to comprehensive healthcare services, ultimately shaping health outcomes and generating significant disparities [2]. These inequities directly affect all stages of the disease, from early diagnosis to active treatment, post-treatment care, and palliative care. Public policy plays a fundamental role in [3] enhancing cancer care by promoting more accessible, high-quality, and equitable approaches. The main aim of this review is to compare the sociodemographic, political, and policy contexts of public cancer care in five countries with the highest net five-year survival rates (2010–2014) per continent.

For the purposes of this review, cancer public policy is defined as the

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set of health and social actions aimed at promoting the well-being and autonomy of individuals facing the disease, as well as their care networks. This definition similarly integrates political, sociocultural, and economic dimensions into the provision of care. From this perspective, cancer policies transcend the biomedical paradigm, addressing all stages of the disease integrally, from early diagnosis to palliative care and survivorship [4].

The five selected countries have distinct political traditions and are located in diverse geographical regions, offering both geographical and political diversity. This diversity has enriched the analysis, by allowing the exploration of socio-geopolitical contexts of public cancer care policies, and, thereby, enabling the identification of patterns, challenges, and strategies that contribute to high cancer survival rates in the selected countries.

2. Methodology

This qualitative review explores the context of cancer care policy in five selected countries through a comparative approach. The country selection was based on the highest five-year net survival rates (2010–2014), according to data from the CONCORD-3 project [5] (see Table 1). For this purpose, five of the six most prevalent cancers were included: breast, lung, colorectal, prostate, and gastric, excluding non-melanoma skin cancer due to insufficient detailed data. In addition, geographic and political representation was ensured, with 5 countries from different geographical zones and political traditions included: Canada was chosen for North America, Costa Rica for Latin America, Belgium for Europe, Australia for Oceania and Japan for Asia. Africa was excluded due to the limited reliability of data reported in CONCORD-3.

Data for each country was gathered through a comprehensive review of official and international public documents on cancer treatment policies, drawing from sources such as the World Bank, OECD, academic literature, policy papers, and government websites.

The analysis was descriptive and comparative, based on four key domains developed through a reflective process conducted by the research team. The information retrieval and the description of each country were structured around:

- Population and socio-demographic characteristics (Table 2): This dimension included population size (male and female), percentage of rural population, ageing rate, life expectancy and average years of schooling. These indicators were selected because they are essential for understanding the potential demand for health services and the territorial needs of the population in each of these countries.
- State type and socio-political traditions (Table 3): The type of state was analysed according to the Esping-Andersen classification [6]. The political traditions of the selected countries, and the historical emphasis placed on democracy and political participation are explored as they are widely accepted as key determinants of health.
- Health system structure (Table 4): Data on coverage, financing, health expenditure, and organisation of health services were analysed as these determine the accessibility and quality of services available for cancer treatment.
- Cancer policy frameworks (Table 5): This dimension covers the name and origin of the current cancer policy, the actors involved, and the principles or values underpinning it. The participants in the policy process were included as a descriptive category, since the available evidence suggests that when governance is in place, health policies are more effective [7–10].

The comparative analysis allowed for the identification of patterns and differences in the cancer care policy contexts of the selected countries. The data analysis was guided by methodological and theoretical reflexivity, as well as critical reading [21], to enable a systematic and reflective assessment of policy frameworks. This approach ensured consistency between the data and its interpretation.

Table 1
Five-year age-standardised net survival: adults (15–99 years) diagnosed by calendar period of diagnosis 2010–2014.

Country	Stomach (%)	Colon (%)	Lung (%)	Breast (%)	Prostate (%)
Australia	31.8	70.7	19.4	89.5	94.5
Belgium	37.5	67.9	18.2	86.4	93.8
Canada	29.6	67.0	20.6	88.2	93.6
Costa Rica	40.6	60.1	20.1 §	86.7	93.2
Japan	60.3	67.8	32.9	89.4	93.0

Data with full national population coverage, except for Costa Rica's lung cancer survival estimate (§), which is less reliable due to fewer than 15 % of patients.[5]

3. Results

The results are presented according to the four key domains, comprising both a descriptive and a comparative analysis of the selected countries. Tables outline the elements or indicators that characterise each domain.

3.1. Population and socio-demographic characteristics

The populations of the five analysed countries (see Table 2), all OECD members [22], exhibit life expectancies at birth ranging from 75 to 87 years, alongside high levels of educational attainment, with over 50 % of the population having completed tertiary education. Costa Rica demonstrated lower life expectancy (80 years for women and 75 for men) and a lower proportion of tertiary education (25.34 %) relative to the other countries. However, this country stands out as rural populations exhibit higher life expectancy than urban populations [23]. This outcome is attributed to the strong provision of primary care services in rural areas, although cancer diagnoses and mortality are concentrated in urban regions, which also demonstrate higher socio-economic status [23].

Despite these similarities, the countries differ in terms of their demographic transitions, as reflected in varying rates of population ageing. Higher rates of ageing typically correlate with increased demand for services addressing chronic diseases, including cancer [24] thereby challenging the capacity and effectiveness of health systems. This trend is particularly pronounced in Japan, Australia, Canada, and Belgium, where higher levels of tertiary education are similarly associated with enhanced health awareness and preventive behaviours [25,26].

Australia and Canada, two of the largest countries by land area, face significant logistical challenges due to their low population densities of approximately 3 and 4 persons per km^2, respectively.

Geographical and demographic characteristics further underscore disparities among the selected countries in terms of size, population density, and rural distribution. Australia and Canada, two of the largest countries by land area, face considerable logistical challenges due to their low population densities of approximately 3 and 4 persons per km^2, respectively. These nations also exhibit the highest proportions of rural populations among the selected countries (13.5 % in Australia and 18.2 % in Canada). Such factors pose logistical difficulties for cancer care delivery, particularly in remote areas.

In Canada, disparities are evident between the northern (predominantly rural) and southern regions, with the latter demonstrating superior health outcomes due to the concentration of radiotherapy centres and other health facilities [27]. To mitigate these barriers, Australia, for instance, has introduced a range of initiatives, including patient lodges, mobile clinics, and virtual services (via telephone, chat, and email), designed to provide accessible, inclusive, and culturally safe care [28]. Additionally, this country employs telemedicine programmes enabling patients to receive medical attention without travelling [28,29].

Table 2
Socio-demographic characteristics of the selected countries.

Subdimension/Countries	Japan	Australia	Costa Rica	Canada	Belgium
Population size	125124989	26005540	5180829	38929902	11685814
Rural Population	10066305 (8.0 %)	3513869 (13.5 %)	930373 (18.0 %)	7103929 (18.2)	215837 (1.8)
% of Rural Population	8.0	13.5	18.0	18.2	1.8
Population density per km2	345	3	101	4	383
Life expectancy at birth of women	87	85	80	84	84
Life Expectancy at Birth of Males	81	81	75	79	80
Ageing index	257.5	93.0	53.6	122.2	119.3
% Adult (25–64 years) education Tertiary	56.13 %	51.50 %	25.34	62.74 %	45.77 %

Source: Own elaboration with information from the World Bank [11]

Table 3
State Type and Political Tradition.

Subdomains/ Country	Japan	Australia	Costa Rica	Canada	Belgium
Type of State	Monarchy and constitutional democracy	Representative democracy and constitutional monarchy	Democratic, free, independent, multi-ethnic and representative state	Parliamentary government and federal constitutional monarchy	Federal constitutional monarchy with linguistic and regional divisions
Political Tradition	Corporate or Conservative.	Residual or Liberal.	Corporate or Conservative.	Residual or Liberal.	Corporate or Conservative
Health expenditure (% of GDP)	7.03 % [2000] 11.19 % [2021]	7.59 % [2000] 10.43 % [2021]	6.56 % [2000] 7.61 % [2021]	8.25 % [2000] 12.42 % [2021]	8.00 % [2000] 11.05 % [2021]

Source: Own elaboration based on the theoretical perspective of Esping-Andersen [6]and data from the WHO [12]

Table 4
Health system characteristics.

Subdimensions/ Countries	Japan	Australia	Costa Rica	Canada	Belgium
Coverage	Universal, 98.3 % coverage via compulsory insurance	Universal, Medicare covers 99 % of the population	Universal health insurance, 95 % coverage	Universal, Medicare ensures 99 % coverage	Universal, compulsory insurance covers 99 %
Revenue Collection	Two compulsory insurances: employment- and residence-based	Tax revenues fund compulsory insurance	Contributions from workers, employers, and the State	Single-payer model financed by taxation	Public financing through taxes and transfers
Organisation of the Health System	National and local governments ensure quality care	Multiple levels of government administer the system	Shared health responsibilities across governments	The federal government, provinces and territories manage the system	Independent medical practice under state regulation

Source: Own elaboration based on the data from the Commonwealth Fund [13,14] the European Observatory [15] and WHO [14]

Geographical information has been facilitated by a national cancer atlas [30] with a comprehensive visualisation of cancer incidence and survival across geographic areas.

In contrast, countries with higher population densities, such as Japan (345 persons per km^2) and Belgium (383 persons per km^2), benefit from more advantageous access to health services. In 2022, Japan reported approximately 181,100 healthcare institutions, including hospitals, medical, and dental clinics, translating to an average of 124.9 institutions per 100,000 inhabitants. Belgium similarly leverages its population density to ensure extensive healthcare coverage. Costa Rica, with a moderate population density of 101 persons per km^2 and a rural population of 18 %, achieves favourable health outcomes in rural areas, largely attributable to the robustness of its primary healthcare system [23], a contrast to the more dispersed models in Australia and Canada.

Despite these differences, all five countries have implemented measures to address the geographical and demographic challenges affecting cancer care delivery. Australia and Canada focus on transport, accommodation, and telemedicine strategies to reach dispersed populations [28,29]. Conversely, Belgium, Japan, and Costa Rica capitalise on their population densities and well-established primary care services to enhance health outcomes.

3.2. State type and socio-political tradition

All the selected countries are democracies (see Table 3).; four are constitutional monarchies, and three have corporatist or conservative political systems [6,31]. It has been demonstrated that in countries with democratic electoral systems, life expectancy is, on average, 11 years higher, and infant mortality rates are 62.5 % lower compared to non-democratic countries [32,33], indicating the determination of political structures to health outcomes population. Monarchical traditions -as seen in Australia, Belgium, Canada, and Japan- can coexist seamlessly with democracy and, in some instances, reinforce public trust and loyalty to the government [34,35].

From Esping-Andersen's perspective, three of the five countries examined (Belgium, Costa Rica, and Japan) can be classified as corporatist [31]. Public policies in these nations are marked by strong collaboration between public, private, and academic sectors. Trade unions and family networks play a pivotal role in driving collective objectives. Cancer outcomes in these countries reflect that coordinated efforts are vital for addressing health challenges effectively [6,31].

Belgium, Canada, and Australia operate as federal states, enabling decentralised governance, which enhances autonomy and local engagement in decisions regarding resource allocation, including within the health sector [34]. This federal model allows public policies to be tailored to the distinct territorial and socio-cultural needs of their populations [36]. In contrast, Japan and Costa Rica are unitary states. Japan is distinguished by its efficient and cohesive administration, facilitating uniform policy implementation and equitable resource distribution [37]. Costa Rica centralises political power at the national level, ensuring consistent governance across the country and promoting the uniform execution of policies.

Throughout much of the last century, these countries were predominantly governed by political parties representing workers' groups and trade unions, often aligned with socialist labour movements [38–41], except for Costa Rica. This political orientation facilitated the adoption of policies focused on social investment, including substantial expenditure on healthcare.

Over the past two decades, there has been a steady increase in the proportion of GDP allocated to healthcare (see Table 3). By 2021, all the selected countries, except Costa Rica, had healthcare expenditure as a percentage of GDP higher than the global average, which, according to the World Health Organization (WHO), stood at 10.3 % in 2023 [42]. This growth reflects these countries' sustained commitment to protecting vulnerable populations.

The success of these democracies also lies in their recognition of socio-cultural specificities, where cultural sensitivity and acknowledgement of indigenous populations have been central to the development of inclusive and effective policies. For instance, Australia has implemented targeted strategies to engage with indigenous communities in rural areas, while Canada and Belgium formally recognise their linguistic communities. Similarly, Costa Rica defines itself as a multiethnic state. In contrast, as Burgess observes, "there is little concrete evidence of multiculturalism at work in contemporary Japan" [11].

The countries examined stand out for their ability to integrate public-private partnerships, adopt governance structures tailored to their contexts, and maintain an unwavering commitment to equity and socio-cultural relevance. These attributes have been pivotal in improving population health, as reflected in high cancer survival rates, despite growing economic and social challenges.

3.3. Health systems

The health systems of these countries provide universal health coverage (UHC) and have implemented mechanisms to ensure that nearly all their populations are covered, regardless of their capacity to pay (see Table 4). UHC is defined as equal access for all citizens to a specified package of healthcare services of the highest quality that the country can afford, without exposing individuals to financial hardship therefore [38]. This approach ensures not only financial protection for citizens but also cultivates an environment that enables the comprehensive and equitable prevention and treatment of diseases, including cancer.

Japan and Belgium operate centralised health systems, where the government regulates and administers a significant proportion of health services, ensuring quality and equitable access. Japan's system is based on compulsory insurance and dedicated taxation, achieving 98.3 % population coverage [38]. Belgium combines general taxation with a framework of independent medical practice, underpinned by robust state regulation, resulting in 99 % coverage of its residents [39]. This system achieves a balance by integrating centralised financing with decentralised service delivery, allowing care to be tailored to the individual needs of patients.

Costa Rica stands out for its collaborative approach and tiered healthcare system. At the primary level, Basic Comprehensive Health Care Teams (EBAIS) manage preventive and primary care services; secondary-level care is provided by peripheral hospitals and specialised clinics, while tertiary care is delivered through national hospitals that address highly complex conditions [15]. This model, financed through compulsory contributions from workers, employers, and the state, provides coverage for 95 % of the population and ensures the equitable allocation of resources [15].

Conversely, Australia and Canada employ decentralised models that enable services to be adapted to local needs. In Australia, the Medicare programme provides coverage for 99 % of the population, funded primarily through general taxation and supplemented by an additional levy. This model combines administrative decentralisation with a robust system of compulsory insurance [43]. In Canada, a single-payer model ensures universal coverage, with financing managed at the provincial and territorial levels [43].

Despite these organisational differences, all five countries have achieved high cancer survival rates, illustrating that a strong welfare state with universal health coverage and minimal out-of-pocket expenses can effectively address country-specific health challenges, even within diverse administrative frameworks.

Table 5
Cancer policies by country.

Subdomains/ Countries	Japan	Australia	Costa Rica	Canada	Belgium
Name of the Policy	Cancer Control Act (2007)	Australian Cancer Plan (the Plan) (2006)	National Plan for the Prevention and Control of Cancer 2011–2017, National Cancer Control Plan 2024–2030	Canadian Strategy for Cancer Control (2006)	Nationaal kankerplan 2008–2010 (2008)
Policy Development	Collaborative process with governments, health professionals, patients, and communities. Initiated with epidemiological assessment, involving experts, patients, families, and communities in decision-making	Extensive consultations with governments, patients, indigenous communities, health professionals, researchers, and support organizations	Collaborative design involving local governments, community organizations, and key entities under PAHO and Ministry of Health supervision, ensuring continuity until 2030. Designing a 2030 policy to ensure continuity with past efforts	Participatory approach, with feedback from 7500 people, collaboration with governments, organisations, and indigenous communities (Inuit and Métis)	Participatory-inclusive approach: A multi-stakeholder coalition led by Sciensano ensured strategy effectiveness, involving 400 + experts from cancer centers, health agencies, societies, industry, and patients
Principles/ Values	Focus on equity, solidarity, innovation, and participation, led by strong central government ensuring equal healthcare access	Focus on vulnerable groups through a decentralized model with regional policy adaptation for cancer prevention, treatment, and management	Equity, prevention, comprehensiveness, participation, intersectorality, sustainability, and quality through central-regional collaboration, ensuring transparent, locally adapted policies	Comprehensive, universal, accessible, and portable public administration	Quality care, accessibility, innovation, intersectoral collaboration, and comprehensive support

Source: Own elaboration based on data from cancer policies of these countries [16–20]

3.4. Cancer policy

These countries share common elements in the formulation and governance of their cancer policies, as well as the principles and values underpinning them (see Table 5). These policies were designed using a participatory, collaborative, and bottom-up approach, involving both affected communities and governmental authorities. The names assigned to these policies also reflect each country's specific priorities. For instance, Japan adopts a clear legislative approach with its Cancer Control Act [17], while Australia and Canada use strategic terminology, such as the Australian Cancer Plan [16] and the Canadian Strategy for Cancer Control [17]. In contrast, Costa Rica and Belgium emphasise continuity and evolution in their approaches, as reflected in terms like the Costa Rican National Plan for Cancer Prevention and Control 2024–2030 [18] and the Belgian Cancer Plan 2008 [20].

Japan states that its policy began with a comprehensive analysis of epidemiological data and health care needs, incorporating the perspectives of experts, patients, families and communities in decision-making [44]. This approach included broad consultation and a structured process to ensure that strategies reflected the needs of those facing the disease, along with regular evaluations to assess their effectiveness [40]. Similarly, Australia's plan was developed through consultation with state and territory governments, Indigenous communities, health professionals, and support organisations, ensuring it was adapted to cultural and regional needs. In Belgium, the cancer policy was developed through an inclusive approach led by the Sciensano Cancer Centre, which coordinated a diverse coalition of more than 400 experts, including cancer centres, health agencies and patients [41]. Costa Rica, with the support of the Pan American Health Organisation (PAHO) and the coordination of the Ministry of Health, implemented a phased approach involving local governments, and community organisations. It is currently working on a new policy for the period 2024–2030 [45]. In Canada, the policy was formulated based on input from 7500 stakeholders, including governments and Inuit and Métis communities, adopting an inclusive and decentralised model to ensure local relevance [17].

Despite their contextual differences, the cancer policies of these countries converge on core values such as equity, accessibility, and innovation. Japan distinguishes itself by prioritising equity, solidarity, and participation, ensuring equal access and a comprehensive approach to care [44]. Australia also emphasises equity and the inclusion of Indigenous communities, with a strong focus on prevention [45]. Costa Rica adopts a collaborative approach centred on equity, prevention, and comprehensiveness, fostering sustainable policies [46] Canada prioritises universality and accessibility [47] while Belgium emphasizes quality and innovation [48].

4. Summary of the policy review

The main findings of this review reveal several consistent patterns in the context surrounding public cancer care policies in the five countries with the highest survival rates worldwide.

The comparative analysis identifies shared elements in the sociopolitical traditions and governance systems of the selected countries, such as the strength of their democratic institutions, robust state regulation within public-private partnerships, and a significant contribution of public expenditure to healthcare.

All countries adopt an ethical-political approach in the formulation and implementation of their cancer strategies, grounded in the principles of equity, accessibility, and sustainability. A key feature is the participatory, bottom-up design of the policies, which are implemented within universal healthcare systems that are adapted to diverse contexts.

The diverse configurations of population concentration and dispersion, along with varying degrees of territorial fragmentation both between and within these countries, are addressed through a range of strategies. These approaches aim not only to secure access to care but also, in many cases, to ensure quality and territorial equity by delivering comprehensive, locally accessible services with minimal out-of-pocket costs for individuals living with cancer and their families. All countries prioritise cancer through national policies operationalised at the local level.

This review offers a valuable perspective for the analysis of cancer policies by providing a methodological approach that enables the identification of the socio-geopolitical contexts in which these policies are designed and implemented. Specifically, this article highlights the common elements that contribute to high cancer survival outcomes in the selected countries.

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CRediT authorship contribution statement

Flores Figueroa Carla: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing, Investigation. **Castillo-Delgado Alondra:** Conceptualization, Formal analysis, Methodology, Writing – original draft, Writing – review & editing, Investigation. **Fuentes-Garcia Alejandra:** Conceptualization, Formal analysis, Methodology, Supervision, Validation, Writing – original draft, Writing – review & editing, Investigation.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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