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The Global Economic Cost of Cancer: Improving Outcomes and Cost by Reducing International Barriers to Care

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**THE GLOBAL ECONOMIC COST OF CANCER:
IMPROVING OUTCOMES AND COST BY REDUCING
INTERNATIONAL BARRIERS TO CARE**

Alexandra Gross*

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Abstract

The cost of cancer is vastly different across the globe, which inevitably results in decreased access to lifesaving medication and treatment for individuals who cannot afford the rising costs. This conflict poses a questionable violation of the international human right to health care when a patient in one country has access to a lifesaving drug, but a patient in another country is refused the same treatment. While several governments across the globe have refuted the ideology behind the right to health, governments that recognize a right to health should act as models for improved access to care and decreased direct costs for patients. Governments across the globe are called to look to their respective human rights treaties, modeled by the World Health Organization, to effectively analyze a possible human rights violation and come together to create equality in the access to cancer treatments across the world.

I. Introduction

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

—Dr. Martin Luther King, Jr.

Economists have recently endeavored to measure and rank the best countries to be born in, using a quality-of-life index that measures the opportunities that each country provides for its children to live a healthy and prosperous life.¹ child born in the study’s top ranked country is said to have “won the lottery of life”

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¹ *The Lottery of Life*, THE ECONOMIST (Nov. 21, 2012), <http://www.economist.com/news/21566430-where-be-born-2013-lottery-life>.

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because he or she will have the best opportunity for a healthy and prosperous life.² The same idea can be applied to those born in countries that guarantee access to lifesaving health care. If a child is born in a country that recognizes the right to health or the highest attainable standard of life, he will be guaranteed access to the best treatment and medicine despite inability to pay. He has “won the lottery.” However, if a child is born in a country that does not recognize the right to health, he will not be guaranteed access to lifesaving medicine should he ever need it, he may be turned away from hospitals and medical providers, and he may not be given a chance to survive. He has lost.

It is difficult to define the right to health. Human rights activists often have a difficult time determining what the phrase encompasses, where the line is drawn between a right and a privilege, and who is entitled to the right. While international meetings to negotiate and draft documents defining the global right to health have made significant strides toward universal health care or a right to health for all individuals, not all countries have adopted the documents or fully accepted the ideology.³ As a result, a significant portion of the world does not have a meaningful right to health. Ultimately, those living in countries that do not recognize a right to health pay exuberant amounts for lifesaving care. Approximately 150 million people across the world suffer from financial devastation following necessary medical care, and 100 million people are forced below the poverty level as a result of health care expenditure.⁴ Specifically, the cost cancer patients incur for cancer treatment leaves many completely unable to meet their financial obligations or worse – left without care because they are unable to afford it.⁵

This article will first analyze several important international documents that have addressed the basic human right to health. Each one builds off the former and further defines the rights, services, and advancements in technology all humans are entitled to in order to sustain a healthy well-being.⁶ Next, this article will determine what effect a right to health and increased access to cancer treatment can have on the global economic cost of cancer. Furthermore, the value of prevention and detection services will be addressed as a method for reversing the global economic cost of cancer. Third, this article will compare France’s approach to the right to health and the resulting access to care and cost of treatments for cancer patients with the United States’ approach, access, and cost for cancer treatment. Lastly, this article will propose heightened responsibilities for the United States to address its stance on the right to health in order to reduce or reverse the epidemiological and economic implications of cancer.

² *Id.*

³ *The Right to Health*, WORLD HEALTH ORG. (last updated Nov. 2013), www.who.int/mediacentre/factsheets/fs323/en/ (universal health care is a health system which provides health care and financial protection to all citizens).

⁴ *Id.*

⁵ See THE GLOBAL ECONOMIC COST OF CANCER, AM. CANCER SOC’Y & LIVESTRONG 2, 4-5 (2011), available at <http://www.cancer.org/acs/groups/content/@internationalaffairs/documents/document/acspc-026203.pdf>.

⁶ *The Right to Health*, *supra* note 3.

II. Background

Several key international treaties, reports, and documents have addressed the universal right to health—each defining the right differently, but with the same focus on the citizen’s well-being. This section will first discuss the United Nation’s (“UN”) Universal Declaration of Human Rights, established in 1948, which was the first treaty to internationally recognize the right to health.⁷ Second, this section will discuss the significant creation of the World Health Organization and its Constitution, which addresses an individual’s standard of health.⁸ Lastly, this section will look at the International Covenant on Economic, Social, and Cultural Rights (“ICESCR”), a human rights treaty passed by the UN in 1966 in order to set out goals for achieving the international right to health.⁹

The concept of an international right to health was introduced in what would become the Universal Declaration of Human Rights during the UN’s inaugural meetings in 1946.¹⁰ The UN was created immediately after World War II to promote peace between member states and to ensure that its citizens’ basic human rights would be protected.¹¹ Among the drafters and member states were: China, the USSR, France, the United States, United Kingdom, Lebanon, Australia, Chile, and Canada as well as forty-one other developing nations.¹² In a time of international turmoil, the member states, all of which were comprised of different political, cultural, and religious backgrounds, agreed to draft the Universal Declaration of Human Rights to serve as an “International Bill of Human Rights.”¹³ The UN eventually adopted the Declaration on December 10, 1948.¹⁴ Fundamental themes of the document are the equal rights of men and women across the world, as well as the promotion of social progress and a better standard of life.¹⁵ Article 25 of the Declaration specifically addresses an individual’s right to health.¹⁶ The Declaration indicates that all individuals are entitled to an adequate standard of living in order to maintain their health and well-being.¹⁷ An individual’s standard of living is measured in terms of necessary food, clothing,

⁷ Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III), at art. 25 (Dec. 10, 1948); *see also History of the Document*, UNITED NATIONS (last visited Apr. 8, 2014), <http://www.un.org/en/documents/udhr/history/shtml>.

⁸ *The Right to Health*, *supra* note 3.

⁹ International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. Doc. A/6316, at art. 12 (Dec. 16, 1966) [hereinafter Int’l Covenant on Econ., Soc. & Cultural Rts].

¹⁰ Universal Declaration of Human Rights, *supra* note 7, at art. 5; *see also History of the Document*, *supra* note 7.

¹¹ Universal Declaration of Human Rights, *supra* note 7, at art. 5; *see also History of the Document*, *supra* note 7.

¹² United States human rights activist, Eleanor Roosevelt was the driving force for the Declaration’s adoption. She produced a memoir about the drafting process, speaking about each nation’s preferences and beliefs. *See History of the Document*, *supra* note 7.

¹³ Universal Declaration of Human Rights, *supra* note 7, at art. 25.

¹⁴ *History of the Document*, *supra* note 7.

¹⁵ Universal Declaration of Human Rights, *supra* note 7, at art. 25.

¹⁶ *Id.*

¹⁷ *Id.*

housing, and medical care, as well as the right to aid in the event of disability, unemployment, sickness, or old age.¹⁸

Possibly the most significant result of the UN's meetings throughout the 1940s and the development of the Universal Declaration of Human Rights was the creation of the World Health Organization ("WHO") in 1948.¹⁹ All members of the UN could become members of the WHO by signing or otherwise accepting its Constitution.²⁰ Through drafting and the subsequent process by which member states signed the Constitution, all states effectively accepted that the highest attainable standard of health is one of the fundamental rights of every human being regardless of economic position.²¹ In addition, contracting parties agreed to promote and protect the right to health for all people.²² Substantively, the Constitution defines the right to health as "timely, acceptable, and affordable healthcare of appropriate quality."²³ The Constitution further clarifies that all member states must create conditions in their respective countries, in which everyone can be healthy, namely by ensuring the availability of health services.²⁴ Article 20 of the Constitution requires individual member states to take action toward acceptance of WHO conventions or agreements within eighteen months of enactment.²⁵ Those that do not accept such conventions or agreements are required to provide a written statement detailing their reasons.²⁶

The WHO and its Constitution require member states to make access to health a priority at the national level, and yet several member states have signed and accepted the Constitution without ratifying such documents or implementing the components of a right to health at a national level.²⁷ Therefore, certain member states reap the benefits of membership in the WHO, such as technical and policy-based support, but only recognize a right to health as a progressive movement some sixty years after the Constitution's acceptance.²⁸ In 2011, at the Executive Board's 129th session, the WHO designed a method for reforming its structure and organization to facilitate uniformity in global health and enable all member

¹⁸ *Id.*

¹⁹ *History of WHO*, WORLD HEALTH ORG., <http://www.who.int/about/history/en/> (last visited Apr. 10, 2014).

²⁰ *Countries*, WORLD HEALTH ORG., <http://www.who.int/countries/en/> (last visited Apr. 10, 2014) (among the other 194 member states, France and the United States are members of the WHO and have accepted the WHO Constitution at an international level).

²¹ Constitution of the World Health Organization ch. IV, July 22, 1946, 62 Stat. 6279, 14 U.N.T.S. 185, available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

²² *Id.*

²³ *The Right to Health*, *supra* note 3; Constitution of the World Health Org., *supra* note 21, at art. I.

²⁴ *The Right to Health*, *supra* note 3.

²⁵ Constitution of the World Health Org., *supra* note 21, at art. I.

²⁶ *Id.*

²⁷ See Eleanor D. Kinney, *The International Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1464 (2001) (as will be touched on later in the article, the United States is among the member states who have not accepted the WHO Constitution at a national level).

²⁸ See generally *About WHO*, WORLD HEALTH ORG., <http://www.who.int/about/en/> (last visited Apr. 12, 2014); see also *The Right to Health*, *supra* note 3; see also *Observations by the United States of America on "The Right to Health, Fact Sheet No. 31,"* U.S. STATE DEP'T 1,1 (Mar. 19, 2010).

states to take a more active stance on universal care to its citizens and a right to health for all people.²⁹

As a result of the WHO's development of an international right to health, the UN passed the International Covenant on Economic, Social, and Cultural Rights ("ICESCR") in 1966, a human rights treaty that further defines the right to health and creates steps for member states to realistically implement universal access to care.³⁰ The ICESCR indicates that, in order to realize the highest attainable standard of health, member states must take steps to ensure access to the prevention, treatment, and control of epidemics, as well as create conditions that allow all citizens to seek medical attention in the event of illness.³¹ The UN Committee on Economic, Social, and Cultural Rights, which monitors member states' compliance with ICESCR, adopted General Comment 14 on the Right to Health in 2000 to provide clarity on Article 12 of the ICESCR and further define a right to health, which includes timely and appropriate health care.³² General Comment 14 indicates that the right to health is comprised of the availability and accessibility of ethically acceptable health facilities, goods, and services.³³ The Committee defines accessibility in physical terms, or access within safe reach, but also in economic terms, meaning the requirement that health care is affordable for all.³⁴ General Comment 14 also indicates that all individuals are entitled to essential drugs that will help to maintain their well-being.³⁵

While not all member states have fully realized their obligations under the ICESCR on a national level, they are required by General Comment 14 to make progression toward a national right to health; therefore, member states are called to expeditiously utilize maximum available resources and make calculated steps toward universal health care.³⁶ General Comment 14 also uses a three-tier approach to outline member states' obligations under the ICESCR.³⁷ It obligates member states to: (1) refrain from interfering with citizens' right to health or limiting equal access to care; (2) protect their citizens' from third party intervention with citizens' right to health by adopting legislation which ensures equal

²⁹ WHO Reform, WORLD HEALTH ORG., http://www.who.int/about/who_reform/en/ (last visited Apr. 12, 2014).

³⁰ See generally Int'l Covenant on Econ., Soc. & Cultural Rts., *supra* note 9; see also *The Right to Health*, *supra* note 3.

³¹ Int'l Covenant on Econ., Soc. & Cultural Rts., *supra* note 9, at art.12; see also *The Right to Health*, *supra* note 3.

³² United Nations, Econ. & Soc. Council, Comm. on Substantive Issues Arising in the Implementation of the Int'l Covenant of Econ., Soc., & Cultural Rts., ¶ 11, E/C.12/2000/4 (2000); see also *The Right to Health*, *supra* note 3.

³³ United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 12; see also *The Right to Health*, *supra* note 3.

³⁴ United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 12; see also *The Right to Health*, *supra* note 3.

³⁵ United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 12; see also *The Right to Health*, *supra* note 3.

³⁶ United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 30; see also *The Right to Health*, *supra* note 3.

³⁷ United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 33.

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access to care in a private health care system and controls the marketing of medicines by third parties; and (3) implement legislation to promote the right to health and ultimately adopt a national policy for realizing the full right to health.³⁸

General Comment 14 also adopts the Alma-Ata Declaration of 1978, an international treaty, which indicates that governments have a responsibility to create access to health such that people are able to maintain a socially and economically productive lifestyle.³⁹ The Alma-Ata Declaration also calls for international cooperation to ensure primary care to all individuals because “the attainment of health by people in any one country directly concerns and benefits every other country.”⁴⁰ Perhaps most significantly, General Comment 14 differentiates some member states’ inability to progress toward universal health care from other states’ unwillingness to do so.⁴¹ General Comment 14 goes on to declare that a member state’s unwillingness to use its maximum resources to realize a right to health for its citizens is in violation of its obligations under Article 12 of the WHO constitution.⁴²

III. Discussion

The right to health and access to lifesaving care may play significant roles in the global economy due to cancer’s affect on citizens’ social and economic productivity and cancer treatments’ impact on a citizen’s financial standing. First, this section will discuss the global implications of cancer both in a social and economic capacity. Second, this section will discuss proposals for access to primary care, as well as prevention and detection mechanisms to reduce prevalence and costs. Third, this section will discuss the various world health organizations that are seeking reform in the treatment of cancer, in order to reduce the global economic burden. Lastly, this section will discuss a specific example of the cost of cancer drugs and the anomaly it presents.

It is arguably in a country’s best interest to protect its citizens’ right to health and adopt programs related to cancer prevention and treatment, in an effort to reduce the cost of cancer at a macroeconomic and microeconomic level. In developed nations, cancer is currently the leading cause of death, and it is the second leading cause of death in developing nations after heart disease. However, experts at the World Health Organization project that cancer could soon be the leading cause of death worldwide.⁴³ In 2008, there were approximately 4.8 mil-

³⁸ *Id.*

³⁹ See generally World Health Org., Declaration of Alma-Ata, International Conference on Primary Health Care, USSR, Sept. 6-12, 1978, U.N. Doc. A56/27 (1978) [hereinafter W.H.O., Declaration of Alma-Ata] (134 health ministries signed the Alma-Ata Declaration, which focused on the importance of universal primary care for all individuals).

⁴⁰ W.H.O., Declaration of Alma-Ata, *supra* note 39 at art. IX; see also United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 38.

⁴¹ United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 47; *The Right to Health*, *supra* note 3.

⁴² United Nations, Econ. & Soc. Council, *supra* note 32, ¶ 47.

⁴³ *Global Cancer Facts & Figures*, AM. CANCER SOC’Y, 2d ed. 1, 1 (2008), <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-027766.pdf>.

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lion cancer deaths in developing countries, as well as 2.8 million in developed countries, with the number of deaths estimated to increase due to aging populations and western habits like smoking and physical inactivity.⁴⁴

The American Cancer Society and LIVESTRONG published the first study quantifying the global economic cost of cancer in 2010, and the study showed that cancer has the greatest economic impact from premature death and disability of all causes of death worldwide. The economic cost of heart disease, the second leading global cause of death, trails cancer by nearly 20%.⁴⁵ Using data collected from the WHO, the study estimated the number of life years lost due to death and disability across seventeen types of cancer and the top fifteen leading causes of death—the variable would become known as the “DALY” (disability-adjusted life year).⁴⁶ In order to account for income disparities across the globe, the study grouped countries into four income brackets and measured the economic value of a year of healthy life in an attempt to measure the corresponding economic loss due to death and illness.⁴⁷ It was estimated that 83 million years of healthy life were lost due to death and disability from cancer in 2008.⁴⁸

By measuring indirect costs due to cancer such as loss of economic output due to missed days at work and premature death, and without measuring direct costs like dollars spent on treatment and rehabilitation, it was estimated that the total cost of cancer worldwide was \$895 billion in 2008.⁴⁹ In sum, the indirect cost of cancer was approximately 1.5% of the world’s gross domestic product.⁵⁰ While the data focuses on the economic impact across the globe, low-to-middle income families are significantly burdened because loss of income due to disability or death in the family takes a more significant toll on their annual income and ability to meet other financial obligations than it does on wealthier families.⁵¹

Furthermore, evidence suggests that even though the technology exists to detect, prevent, and treat forms of cancer, the disease will not be successfully eradicated until access to preventative care is increased.⁵² National policies focused on access to preventative measures, early detection, and quality treatment could significantly increase the proportion of cancer detection and decrease cancer deaths,

⁴⁴ *Id.*

⁴⁵ THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 1; *see also* Zosia Chustecka, *Cancer Has Greater Impact Than All Other Diseases*, MEDSCAPE MED. NEWS (Aug. 25, 2010), <http://www.medscape.com/viewarticle/727459>.

⁴⁶ THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 7.

⁴⁷ *Id.*

⁴⁸ *Id.* at 6.

⁴⁹ THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 2; *see also* Chustecka, *supra* note 45; *see also* *Global Cancer Facts & Figures*, *supra* note 43, at 9.

⁵⁰ THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 6; *see also* Chustecka, *supra* note 45.

⁵¹ *See generally* THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 1; *see also* Chustecka, *supra* note 45.

⁵² *Cancer Costs Projected to Reach At Least \$158 Billion in 2020*, NAT’L CANCER INST. (Jan. 12, 2011), cancer.gov/newscenter/newsfromnci/2011/costcancer2020; *see also* *Cancer Health Disparities*, NAT’L CANCER INST., <http://www.cancer.gov/newscenter/newsfromnci/2011/CostCancer2020> (last updated March 11, 2008) (the Center to Reduce Cancer Health Disparities is a National Cancer Institute initiative aimed at researching and reducing health disparities).

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which will in effect reduce the global economic cost of cancer.⁵³ As a policy matter, primary prevention is the most cost effective strategy for controlling the spread of cancer, by identifying and eliminating exposure to cancer-causing factors such as tobacco use, poor nutrition, physical inactivity, occupational exposures, and chronic infections.⁵⁴ Monitoring preventable forms of cancer could make an especially noteworthy difference in low-to-middle income nations, as many do not currently have preventative resources, and therefore, have the highest rates of preventable cancers in the world.⁵⁵

For instance, death due to cervical cancer, a form of cancer which can be diagnosed and treated with early detection, is significantly more prevalent in low-to-middle income nations due to lack of access to prevention and detection measures.⁵⁶ The access and incidence of pap testing, the detection mechanism for cervical cancer, was higher in the 1960s in the United States than the highest rates found today in Eastern Africa.⁵⁷ The lack of resources to treat cancer and the focus on communicable diseases in Africa creates a regulatory atmosphere where cancer is of low public health priority, and as a result, African cancer patients simply do not have access to preventative care.⁵⁸

Several international organizations have recently gathered to call attention to the rising incidence of cancer and implement policies focused on improved treatment, prevention, early detection, and screening. The WHO addressed the global burden of cancer in its 58th World Health Assembly in 2005, where member states approved a resolution calling for improved cancer prevention and treatment.⁵⁹ Specifically, the resolution calls member states to increase access to care by forming national cancer programs, which will increase early detection and screenings, as well as improve palliative treatment.⁶⁰ In addition, at the World Cancer Congress in 2006, the global cancer community addressed the growing global cancer burden and launched the first World Cancer Declaration, which outlined the necessary steps to begin to reverse the global cancer crisis by 2020.⁶¹ However, the World Health Assembly extended the timeline for cancer control from 2020 to 2025 at a meeting of member states in 2013.⁶² The member states set out nine targets for cancer prevention and control in 2013, four of which

⁵³ See *Global Cancer Facts & Figures*, *supra* note 43, at 9; see also Chustecka, *supra* note 45.

⁵⁴ See *Global Cancer Facts & Figures*, *supra* note 43, at 3-4, 9; see also Chustecka, *supra* note 45.

⁵⁵ See *Global Cancer Facts & Figures*, *supra* note 43, at 9, 37-38.

⁵⁶ See *id.* at 9, 38-40.

⁵⁷ *Id.* at 41.

⁵⁸ *Id.* at 37.

⁵⁹ World Health Assembly Res. 58.22/1, Cancer Prevention and Control, 58th Sess., May 25, 2005; see also *The 58th World Health Assembly Adopts Resolution on Cancer Prevention and Control*, WORLD HEALTH ORG., (May 25, 2005), http://www.who.int/mediacentre/news/releases/2005/pr_who05/en/.

⁶⁰ World Health Assembly Res. 58.22/1, Cancer Prevention and Control, *supra* note 59; see also *The 58th World Health Assembly Adopts Resolution on Cancer Prevention and Control*, *supra* note 59.

⁶¹ Cary Adams et al., *The World Cancer Declaration: From Resolution to Action*, 12 LANCET ONCOLOGY 1091-92 (2011); see generally *World Cancer Declaration*, UNION FOR INTERNATIONAL CANCER CONTROL, (2013), <http://www.uicc.org/world-cancer-declaration>.

⁶² Adams et al., *supra* note 61; see also *World Cancer Declaration*, *supra* note 61.

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specifically address access to care including: (1) universal coverage of HPV vaccination, (2) universal access to screening and early detection, (3) improving access to diagnosis and treatment, and (4) universal availability to essential drugs and pain control.⁶³ The revised World Cancer Declaration of 2013 specifically addresses the need for international organizations to reinforce the human rights established by the ICESCR to expand access to cancer prevention, detection, and treatment methods.⁶⁴

There is an argument that the high cost cancer patients must pay for treatment reflects the cost of developing cancer treatments, and thus, lowering costs will hinder cancer research and development—particularly in the pharmaceuticals industry.⁶⁵ Still, the rising costs seem unwarranted and continue to reduce access to lifesaving treatments. For example, the drug Gleevec, used to treat chronic myeloid leukemia (“CML”), entered the United States market in 2001 at approximately \$30,000 a year, which was intended to reflect and cover the costs of research and development.⁶⁶ After ten years on the market and faced with competition from five newer drugs, the price has tripled.⁶⁷ The developer of Gleevec, Novartis, justifies its pricing by suggesting that few patients pay the full cost and the current price of the drug reflects the high cost of research, as well as the value of the drug to patients.⁶⁸ However, doctors and researchers specializing in myeloid leukemia are now speaking out against drug developers like Novartis.⁶⁹ In an article for *Blood*, the Journal for the American Society of Hematology, the CML specialists suggested that charging an unreasonable price for lifesaving medicine is essentially profiteering and similar to increasing prices of necessary supplies to isolated communities in times of natural disasters.⁷⁰ The majority of the CML experts indicated that the price of CML drugs might compromise patients’ immediate access to treatment that is proven to be effective for their disease and may be their only option for remission.⁷¹ The article indicates that the increasing cost of Gleevec reflects the rising cost of cancer drugs across the board.⁷² In fact, of the twelve cancer drugs approved by the Food and Drug Administration for distribution in 2012, eleven cost more than \$100,000 a year, which is twice the

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ See generally *The Cost of Cancer*, NAT’L CANCER INST., <http://www.cancer.gov/aboutnci/servingpeople/understanding-burden/costofcancer> (last updated Nov. 2011); see generally Camille Abboud et al., *Price of Drugs for Chronic Myeloid Leukemia (CML), Reflection of the Unsustainable Cancer Drug Prices: Perspective of CML Experts*, 121 BLOOD J. AM. SOC’Y OF HEMATOLOGY 4439, 4439 (2013).

⁶⁶ Andrew Pollack, *Doctors Blast Cost of Cancer Treatment*, BOS. GLOBE, Apr. 26, 2013; see also Abboud et al., *supra* note 65, at 4439.

⁶⁷ Pollack, *supra* note 66; see also Abboud et al., *supra* note 65, at 4440.

⁶⁸ Pollack, *supra* note 66; see also Abboud et al., *supra* note 65, at 4440.

⁶⁹ Pollack, *supra* note 66; see generally Abboud et al., *supra* note 65.

⁷⁰ Pollack, *supra* note 66 (Profiteering is the act of making excessive profits on goods which are in short supply. Most types of profiteering is illegal; however, legalities differ from nation to nation.); see also Abboud et al., *supra* note 65, at 4440.

⁷¹ Abboud et al., *supra* note 65, at 4439.

⁷² *Id.*

figures for 2002.⁷³ The doctors and researchers are calling for dialogue on lowering pharmaceutical costs to increase access to care, which they say will save patient's lives.⁷⁴

IV. Analysis

Instituting a right to health at a national level could lead to greater access to health care for individuals, including preventative services and increased treatment options for cancer patients, as well as better health outcomes.⁷⁵ At an individual patient level, instituting a right to health could mean access to lifesaving treatments for cancer patients. At a governmental and macroeconomic level, instituting a right to health and guaranteeing access to preventative services and treatment options for cancer patients could result in reducing the global economic cost of cancer.⁷⁶ If, the right to health is not implemented at a national level worldwide.⁷⁷ In a study performed by the Global Public Health Journal in 2013, researchers found that, out of 191 countries in the UN, only 36% guaranteed the right to overall health in their individual constitutions.⁷⁸ The French and American health care systems have different approaches to the right to health and the following section will discuss how such rights, or lack thereof, impact access to care and cancer costs in the respective countries.

A. France

By signing and accepting the WHO Constitution and further defining the right to health through ratification of the ICESCR, a treaty with one of the most developed definitions of the right to health, France recognizes that all of its citizens have the right to the highest attainable standard of health.⁷⁹ Accordingly, the French health care system has undertaken the obligation to use maximum resources to realize a right to health for all citizens.⁸⁰ In doing so, the French

⁷³ *Id.*

⁷⁴ Pollack, *supra* note 66 (the doctors have not studied other cancer drugs, but merely discuss the negative impact of the price of Gleevec on their patients.); *see also* Abboud et al., *supra* note 65, at 4441.

⁷⁵ *See* Joanna N. Erdman, *Human Rights in Health Equity: Cervical Cancer and HPV Vaccines*, 35 *AM. J.L. & MED.* 365, 386 (2009); *see generally* Kinney, *supra* note 27, at 1457; *see generally* Jody Heymann et al., *Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries*, 8 *Global Pub. Health: An Int'l J. for Research, Policy and Practice* 639, 651-52 (2013); *see generally* Claire Andre & Manuel Velasquez, *System Overload: Pondering the Ethics of America's Health Care System*, 3 *ISSUES IN ETHICS* 3, 3 (1990); *see also* Hiroaki Matsuura, *The Effect of a Constitutional Right to Health on Population Health in 157 Countries, 1970-2007: the Role of Democratic Governance* (Harvard School of Public Health Program on the Global Demography of Aging, Working Paper No. 106, 2013).

⁷⁶ *Global Cancer Facts & Figures*, *supra* note 43, at 9; *see also* Chustecka, *supra* note 45.

⁷⁷ *See* Jody Heymann et al., *supra* note 75, at 652.

⁷⁸ *Id.* at 639.

⁷⁹ *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, ¶ 17, U.N. Doc. A/63/435 (May 5, 2013). *See generally* Int'l Covenant on Econ., Soc. & Cultural Rts., *supra* note 9.

⁸⁰ *The Right to Health*, *supra* note 3.

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government focuses its health care system on its patient.⁸¹ As a result, citizens consider access to health an inherent right, and the public becomes defensive when that right is threatened.⁸²

In 2000, the WHO performed a study on the world's health care systems and ranked each nation based on variables such as the number of years people lived in good health and whether everyone in the country had access to quality health care.⁸³ France ranked first among 191 countries, while the United States ranked thirty-seventh.⁸⁴ Arguably, France ranks higher than the United States because the French government has done a better job protecting liberty, equality, and human rights in its social programs including health care.⁸⁵ Every citizen in France has a right to care and every person is insured.⁸⁶ In fact, the sicker one is in France, the more his health care costs are covered; thus, the sickest patients in France, including cancer patients, are exempt from co-payments and need not worry about going bankrupt over medical bills.⁸⁷ Furthermore, the government pays for cancer patients' health care costs, surgeries, therapies, and drugs.⁸⁸

In addition, French citizens can choose any doctor for treatment, and doctors can choose any drug or treatment they believe best fits the patient notwithstanding the cost.⁸⁹ Therefore, cancer patients rarely discuss costs of cancer treatments with their doctors.⁹⁰ Instead, according to Dr. Fabian Calvo, deputy director of France's National Cancer Institute, the French government has made all cancer drugs available to patients, including the most expensive and experimental.⁹¹ Therefore, doctors can choose drugs that will prolong patients' lives without worrying about barriers like costs.⁹²

In order to fund the single government-run health insurer, French taxpayers pay premiums based on a percentage of their salaries.⁹³ Therefore, costs for

⁸¹ David Gauthier-Villars, *France Fights Universal Care's High Costs*, WALL ST. J., Aug. 7, 2009, <http://online.wsj.com/news/articles/SB124958049241511735>; see also *General National Patient Rights Protection*, CTR. FOR BIOMED. ETHICS & L., <http://europatientrights.eu/countries/signed/france/france.html> (last updated 2008).

⁸² Gauthier-Villars, *supra* note 81; *General National Patient Rights Protection*, *supra* note 81.

⁸³ Joseph Shapiro, *Health Care Lessons From France*, NAT'L PUB. RADIO (July 11, 2008), <http://www.npr.org/templates/story/story.php?storyId=92419273>; *Health Systems: Improving Performance*, THE WORLD HEALTH REPORT 2000, WORLD HEALTH ORG., WA 540, 1, 152 (2000).

⁸⁴ Shapiro, *supra* note 83; see also *Health Systems: Improving Performance*, *supra* note 83, at 153, 155.

⁸⁵ Shapiro, *supra* note 83; see also *Health Systems: Improving Performance*, *supra* note 83, at xiv.

⁸⁶ Shapiro, *supra* note 83; see also *Health Systems: Improving Performance*, *supra* note 83, at xiv (French citizens pay taxes out of their income to fund the government health care system).

⁸⁷ Shapiro, *supra* note 83.

⁸⁸ *Id.*

⁸⁹ Timothy Stoltzfus Jost, Diane Dawson & Andre den Exter, *The Role of Competition in Health Care: A Western European Perspective*, 31 J. HEALTH POL. POL'Y & L. 687, 694 (2006).

⁹⁰ Fergus Walsh, *Why France is So Good at Cancer Care*, BBC NEWS (May 16, 2007), <http://news.bbc.co.uk/2/hi/6660665.stm>.

⁹¹ *Id.*

⁹² *Id.*

⁹³ Gauthier-Villars, *supra* note 81.

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health insurance are relative to citizens' income and are based on citizens' ability to pay.⁹⁴ It can be argued that the seemingly successful French health care system is not "cheap."⁹⁵ Still, it is not as expensive as the U.S. system, which is the most expensive in the world.⁹⁶ For example, in 2011, the total U.S. health care expenditure per capita was \$8,608, while total French health care spending per capita was \$4,086.⁹⁷ In addition, the United States spends \$606 per person on administrative insurance costs, while France, through its government-run insurer pays only \$277 per person.⁹⁸ The U.S. may argue that French citizens are required to pay much more than Americans because 21% of a citizen's income in France goes toward the national health care system, which is significantly higher than U.S. citizens' contribution.⁹⁹ However, U.S. citizens must consider what they are getting for their money. While they pay much less out of their paychecks for health insurance, the out-of-pocket expenses for medicine, doctors, and hospitals in the event of a serious ailment will quickly rise above what the French are paying.¹⁰⁰ In sum, the French government recognizes that its citizens have the right to the highest attainable standard of health and thus, ensures access to care and lifesaving care for cancer patients despite cost.

B. The United States

To the contrary, the United States does not recognize a right to health for its citizens.¹⁰¹ In a report produced by the State Department, the U.S. explicitly categorized the obligations in the WHO Constitution and ICESCR as progressive goals, rather than present obligations.¹⁰² In doing so, the U.S. has effectively accepted the WHO's Constitution at an international level, but has not implemented its standards of health care in U.S. policy, nor accepted or ratified the ICESCR.¹⁰³ Rather, the State Department argues that it has no obligation to enact any laws pertaining to the WHO Constitution and that the WHO Constitution has no authority in the U.S.¹⁰⁴ Furthermore, the State Department does not guarantee

⁹⁴ *Id.*

⁹⁵ Shapiro, *supra* note 83.

⁹⁶ *Id.*

⁹⁷ France, WORLD HEALTH ORG., <http://www.who.int/countries/tra/en/> (last visited Apr. 1, 2014); United States, WORLD HEALTH ORG., <http://www.who.int/countries/usa/en> (last visited Apr. 1, 2014); Shapiro, *supra* note 83; see also *Health Systems: Improving Performance*, *supra* note 83.

⁹⁸ *U.S. Healthcare: Most Expensive, Longest Waits, Most Red Tape*, UNITED PRESS INT'L (Nov. 13, 2013), http://www.upi.com/Health_News/2013/11/13/US-healthcare-Most-expensive-longest-waits-most-red-tape/UPI-30501384398664/.

⁹⁹ Shapiro, *supra* note 83.

¹⁰⁰ *Id.*

¹⁰¹ *Observations by the United States of America on "The Right to Health, Fact Sheet No. 31," supra* note 28.

¹⁰² *Id.* at 2.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

any specific right to health in the United States—a stance that is quite outdated and inefficient compared to the global community's stance.¹⁰⁵

The American Cancer Society has indicated that “lack of health insurance and barriers to care prevent many Americans from getting good, basic [cancer treatment].”¹⁰⁶ In that regard, citizens in the US pay an exuberant amount for health insurance, which inevitably results in fewer insured citizens and decreased access to lifesaving care.¹⁰⁷ Contrary to the French health care system, before 2014, the United States did not require that individuals have health insurance and did not provide universally accessible public programs for citizens.¹⁰⁸ Rather, 62% of U.S. citizens received employer-sponsored health insurance, 15% were enrolled in public health insurance, and 18% were uninsured.¹⁰⁹ Furthermore, in the United States health care system, employers pay citizens' premiums, but citizens are required to pay all out-of-pocket costs like co-payments and direct costs to the provider for services, which can quickly rise to the tens or hundreds of thousands of dollars for cancer patients.¹¹⁰ In the United States, 44% of health spending is funded by government revenue, which is well below the global average of 72% in developed nations.¹¹¹ Lastly, the United States is one of the most inefficient health care countries in the world. Despite being the richest nation in the world, the United States ranks 46th out of 48 for health care efficiency, while France ranks 19th out of 48.¹¹²

Moreover, private costs for serious ailments like cancer fall directly on the patient in the United States, and out-of-pocket costs add up quickly.¹¹³ For instance, U.S. patients are typically required to pay a 25% co-payment for cancer drugs that cost thousands of dollars a month—all of which is due at the time the drugs are administered and cannot be paid on a monthly plan.¹¹⁴ Furthermore, patients often feel unsure asking about costs and payment options upfront, as they are worried it will affect the type of care they receive.¹¹⁵ This is significantly different from the ideology in France, where patients and doctors do not worry about the costs associated with treatment and only focus on the best out-

¹⁰⁵ *Id.* at 3-4.

¹⁰⁶ *Economic Impact of Cancer*, AM. CANCER SOC'Y, <http://www.cancer.org/cancer/cancerbasics/economic-impact-of-cancer> (last visited Apr. 3, 2014).

¹⁰⁷ Kao-Ping Chua, *Overview of the U.S. Health Care System*, AM. MED. STUDENT ASS'N 1, 1 (2006).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ Chua, *supra* note 107, at 2; see also *Aflac Real Cost Calculator Source Information*, AFLAC, (Jan. 15, 2013), available at <http://www.aflac.com/individuals/realcost/source/>.

¹¹¹ Chua, *supra* note 107, at 5.

¹¹² *Most Efficient Health Care: Countries*, BLOOMBERG, (Aug. 19, 2013), <http://www.bloomberg.com/visual-data/best-and-worst/most-efficient-health-care-countries> (data collected from the World Bank, the WHO, and the International Monetary Fund. The researchers considered life expectancy and per capita cost of health care).

¹¹³ *The Cost of Cancer Treatment*, AM. CANCER SOC'Y, (Aug. 8, 2013), <http://www.cancer.org/treatment/findingandpayingfortreatment/managinginsurancissues/the-cost-of-cancer-treatment>.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

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come.¹¹⁶ Historically, U.S. patients have not had the flexibility that French patients have in choosing the best doctors, treatments, or drugs because patients in the U.S. are limited by costs and often settle for the cheaper, less recommended options.¹¹⁷ In addition, uninsured patients and those from ethnic minorities have less access to preventative and diagnostic services related to cancer, leading to higher rates of diagnosis at a later stage in their cancer and, inevitably, a more costly treatment and poorer health results.¹¹⁸

Although the U.S. has largely refuted the global standard of a right to health, the recently adopted Patient Protection and Affordable Care Act (“ACA”) shows a positive step in expanding access to care for cancer patients. With the United States’ roll out of the ACA in late 2013 to early 2014, the government intends to increase coverage for those who are currently uninsured.¹¹⁹ The ACA also strives to create a statutory right to health for American cancer patients and those at risk for cancer by ensuring coverage for pre-existing conditions like cancer, ensuring the right to choose a doctor, and enhancing access to preventative services.¹²⁰ However, recent reports have indicated that the top hospitals for cancer treatment are “off-limits” for newly insured cancer patients under the ACA, which expressly contradicts the right to treatment promised to such patients.¹²¹ Whether or not the rights provided by the ACA will become a constitutional right to health remains to be determined as the ACA is implemented and cancer patients and those at risk begin to benefit from its rights.¹²² There is arguably still a need for a greater push toward a right to health.¹²³

V. Proposal

The right to health care, specifically access to cancer care, should not be compromised for the American people because of the costs and inefficiencies of the American health care system. From an international human rights perspective, it is difficult to understand why French cancer patients have a right to treatment at a reasonable price, but most American cancer patients do not realize the same cost

¹¹⁶ Walsh, *supra* note 90.

¹¹⁷ *The Cost of Cancer Treatment, supra* note 113; *The Health Care Law, How it Can Help People with Cancer and Their Families*, AM. CANCER SOC’Y 1, 1 (2010), <http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-026864.pdf>.

¹¹⁸ *Economic Impact of Cancer, supra* note 106.

¹¹⁹ Barry Furrow, *Health Reform and Ted Kennedy, The Art of Politics and Persistence*, 14 N.Y.U. J. LEGIS. & PUB. POL’Y 445, 447 (2011).

¹²⁰ *What Does the Affordable Care Act Mean for People with Cancer?*, AM. CANCER SOC’Y, <https://www.cancer.org/myacs/eastern/areahighlights/cancernynj-news-aca-guide> (last visited Apr. 3, 2014). *See generally How Does the Health Care Law Protect Me?*, CTR. FOR MEDICARE & MEDICAID SERV., <https://www.healthcare.gov/how-does-the-health-care-law-protect-me/> (last visited Apr. 3, 2014).

¹²¹ *Nation’s Elite Cancer Hospitals Off-Limits Under Obamacare*, N.Y. POST (Mar. 19, 2014), <http://nypost.com/2014/03/19/nations-elite-cancer-hospitals-off-limits-under-obamacare/>.

¹²² *See generally* Erin C. Fuse Brown, *Developing A Durable Right to Health Care*, 14 MINN. J.L. Sci. & TECH. 439, 480 (2013).

¹²³ Mark Wheeler, *A Constitutional Right to Health Care*, UCLA NEWSROOM (July 18, 2013), <http://newsroom.ucla.edu/portal/ucla/a-constitutional-right-to-health-247449.aspx>.

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for treatment or any treatment at all.¹²⁴ Dr. Nils Wilkin, a clinical oncologist at the Karolinska Institute in Stockholm, wrote a report on the disparities in cancer treatments based on geographic region and found that “where you live can determine whether you receive the best treatment or not.”¹²⁵ The global right to health cannot be said to exist while people are denied equal access to existing, lifesaving technology simply because of their geographic location. There is an international human rights issue at stake, and global health leaders should be called to evaluate whether citizens in comparable countries are being treated equally in the administration of lifesaving treatments. Additionally, in an attempt to reduce the global economic cost of cancer, it is in the best interest of international leaders to put pressure on developed nations like the United States to institute a right to health nationally and increase access to lifesaving care.

While the United States has accepted the WHO Constitution, it has failed to implement a right to health on a national level and refuses to take on the heightened responsibilities created by the ICESCR.¹²⁶ The Constitution expressly states that, “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.”¹²⁷ Furthermore, the ICESCR distinguishes a country’s inability to institute a national right to health from a country’s unwillingness.¹²⁸ If a country is simply unwilling to use its maximum resources to realize a right to health, the country is in violation of Article 12 of the ICESCR.¹²⁹

Yet, in the United States’ response to the Right to Health Fact Sheet, No. 31 issued by the World Health Organization, the State Department firmly declares that, while the United States has accepted the WHO Constitution, it did so with the understanding that it is under no obligation to enact specific legislation based on the Constitution.¹³⁰ The State Department reiterates that it has no obligation to meet the requirements set forth in the ICESCR because the United States is not *forced* to ratify the document.¹³¹ Thus, the State Department indicates that the United States has no international obligation to “respect, protect, and fulfill the ‘right to health’ to individuals.”¹³² By expressly dismissing its responsibility to meet the obligations set forth in the Constitution and the ICESCR, the United

¹²⁴ *The Cost of Cancer Treatment*, *supra* note 113; *see also* Walsh, *supra* note 90.

¹²⁵ Nic Fleming, *Cancer Survival Rates Worst in Western Europe*, THE TELEGRAPH (May 10, 2007), <http://www.telegraph.co.uk/news/uknews/1551098/Cancer-survival-rates-worst-in-western-Europe.html>.

¹²⁶ *Observations by the United States of America on “The Right to Health, Fact Sheet No. 31”*, *supra* note 28, at 2-3.

¹²⁷ Constitution of the World Health Org., *supra* note 21, pmbl.

¹²⁸ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 9; *see also* *The Right to Health*, *supra* note 3.

¹²⁹ Int’l Covenant on Econ., Soc. & Cultural Rts., *supra* note 9; *see also* *The Right to Health*, *supra* note 3.

¹³⁰ *Observations by the United States of America on “The Right to Health, Fact Sheet No. 31,” supra* note 28, at 2-3.

¹³¹ *Id.*

¹³² *Id.*

States is allowing the gaps between the rich and the poor and the inequality in international human rights among classes to widen tremendously.¹³³

UN treaty-monitoring committees like the Committee on Economic, Social and Cultural Rights, as well as international judicial institutions, should be called to discuss whether the United States' refusal to acknowledge the right to health directly correlates with its cancer patients' poor access and affordability of life-saving treatments.¹³⁴ In addition, such international leaders should question whether the United States, the wealthiest nation in the world, is in violation of its obligations under the WHO Constitution and the ICESCR.¹³⁵ By allowing hospitals to close their doors to cancer patients seeking lifesaving treatment, even though American hospitals have the technology and resources to treat patients, the United States is standing in the way of its citizens' international right to the highest attainable standard of health. In addition, among the likes of Cuba and Belize, the United States is one of only six countries that have yet to ratify the ICESCR on a national level some thirty years after signing it.¹³⁶ The Committee on Economic, Social and Cultural Rights should define the barriers that prohibit the United States from abiding by and ratifying the ICESCR obligations. Thereafter, the Committee must determine whether the potential social and economic benefits, including increased access to lifesaving treatment and the decreased economic burden of cancer, derived from obliging with the ICESCR outweigh the cost of eliminating such barriers.

Furthermore, the United States arguably has a heightened responsibility to care for cancer patients due to the agreements made in the World Cancer Declaration of 2006 and 2013.¹³⁷ Member states, including the U.S. and France, set out nine targets for cancer prevention and control, four of which focused on access to care issues.¹³⁸ The World Cancer Congress and the World Health Assembly were particularly concerned with the early detection and prevention of cancer.¹³⁹ However, in a country where medical care and health insurance is so costly, it is unlikely that all cancer patients will be able to access detection or prevention services. Thus, it could be argued that countries like the U.S., which have failed to cover multitudes of preventative medicine in its health insurance plans and

¹³³ Anna M. Piccard, *The United States' Failure to Ratify the International Covenant on Economic, Social and Cultural Rights: Must the Poor Be Always with Us?*, 13 SCHOLAR 231, 232 (2010).

¹³⁴ See generally Erdman, *supra* note 75; see generally Kinney, *supra* note 27, at 1457; see generally Heymann, *supra* note 75, at 639-53; see generally Andre, *supra* note 75, at 3; see also generally Matsuura, *supra* note 75; Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 97 AM J. PUB. HEALTH 1156, 1158 (2005).

¹³⁵ Yamin, *supra* note 134, at 1158.

¹³⁶ Piccard, *supra* note 133, at 232 (seventy countries in total have signed and ratified the ICESCR as of 2014).

¹³⁷ *World Cancer Declaration*, *supra* note 59.

¹³⁸ *Id.*

¹³⁹ *Id.*

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have not significantly increased access to preventative measures, are in violation of the World Cancer Declaration.¹⁴⁰

While the ACA aims to increase accessibility to preventative and detection services, it will take some time to determine whether cancer patients and those at risk of cancer are actually experiencing increased access to affordable services. There are already reports that hospitals are turning away cancer patients and those at risk of cancer, even after the 2014 ACA enrollment period, because they do not accept the patients' new health insurance.¹⁴¹ Therefore, national and international leaders should be called to re-analyze countries' obligations under the World Cancer Declaration and enforce such obligations where necessary, in order to meet the World Cancer Congress' goal of reversing the burden of cancer by 2025.¹⁴²

Through enforcement measures by treaty-monitoring committees and the World Cancer Congress, the social effects and the economic costs of cancer can be reversed. If the United States is not willing to consider its cancer patients' quality of life as the sole reason for improving access to lifesaving treatment, perhaps the potential money saved will sway the government in enforcing policies focused on the right to health. National policies focused on access to preventative measures, early detection, and quality treatment are the most cost-effective strategies and could significantly increase the proportion of cancer detection and decrease death due to cancer.¹⁴³ As a result, a right to health and increased access to cancer treatment will decrease low productivity levels due to death and disability, which will ultimately improve the United States' economy.¹⁴⁴

VI. Conclusion

Based on economic and epidemiologic research, it is in the best interests of the international community to focus on global policy guaranteeing access to lifesaving treatments for cancer patients. Not only will the global economic cost of cancer be reduced or possibly reversed, but patients across the globe will finally have the right to health despite geographic location. On a nation-by-nation basis, the technology exists to detect, prevent, and treat cancer; however, the disease will not be eradicated until access to care is increased. International governments should put more pressure on resourceful nations across the globe to institute a national right to health modeling the rights in countries that already guarantee universal access to care and do not turn away cancer patients seeking access to lifesaving treatment.

¹⁴⁰ *Preventative Care: A National Profile on Use, Disparities, and Health Benefits*, PARTNERSHIP FOR PREVENTION, <http://www.rwjf.org/en/research-publications/find-rwjf-research/2007/08/preventive-care-national-profile-on-use.html> (last updated Aug. 2007).

¹⁴¹ *Nation's Elite Cancer Hospitals Off-Limits Under Obamacare*, *supra* note 121.

¹⁴² *World Cancer Declaration*, *supra* note 59.

¹⁴³ THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 9; *see also* Chustecka, *supra* note 45.

¹⁴⁴ THE GLOBAL ECONOMIC COST OF CANCER, *supra* note 5, at 9; *see also* Chustecka, *supra* note 45.