

WORLD CANCER DAY 2022 "CLOSE THE CARE GAP"

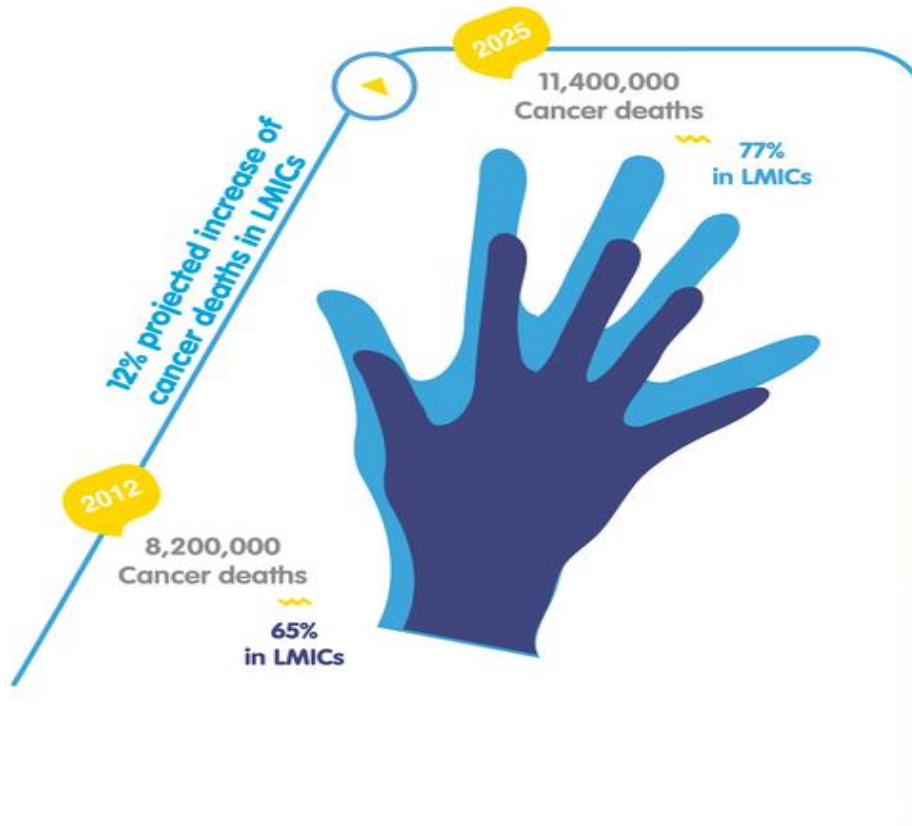
Sanchia Aranda AM



THE GLOBAL CANCER BURDEN

BURDEN IN LOW- AND MIDDLE-INCOME COUNTRIES

(LMICs = Low- and middle-income countries)



Over the next 10 years, **low- and middle-income countries** will see a **disproportionate increase** in cancer deaths.

CANCER IS A GLOBAL EQUITY ISSUE

Only 5% of global cancer spending is in LMICs despite having 80% of the global burden

Tobacco accounts for 30% of global cancer deaths

- 80% of smokers are from LMIC and rising

Cancer kills more people in LMICs than malaria, HIV and TB combined




Cancer drugs remain expensive in LMICs despite 26-29 key agents being off patent

Lessons from HIV

Over 50 countries have little or no access to morphine




UICC GAPRI program/ McCabe Centre for The Law & Cancer

All cancers combined and selected cancers, by socioeconomic area, age-standardised incidence rate (per 100,000), 2010–2014

	 <  < 					
Compared with highest area, people in lowest area are:	1 (lowest)	2	3	4	5 (highest)	
All cancers combined						
5% more likely to be diagnosed	509	503	492	483	485	
Prostate						
17% less likely to be diagnosed	149	160	160	163	180	
Breast						
17% less likely to be diagnosed	113	118	121	125	135	
Colorectal						
19% more likely to be diagnosed	63	62	59	57	53	
Melanoma of the skin						
15% less likely to be diagnosed	46	50	51	48	54	
Lung						
72% more likely to be diagnosed	54	48	43	38	32	
Non-Hodgkin lymphoma						
6% less likely to be diagnosed	19	19	19	20	20	
Uterine						
18% more likely to be diagnosed	20	19	19	18	17	
Head and neck with lip						
57% more likely to be diagnosed	22	19	17	15	14	
Liver						
58% more likely to be diagnosed	9.0	7.3	6.5	6.7	5.7	
Cervical						
52% more likely to be diagnosed	9.1	7.9	6.5	6.3	6.0	

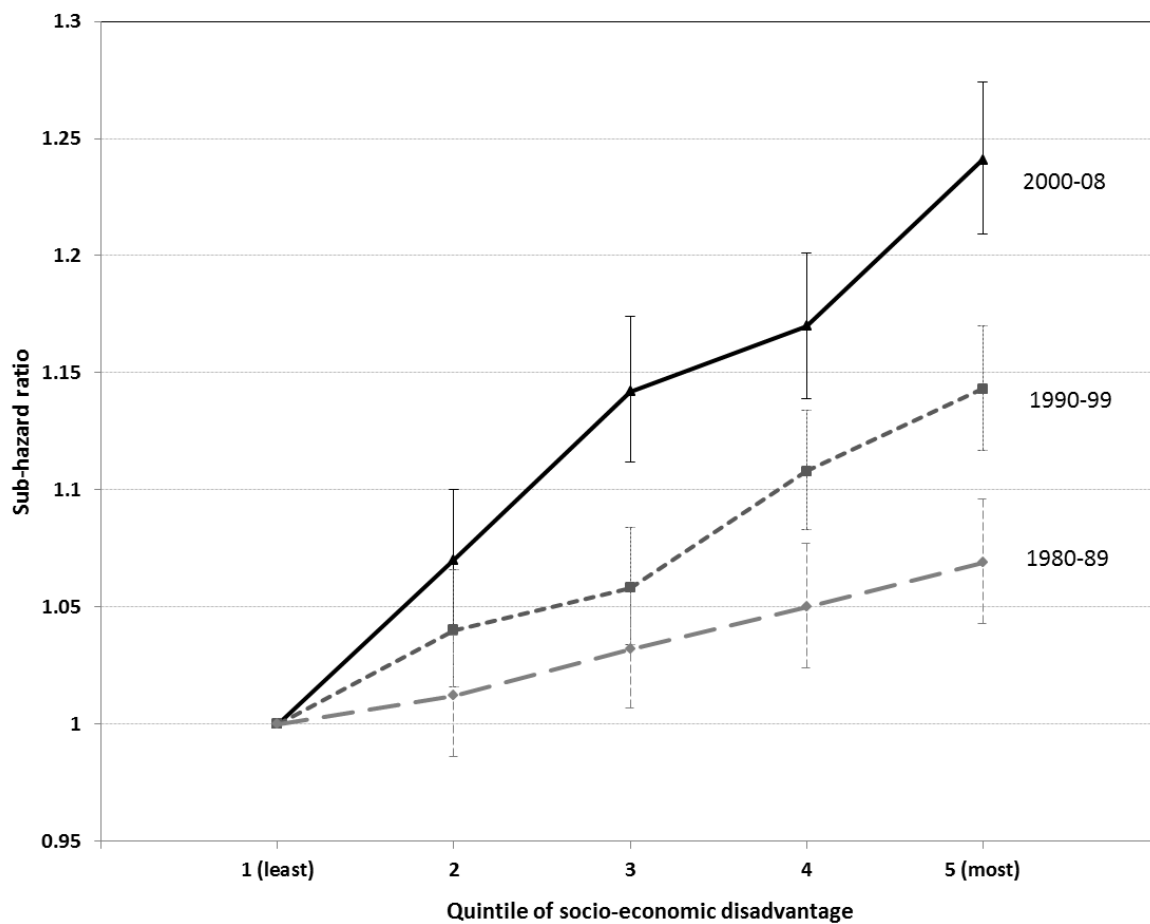
Source: AIHW Australian Cancer Database 2015.

All cancers combined and selected cancers, by socioeconomic area, age-standardised mortality rate (per 100,000), 2012–2016

		<		<	
Compared with highest area, people in lowest area are:	1 (lowest)	2	3	4	5 (highest)
All cancers combined 37% more likely to die from	188	176	164	153	137
Prostate 23% more likely to die from	29	28	26	24	23
Breast 11% more likely to die from	21	21	20	20	19
Colorectal 36% more likely to die from	22	21	19	18	16
Melanoma of the skin 12% more likely to die from	5.8	5.8	5.5	5.2	5.2
Lung 85% more likely to die from	39	35	31	26	21
Non-Hodgkin lymphoma 17% more likely to die from	5.6	5.7	5.5	5.2	4.8
Uterine 25% more likely to die from	3.5	3.6	3.4	3.0	2.8
Head and neck with lip 112% more likely to die from	5.5	4.4	3.6	3.1	2.6
Liver 61% more likely to die from	7.9	6.7	6.1	5.7	4.9
Cervical 136% more likely to die from	2.6	2.0	1.7	1.4	1.1

Source: AIHW National Mortality Database.

Hazard of cancer death by SES quintile of disadvantage over time



Models adjusted for sex, age, remoteness, country of birth, cancer site, and summary stage.

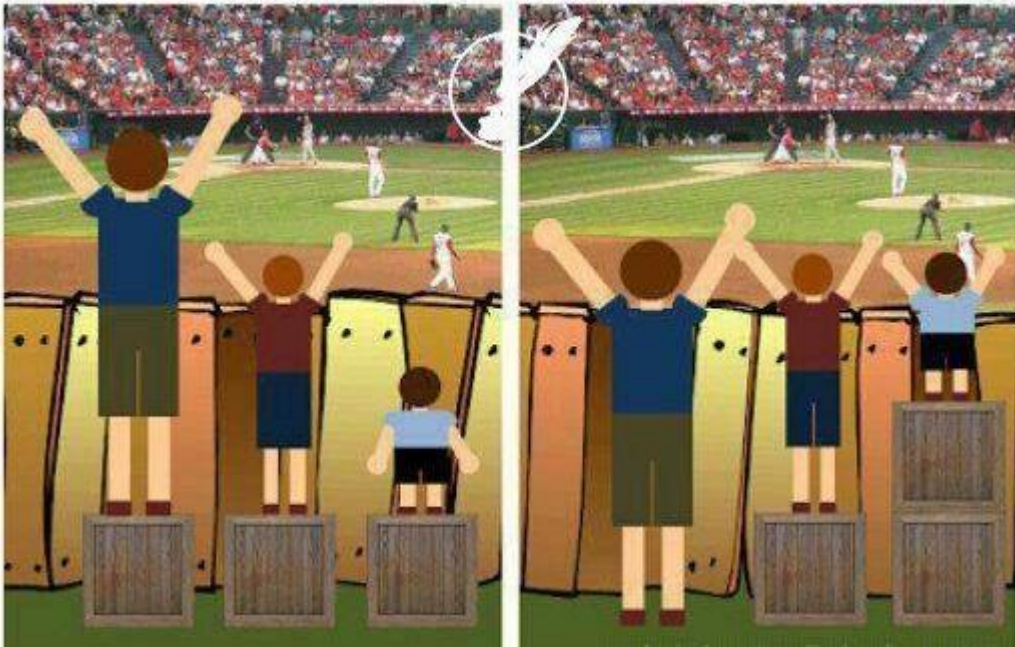
CANCER AND INDIGENOUS AUSTRALIANS – AIHW 2021

- Cancer was the leading cause of death 2014-2018 (23% of all deaths)
- Incidence of cancer in Indigenous Australians is 495/100,000 vs 472/100,000 non-Indigenous
- 12% increase in mortality rate 2006 to 2018 for Indigenous Australians while rate declined by 12% for non-Indigenous.
- Hospitalisations for cancer were 12/1000 for Indigenous Australians versus 16/1000 for non-Indigenous July 2015 – June 2017 but hospital stays were longer
- Survival differences 2007-2014
 - 50% for Indigenous Australians up from 47% in 1999-2006 (3% gain)
 - 65% for non-Indigenous Australians up from 58% in 1999-2006 (7% gain)

IMPACT OF INDIGENOUS STATUS ON STAGE AND SURVIVAL BY SES AND REMOTENESS OF RESIDENCE – NSW POPULATION BASED ANALYSIS

- **Aboriginal people were more likely to:**
 - live in disadvantaged areas (70% Q 4-5 vs 45%)
 - live outside of major cities (57% vs 31.6%)
- **For each SES and remoteness category Aboriginal people:**
 - were diagnosed at a younger age
 - were more likely to be diagnosed at a later stage
 - were more likely to die of their cancer

EQUALITY VS EQUITY



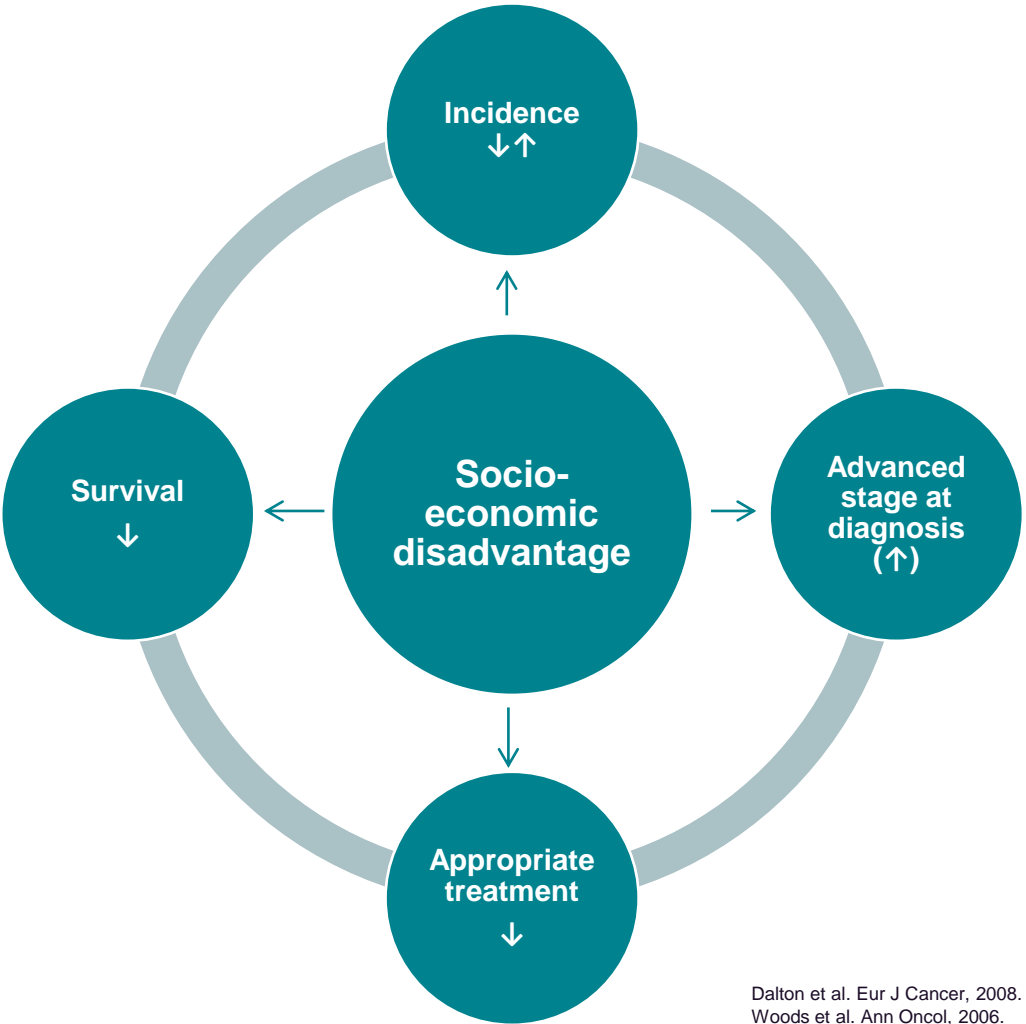
Equality:

- The degree to which all persons are treated as indistinguishable, thus treating them identically or granting them the same quantity of a good per capita

Equity:

- How fairly and socially just are resources distributed throughout the population?
- Equal resources for equal need.
- Higher resources for higher need

Socio-economic disadvantage and cancer



Tervonen, 2015

Dalton et al. Eur J Cancer, 2008.
Woods et al. Ann Oncol, 2006.
Abdoli et al. PLoS One, 2014.
Brewster et al. BMJ, 2001.

ACCESS TO SERVICES IS ABOUT MORE THAN AVAILABILITY

Levesque et al, 2013

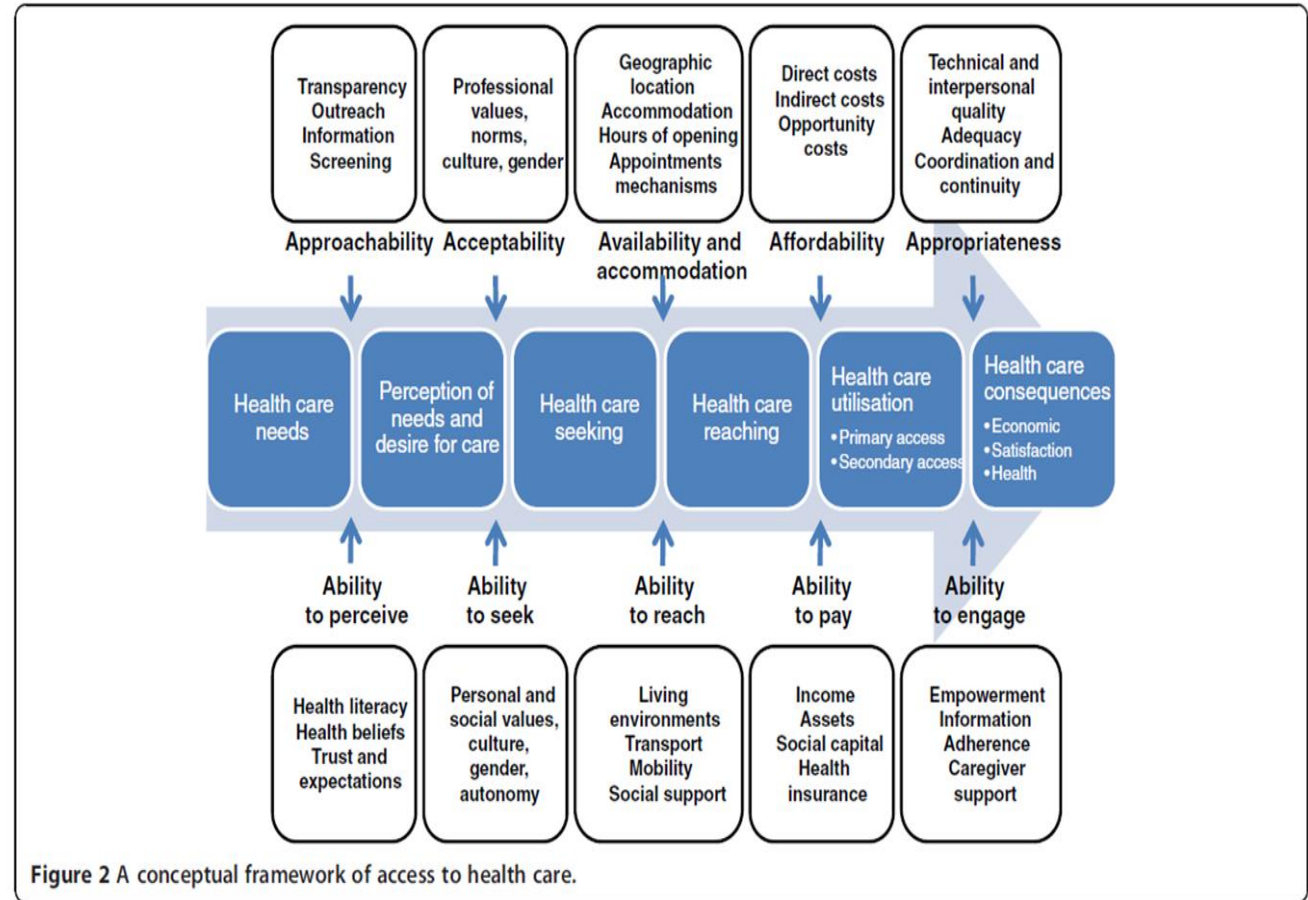


Figure 2 A conceptual framework of access to health care.

THE INVERSE CARE LAW

Julian Tudor Hart 1971

“The availability of good medical care tends to vary inversely with the need for it in the population served”

SURPRISINGLY FEW INTERVENTION STUDIES? BYGRAVES ET AL 2020

- **Systematic review of interventions to address socio-economic inequalities in cancer-related outcomes in high income countries**

16 studies reported on 19 interventions

7 interventions (37%) reduced SE inequalities, but all were in screening

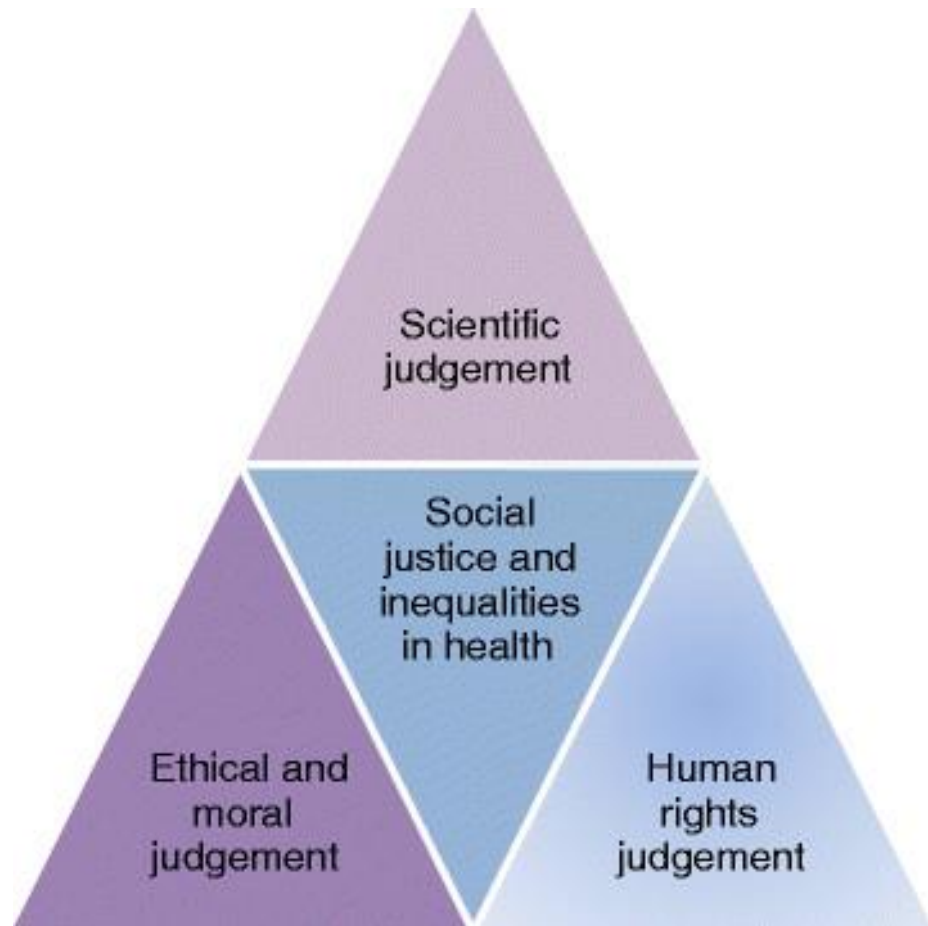
- Included GP-endorsement, invitations to screen, text and letter reminders and organized screening

Limited evidence for reducing inequalities

- Few studies exist that seek to improve outcomes beyond screening participation



THE TRIAD MODEL OF HEALTH INEQUALITIES - MABHALA



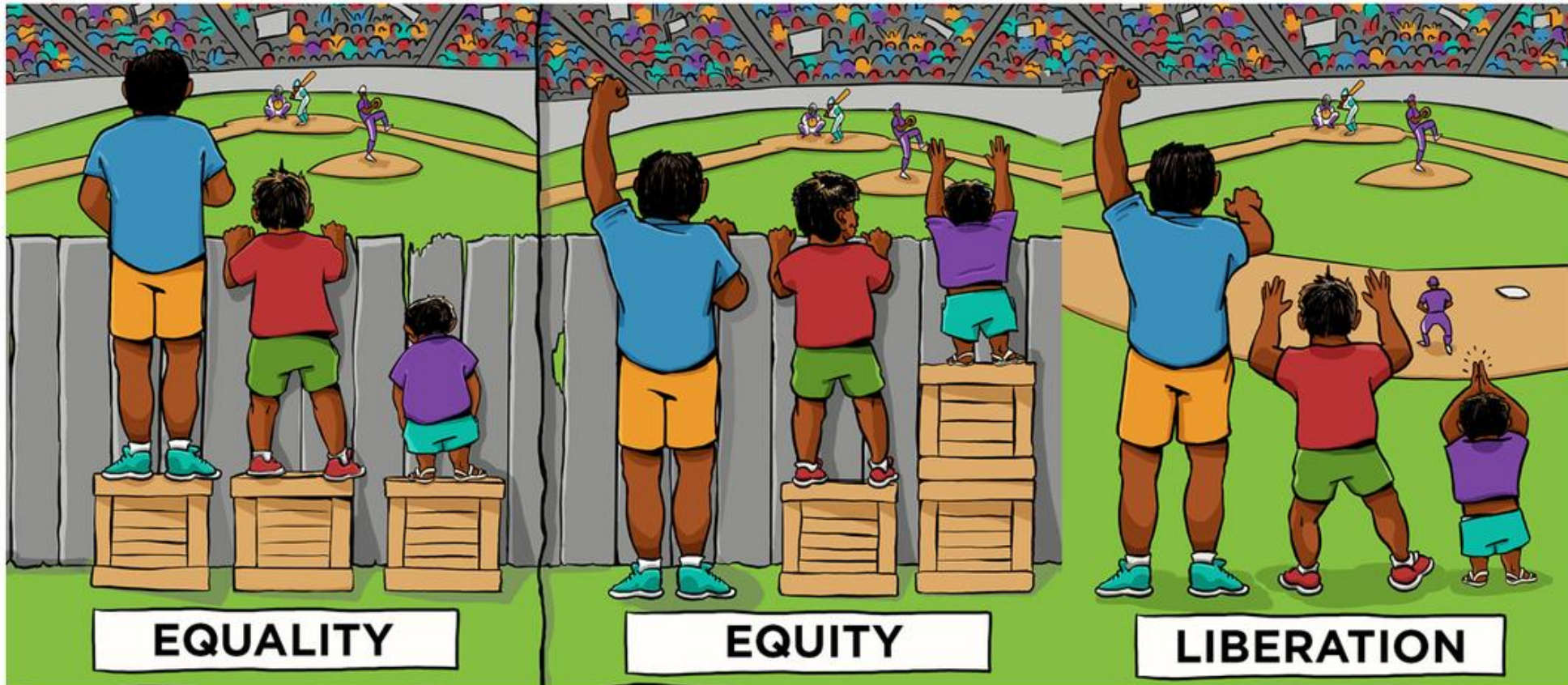
- Scientific – association between disease and social environment
- Ethical and Moral – socially produced diseases and poorer health outcomes are preventable or avoidable and therefore are unfair and unjust. Tackling them is the right thing to do
- Human Rights – based on the Alma-Ata declaration of health as a human right. Aim to shift concern about health of disadvantaged populations from the charity sector to the realm of law and entitlement

INTERVENTION THINKING

- **Measurement and feedback**
- **Equity oriented healthcare**
 - Training of health professionals
 - Early identification of need
 - Needs adjusted levels of service
 - Co-design with higher risk communities
- **Resourcing models based on vulnerability to poorer outcomes**



Don't just tell a different version of the same story.
Change The Story!



REFERENCES

- ACROSS & UNSW, Poverty in Australia 2020: Part 1: Overview. http://povertyandinequality.across.org.au/wp-content/uploads/2020/02/Poverty-in-Australia-2020_Part-1_Overview.pdf
- AIHW – Australia’s Health 2018
- Bygraves et al, Australian experiences of Out-of-Pocket Costs and Financial Burden Following a Cancer Diagnosis: A Systematic Review. *Int J of Environmental Research and Public Health*, 2021, 18, 2422
- Bygraves et al, The impact of interventions addressing socioeconomic inequalities in cancer-related outcomes in high income countries: a systematic review. *J of Public Health Research*, 2020: (9) 1711
- Levesque et al
- Mabhala, MA., Public health nurse educator’s conceptualization of public health as a strategy to reduce health inequalities: a quantitative study. *Int J for Equity in Health*, 2015: 14
- Tervonen et al, The impact of geographic unit of analysis on socioeconomic inequalities in cancer survival and distant summary stage – a population based study. *ANZ J of Public Health*, 2016.
- Tervonen et al, Cancer Survival disparities worsening by socio-economic disadvantage over the last 3 decades in New South Wales, Australia. *BMC Public Health*, 2017: 17; 691.

VCCC Alliance
Level 10, Victorian Comprehensive Cancer Centre
305 Grattan Street, Melbourne VIC 3000
Tel: 03 8559-7160 | www.viccompcancerctr.org



Supported by



VCCC Alliance members

