Stakeholder Forum, Brussels

Equity framework

Addressing Equity in CanCon

Brussels, 12th May 2015

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CanCon
Cancer Control Joint Action

Objectives of the presentation

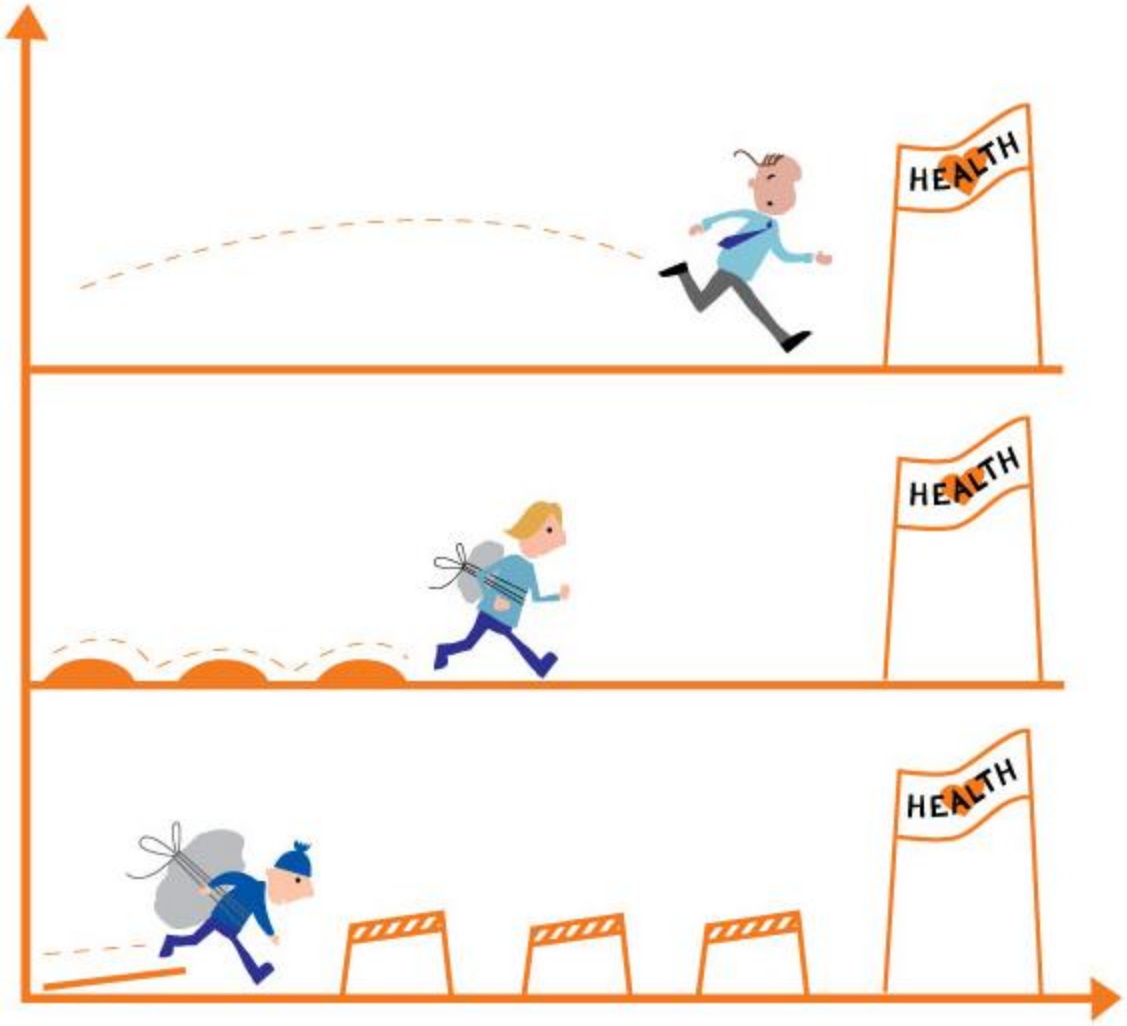
1. Introduce **the WHO theoretical model of inequalities** production
2. What is the situation: **examples of inequalities situation**
3. What can we do? Framework for policies
4. What is the situation: **examples of intervention for reducing inequalities**
5. CANCON . What are we doing?

1. Concepts and theoretical models of inequalities

SOCIAL INEQUALITIES IN HEALTH

Systematic and socially produced

Unfair, and avoidable



From: Norwegian Ministry of health and care servicies. National strategy to reduce social inequalities in health. Report No. 20 (2006–2007).

Whitehead M, WHO 1990

1. Concepts and theoretical models of inequalities

SOCIAL INEQUALITIES IN HEALTH

Health inequities are **systematic differences in health outcomes** across **different population groups** (often defined by place of residence or on a socio-economic basis)

which arise **not from chance or from the decision of the individual** but from **avoidable differences in social, economic and environmental** variables

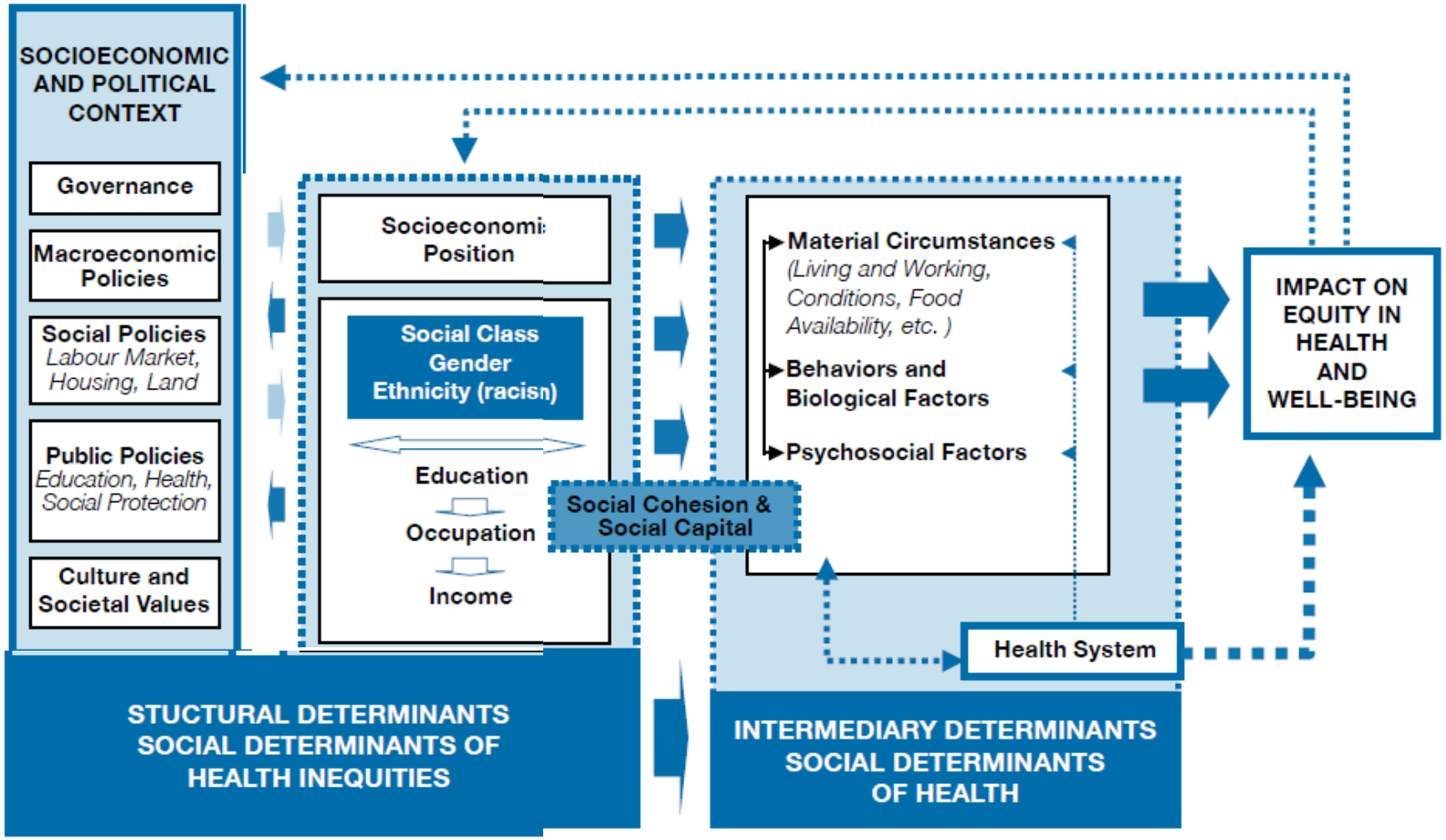
that are largely **beyond individual control**, yet can be **addressed by public policy**.

In common usage and in many policy circles, the term health inequality is used as a synonym for health inequity

Commission staff working document. Communication from the commission to the european parliament, the council, the european economic and social committee and the committee of the regions. Solidarity in health: reducing health inequalities in the EU. Brussels, SEC(2009) 1396

1. Concepts and theoretical models of inequalities

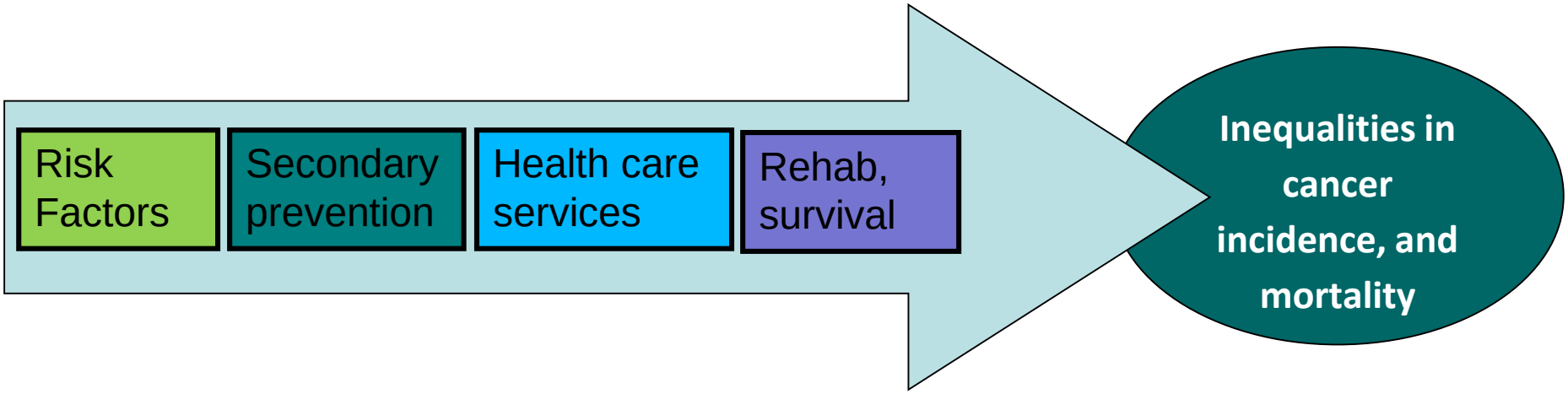
SOCIAL DETERMINANTS OF HEALTH MODEL (WHO. 2010)



Source: World Health Organization (2010). A conceptual framework for action on the social determinants of health. Social Determinants of Health discussion paper 2. Geneva: World Health Organization

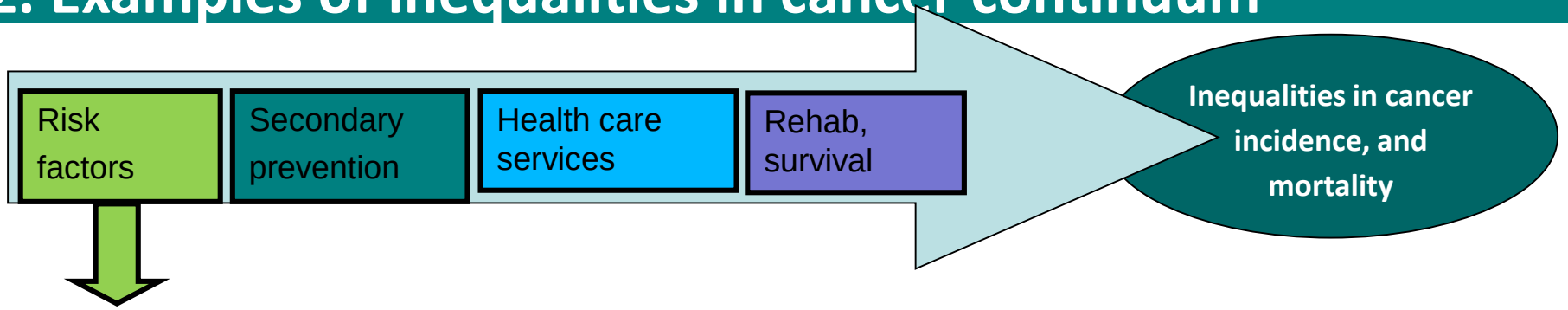
1. Concepts and theoretical models of inequalities

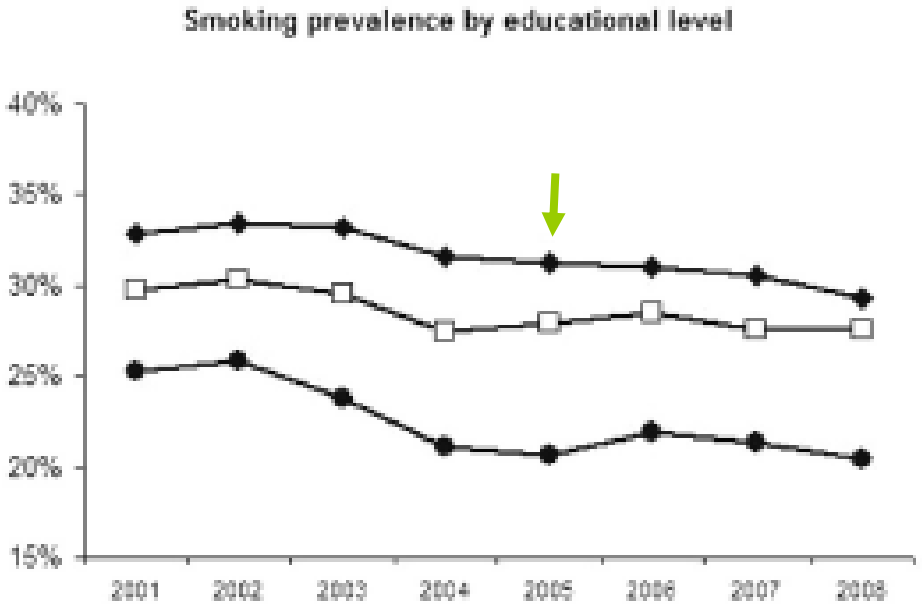
Social inequalities in cancer refer to health inequities spanning the full cancer continuum, across the life course (Krieguer 2005).

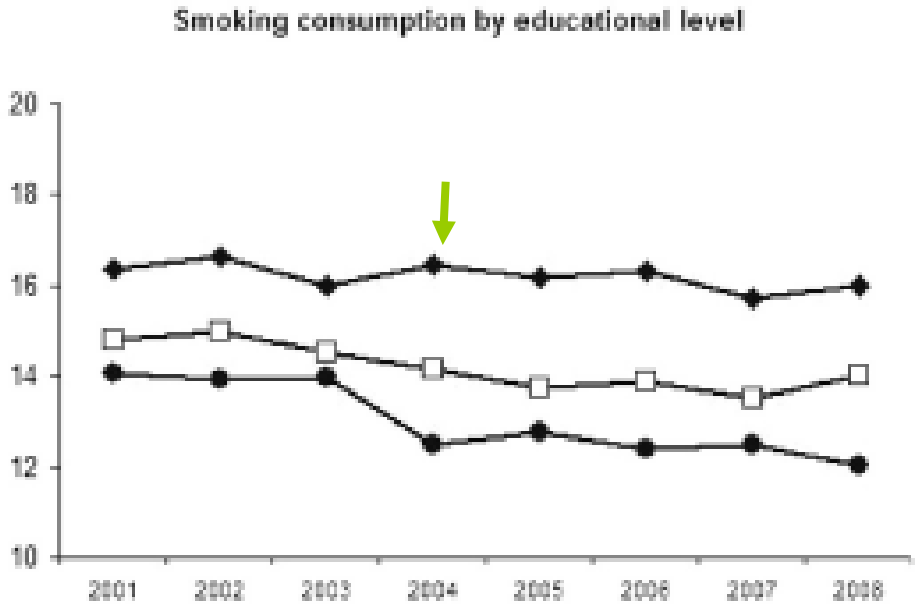


These cancer inequalities involve social inequalities in **the prevention, incidence, prevalence, detection and treatment, survival, mortality** and other cancer related health conditions and behaviours.

2. Examples of inequalities in cancer continuum







Low Moderate High

Trends in socioeconomic inequalities in smoking prevalence, consumption, initiation, and cessation between 2001 and 2008 in the Netherlands. Findings from a national population survey. Nagelhout et al. BMC Public Health. 2012; 12: 303.

2. Examples of inequalities in cancer continuum

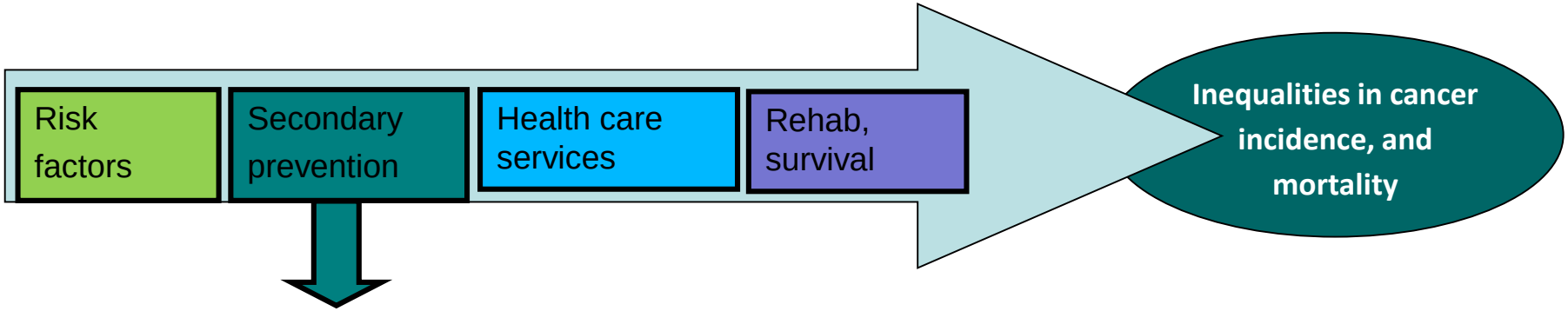


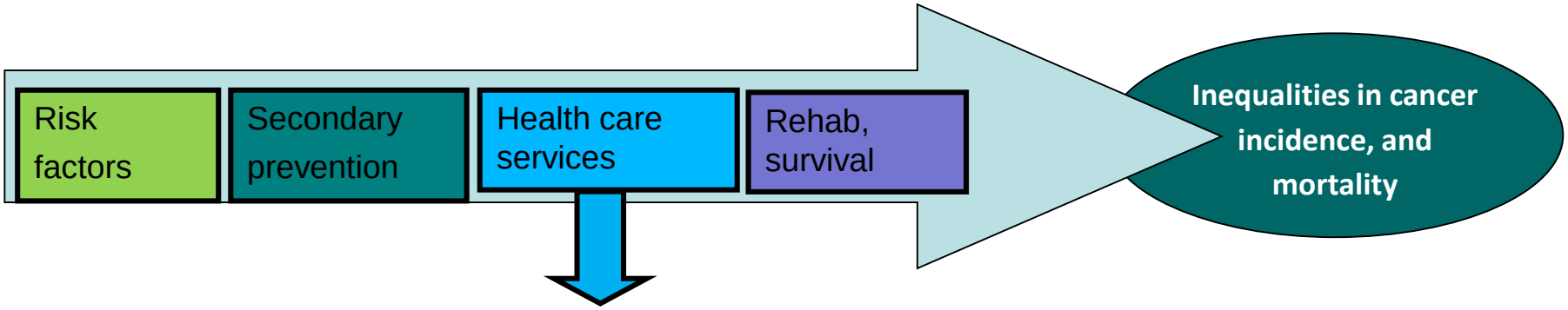
Table 2 Uptake of FOBT and deprivation category (numerator in brackets)

Deprivation category	Women					Men					*P* value
	1	2	3	4	5	1	2	3	4	5	
Round 1	66.5% (25,547)	63.2% (28,098)	58.5% (18,987)	51.2% (12,198)	44.5% (6318)	57.3% (21,534)	53.6% (23,400)	48.7% (15,233)	42.8% (9596)	37.7% (5506)	$F < 0.001$ $M < 0.001$
Round 2	65.1% (40,044)	61.3% (46,095)	55.5% (32,979)	47.7% (23,188)	40.3% (13,811)	56.2% (39,208)	52.3% (45,428)	46.8% (31,890)	40% (22,235)	34.6% (14,188)	$F < 0.001$ $M < 0.001$
Round 3	67.1% (37,364)	64.2% (44,909)	58.9% (34,234)	51.9% (24,463)	44.1% (17,803)	57.7% (36,991)	55.2% (44,629)	50.7% (33,297)	43.7% (23,678)	37.3% (18,316)	$F < 0.001$ $M < 0.001$

Overall there was a significant negative association between uptake and increasing deprivation ($P < 0.001$), and the overall uptake in women was higher than that in men ($P < 0.001$)

Effect of **gender**, age **and deprivation** on key performance indicators in a **FOBT-based colorectal screening** programme (North East Scotland).Steele et al, J Med Screen 2010 17: 68

2. Examples of inequalities in cancer continuum



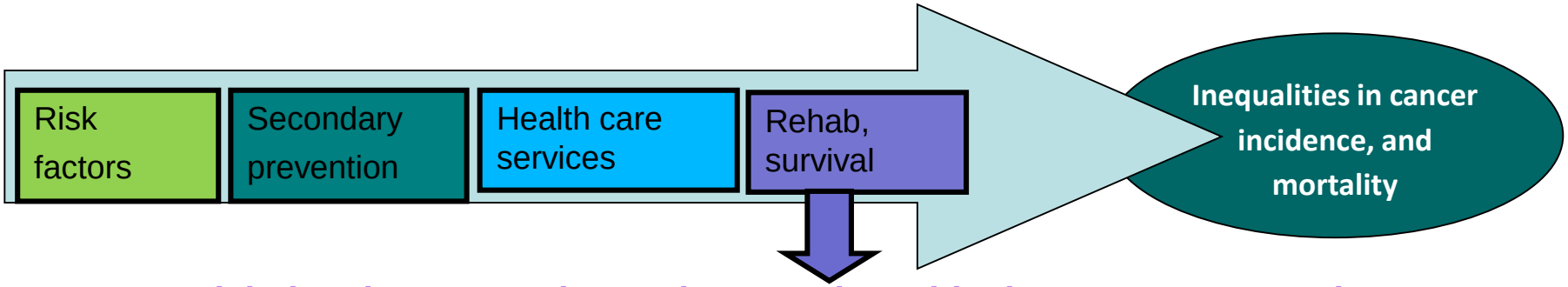
Odds ratios with tests for trend of odds of advanced stage or high grade of breast cancer at diagnosis by fifths of Townsend deprivation score, adjusted for age (Northern and Yorkshire region, 1998-2000)

		Advanced stage at diagnosis*		High grade at diagnosis†	
Fifth of TDS	TDS range	No (%)	Odds ratio (95% CI)	No (%)	Odds ratio (95% CI)
1 (most affluent)	−8.89 to −3.32	247/2349 (10.5)	1.00	635/2139 (29.7)	1.00
2	−3.32 to −1.82	253/2319 (10.9)	1.02 (0.84 to 1.23)	603/2115 (28.5)	0.94 (0.82 to 1.07)
3	−1.82 to 0.07	300/2325 (12.9)	1.19 (0.99 to 1.43)	632/2097 (30.1)	1.01 (0.89 to 1.16)
4	0.07 to 2.59	290/2242 (12.9)	1.20 (1.00 to 1.44)	642/2028 (31.7)	1.10 (0.96 to 1.26)
5 (most deprived)	2.59 to 8.45	365/2277 (16.0)	1.53 (1.28 to 1.82)	664/2009 (33.1)	1.15 (1.00 to 1.31)
Test for trend of odds			χ^2=25.52, P<0.0001		χ^2=8.34, P=0.004

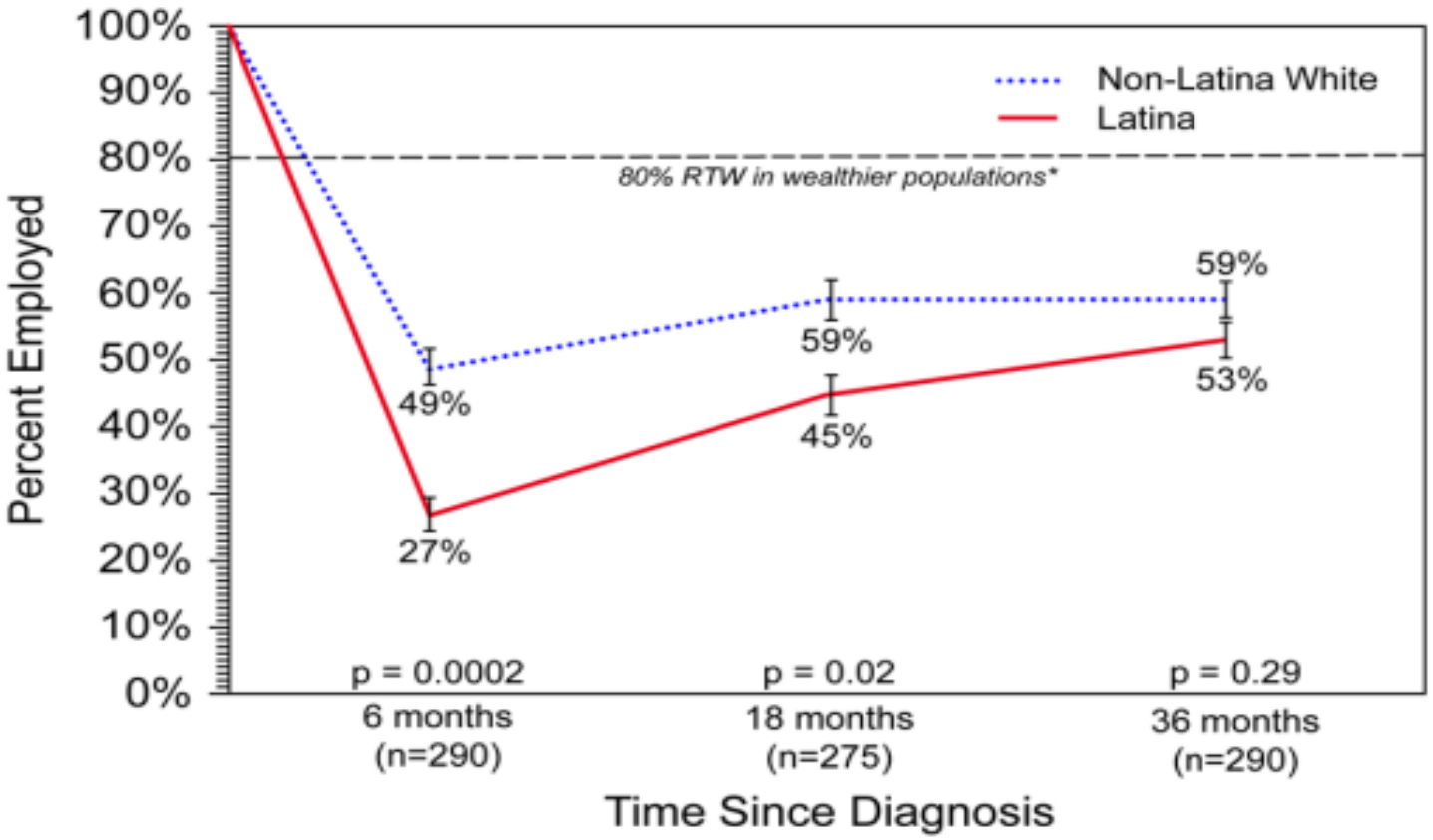
TDS=Townsend deprivation score.
*Defined as nodal or metastatic spread.
†Defined as poorly differentiated, undifferentiated, or anaplastic.

Are there **socioeconomic gradients in stage and grade of breast cancer diagnosis?** Cross sectional analysis of UK cancer registry data. Adams et al. BMJ 2004;329:142

2. Examples of inequalities in cancer continuum



Return to work in low-income Latina and non-Latina white breast cancer survivors



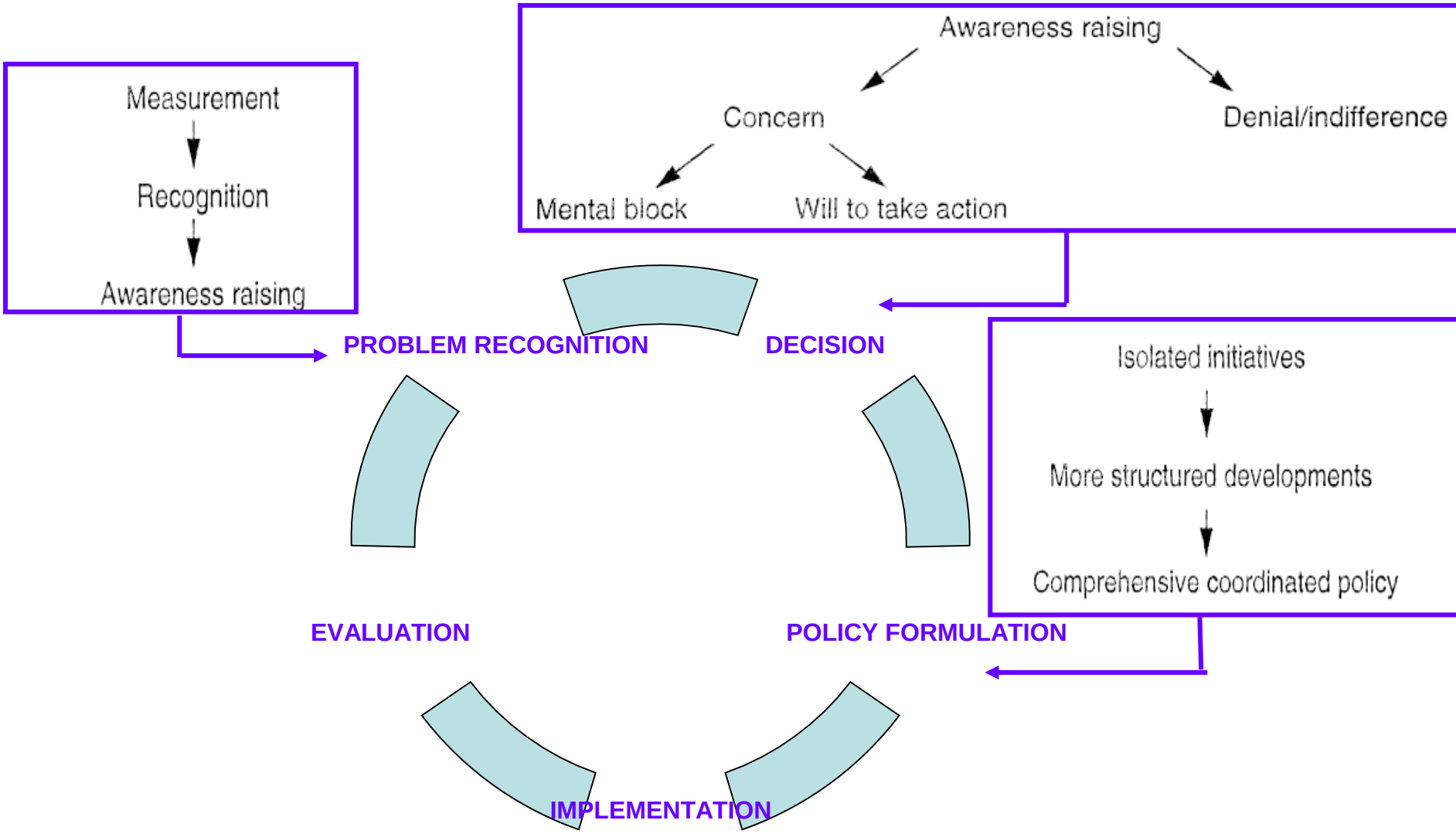
Return to work in low-income Latina and non-Latina white breast cancer survivors: a 3-year longitudinal study.
Blinderet al. Cancer. 2012 Mar 15;118(6):1664-74.

What can we do?

Policies!!!

3. What can we do? Framework for policies

Policy: A course or principle of action adopted or proposed by a government, party, business, or individual: the written or unwritten aims, objectives, targets, strategy, tactics and plans that guide the actions of a government or an organization.



The public policies, Meny

Whitehead M. Milbank Quaterly,

3. What can we do? Framework for policies

- **Policy Tackling health inequalities** requires a **firm evidence-based**

- There is a **lack of Information:**
  - Lack of a good routine date with which to monitor inequalities
  - There is a **lack of research of the effects of policies on equity** (research in inequalities situation)
  - **Soft** methodologies vs **hard** methodologies
    - PRISMA plus (systematic reviews)

- Lack of clear evidence **should not be a reason** for not trying **to act to minimise inequalities**, using the most plausible mechanisms

3. What can we do? Framework for policies

TEN PRINCIPLES FOR POLICY ACTION TO REDUCE SOCIAL INEQUALITIES IN HEALTH

1) **Polices should strive to level up**, **not level down**: to bring up the level of health of the worse groups of people to that of the groups who are better.

2) **Three main approaches:** interdependent and should build on one another:
   - **Targeting approach**: focusing on **people in poverty** only.
   - **Narrowing the health divide**: **reducing the gap** between **worst and best**
   - **Whole population approach**: **between high-, midle- and low-income groups** by equalizing healthy opportunities across socioeconomic spectrum.

3) Population health policies should have the **dual purpose** of **promoting health gains in the population as a whole and reducing health inequities**.

4) Actions should be concerned with **tackling the social determinants of health inequities**

5) Stated policy intentions are not enough, **the possibility of actions doing harm must be monitored.**

(Whitehead M, WHO 2007)

3. What can we do? Framework for policies

6) Select **appropriate tools to measure the extent of inequities and the progress towards goals**

7) Make concerted efforts to **give a voice to the voiceless.**

8) Wherever possible, **social inequities in health should be described and analysed separately for men and women**:

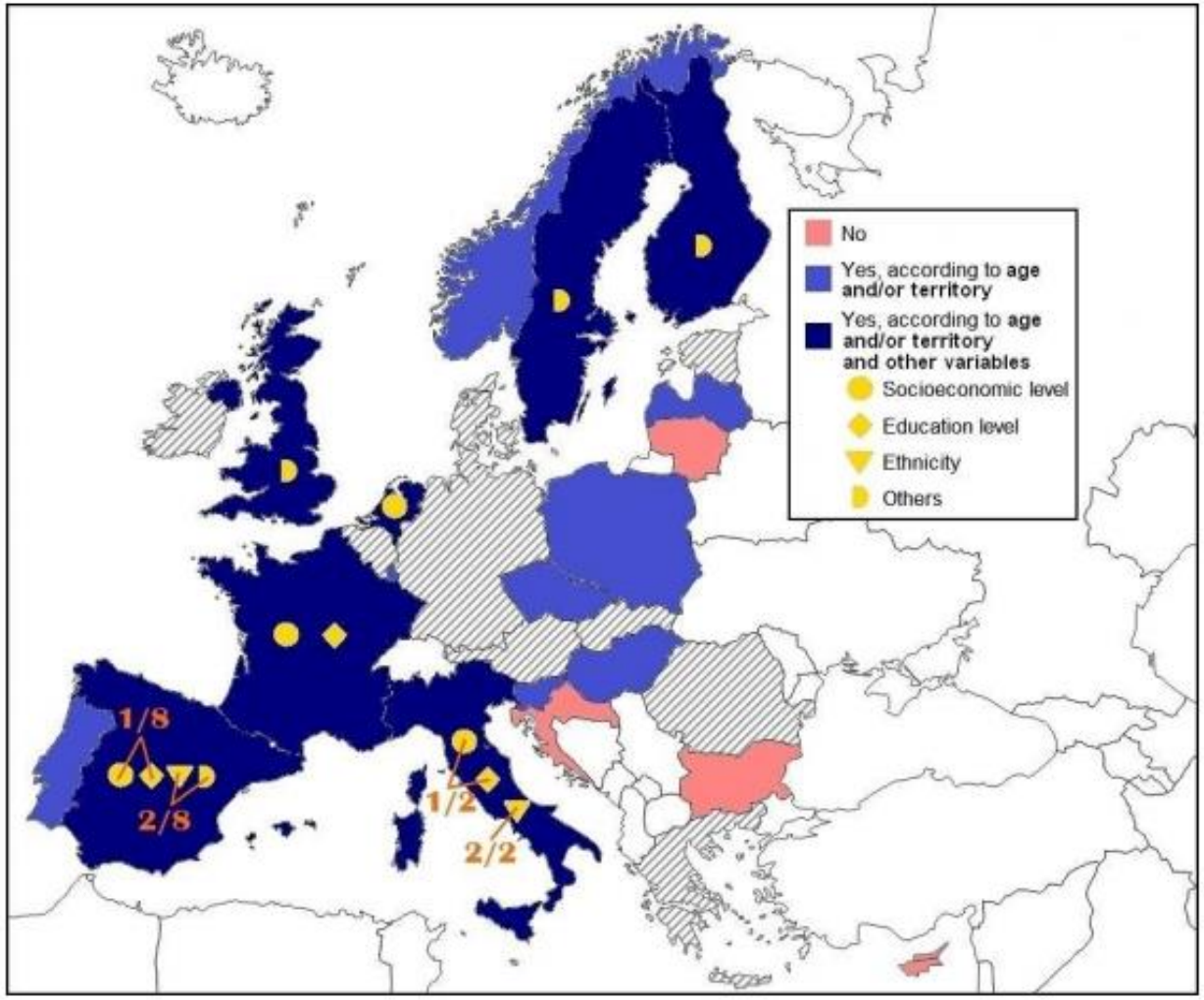
9) Relate **differences in health by ethnic background or geography to socioeconomic background**

10) Health systems should be built on **equity principles:**

- Public health services should not be driven by profit, and patients should never be exploited for profit.
- Services should be provided according to need, not ability to pay.
- The same high standard of care should be offered to everyone, without discrimination with respect to social, ethnic, gender or age profile.
- The underlying values and equity objectives of a health system should be explicitly identified, and the monitoring carried out to ensure these objectives are approached in the most efficient way possible.

4. Examples of inequalities in action and policies

Map 12. Participation periodically analysed by socioeconomic variables (colorectal cancer).



Mapping social inequalities in European cancer screening programmes.(An EPAAC report . Molina A et al

4. Examples of inequalities in action and policies

Table 2: Relative survival (%) by deprivation category, and deprivation gap (%) at five and ten years after diagnosis

	Relative survival	95 % CI		Relative survival	95 % CI	
		Lower	Upper		Lower	Upper
	98.8	95.8	99.7	98.2	95.2	99.3
	97.3	94.5	98.7	96.4	92.9	98.2
	100.0	–	–	99.2	93.3	99.9
	100.0	100.0	–	99.5	90.4	100.0
	99.8	–	100.0	99.8	–	100.0
	1.4			**2.2**		
	95.3	94.6	95.9	94.8	94.0	95.4
	94.9	94.2	95.6	94.5	93.7	95.2
	94.2	93.4	94.9	93.3	92.4	94.1
	93.8	93.0	94.5	93.3	92.4	94.1
	91.6	90.6	92.5	91.1	90.0	92.1
	-3.1*			**-3.1***		

Socioeconomic inequalities in testicular cancer survival within two clinical studies. Nur u, et al. Cancer epidemiology, 2012

4. Examples of inequalities in action and policies

National Cancer Action Team
Part of the National Cancer Programme

NHS
NCEI
National Cancer Equality Initiative
Part of the National Cancer Programme

General equality Strategy

Strategy in cancer inequalities

Data analysis of data by socioeconomic characteristics

Evaluation

Mainstreaming equity in CANCON project.

- GUIDE COORDINATION COMITTE
  - Trasversal issue

Many thanks

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