

www.bpac.org.nz keyword: cancer

THE UNEQUAL IMPACT OF CANCER

Key Reviewer: Dr Wendy Stevens, Senior Research Fellow, University of Auckland

Cancer has a significant and disproportionate impact on Māori and there are significant disparities in experiences, quality of health care from diagnosis to treatment and resulting outcomes. This suggests that focused interventions for Māori are needed.

There is greater incidence and mortality for all cancers in Māori compared to non-Māori.^{1, 2} Inequalities in cancer death rates are increasing and this is a major reason for the significant gap in life expectancy (8.2 years³) between Māori and non-Māori.^{4, 5} Survival rates for Māori diagnosed with cancer are poorer^{6, 7, 8} and there are disparities in access to all cancer services.⁹

Māori are nearly twice as likely to die from cancer, even though they are only 18% more likely to have cancer. One reason for this may be that Māori are more likely to be diagnosed with cancer at a more advanced stage.¹⁰

Māori have the highest rate of lung cancer in the world

New Zealand survival rates from lung cancer are one of the poorest in the developed world. Lung cancer is the leading cause of cancer deaths with a five year relative survival rate of 10.2%,¹¹ considerably worse than Australia (14%)¹² and the USA (15.5%).¹³


The incidence of lung cancer in Māori is the highest in the world. The mortality rate for Māori from lung cancer is three times higher than for non-Māori and the average age of death is lower (63 years compared to 70 years¹⁴). The five year relative survival rate for Māori is just 5.4%.¹⁰

Recent studies of lung cancer in New Zealand found that:^{15, 16}

- High mortality from lung cancer is largely due to late presentation, delays in treatment and low surgical rates for early stage disease.
- The most common method of entry to secondary care was through the emergency department (Pacific 52%, Māori 38%, European 32%, Asian 26%).
- A high proportion of people with lung cancer are not managed within recommended timeframes.
- Timely access to specialist oncology services was associated with improved outcomes.
- Māori were more likely to have delays in receiving treatment.
- Māori were four times less likely than Europeans to receive curative treatment.
- Treatment for Māori was aimed at relieving symptoms.

The high proportion of patients with lung cancer entering secondary care through the emergency department suggests that access barriers (e.g. financial, cultural, geographic) may still exist in the primary care sector. However, there may be other factors influencing late presentation such as patient fear. Presentations to the emergency department are associated with severe presenting symptoms, late stage disease, and Māori and Pacific ethnicity. The differences between Māori and non-Māori in types of treatment received may reflect the stage of cancer at presentation and higher rates of comorbidity (e.g. renal disease, cardiovascular disease) for Māori, which would preclude the use of curative treatments.

Planning and efforts to eliminate barriers, improve access and ensure earlier presentation to primary care services along with timely appropriate referral to secondary services when necessary, is required. An increase in the early detection of lung cancer and subsequent treatment would have an immediate benefit to the patient and their whānau.

 BPJ 13 – Improving Māori health detailed the following practical solutions that can be used to assist in eliminating disparities in your practice:

1. Plan to improve Māori health

Change does not happen by accident, it needs to be planned.

2. Set realistic practice goals

You don't have to change everything at once. Prioritise and develop achievable goals that can be measured.

The first goal may be as simple as correctly recording ethnicity or smoking status.

3. Invest time in establishing relationships

Invest time in building trusting therapeutic relationships with patients and whānau.

An effective therapeutic relationship may mean that patients are more likely to attend regularly, enabling identification of early symptoms such as persistent cough.

4. Engage patients in their health issues

Consider each contact as an opportunity to educate and engage patients in their health care and address wider issues.

Encouraging young Māori not to start smoking and offering smoking cessation advice for those that do smoke are important factors in reducing the incidence of lung cancer.

5. Agree on realistic patient-centred health goals

Break up the health issue into manageable pieces. Agree on achievable treatment goals, activity goals and lifestyle changes.

Encouraging a smoke-free environment at home may be the first step towards smoking cessation.

6. Make it easy for patients to come back

Give patients a reason and create an expectation to return. Use reminders. Make the environment welcoming. Offer solutions for any barriers that may exist. Ensure you validate their attendance, encourage and arrange for them to return.

Not every presentation of cough in a patient who smokes will be cancer, but it is useful to let patients know that cough is an important symptom in smokers, without being judgemental.

7. Form partnerships

Find out who is taking responsibility for a patient's healthcare – it may be another whānau member.

Involve Māori health providers and encourage community initiatives e.g. smoke free marae. Cancer is a whānau condition.

What methods have worked for you?

We are interested in hearing about successful initiatives for improving Māori health in your practice.

Contact peter@bpac.org.nz

References:

1. Ministry of Health. The New Zealand Cancer Control Strategy. Wellington: Ministry of Health and the New Zealand Cancer Control Trust. 2003.
2. NZHIS. Cancer: New registrations and deaths 2001. Ministry of Health, Wellington. 2005.
3. Statistics New Zealand. New Zealand life expectancy increases. Available from <http://www.stats.govt.nz> (Accessed November 2008).
4. Ajwani S, Blakely T, Robson B, et al. Decades of Disparity: Ethnic mortality trends in New Zealand 1980–1999. Ministry of Health and University of Otago, Wellington. 2003.
5. Blakely T, Ajwani S, Robson B, et al. Decades of disparity: widening ethnic mortality gaps from 1980 to 1999. *N Z Med J* 2004;117(1199): 995.
6. Gill A, Martin I. Survival from upper gastrointestinal cancer in New Zealand: the effect of distance from a major hospital, socioeconomic status, ethnicity, age and gender. *A NZ J Surgery* 2002;72: 643–6.
7. Cormack D, Robson B, Purdie G, et al. Access to cancer services for Māori. Wellington: Wellington School of Medicine and Health Sciences. 2005.
8. Jeffreys M, Stevanovic V, Tobias M, et al. Ethnic inequalities in cancer survival in New Zealand: linkage study. *Am J Pub Health* 2005; 95(5): 834–7.
9. Ministry of Health. The health and independence report 2004: Director-General of Health's annual report on the state of public health. Ministry of Health, Wellington. 2004.
10. Robson B, Purdie G, Cormack D. Unequal Impact: Māori and Non-Māori cancer statistics 1996–2001. Ministry of Health, Wellington. 2005.
11. New Zealand Health Information Service. Cancer patient survival covering the period 1994 to 2003. Government Press, Wellington, 2006.
12. Australian Institute of Health and Welfare. Cancer survival in Australia, 2001: lung cancer. Australian Institute of Health and Welfare (AIHW) and Australasian Association of Cancer Registries, Canberra 2001. Available from: <http://www.aihw.gov.au/publications/can/csa01part1/> (Accessed 28 March 2008).
13. National Cancer Institute. Lung and bronchus cancer: survival statistics. *Cancer Statistics Review, 1975–2004*. SEER, National Cancer Institute, USA, 2006. Available from: http://seer.cancer.gov/csr/1975_2004/results_merged/sect_15_lung_bronchus.pdf (Accessed August 2007).
14. Shaw C, Blakely T, Sarfati D, et al. Varying evolution of the New Zealand lung cancer epidemic by ethnicity and socioeconomic position (1981–1999). *N Z Med J*. 2005;118(1213).
15. Stevens W, Stevens G, Kolbe J, Cox B. Lung cancer in New Zealand: Patterns of secondary care and implications for survival. *J Thorac Oncol*, 2007; 2(6):481–493.
16. Stevens W, Stevens G, Kolbe J, Cox B. Varied routes of entry into secondary care and delays in the management of lung cancer in New Zealand. *Asia-Pacific Journal of Clinical Oncology* 2008; 4: 98–106.