

# Tackling Inequities in Lung Cancer Outcomes: Policy Takeaways

## CONTEXT

Although some individuals may be at a higher risk of developing lung cancer due to biology and genetics, lung cancer incidence and outcomes are largely affected by geographical and socio-economic factors. These factors ultimately affect specific populations more than others, placing a disproportionate burden on certain demographics.

### How does lung cancer disproportionately affect certain groups?

Low income individuals, racialized minorities, Indigenous communities, and those living in rural or remote areas have an increased chance of receiving a lung cancer diagnosis or dying from this disease compared to other segments of the population.<sup>1</sup> In fact, even when two patients are diagnosed at the same stage, people with lower income are 26% less likely to receive curative surgery; contributing to lower lung cancer survival rates.<sup>1</sup>

These inequities are especially pronounced for First Nations, Inuit and Métis communities, as they are more likely to have lower incomes and live in rural or remote communities. For example, First Nations adults are 35% less likely to survive lung cancer five years after diagnosis and people living in Inuit Nunangat are more than twice as likely to be diagnosed with lung cancer. This disproportionate burden stems from an unequal distribution of power and uneven access to resources that results in health inequities.<sup>1</sup> Systemic, economic, and geographic barriers continue to stand in the way of improving outcomes for those with lung cancer. Appropriate interventions at the policy and system levels are needed to begin to address these gaps.

### How can we improve lung cancer survival rates?

Screening and early detection are critically important. 70% of lung cancer cases are diagnosed at a late stage (stage III or stage IV).<sup>2</sup> Without screening, by the time lung cancer signs and symptoms develop, the cancer is usually too advanced for any curative treatment. Because of this, only about 19% of those diagnosed with lung cancer survive past the five year mark.<sup>2</sup>

Studies show that screening with low-dose computerized tomography (CT) scans increase lung cancer survival rates in high-risk individuals by about 20%.<sup>3</sup> By improving access to screening, lung cancer can be detected at earlier and more treatable stages, giving lung cancer patients a fighting chance.

### Are there inequities in access to screening?

Currently, only three provinces have established screening programs: British Columbia, Ontario, and Quebec. To date, Ontario's program is the only permanent one. However, even in provinces with established screening programs, residents face access inequalities. As testing sites tend to be located in large urban areas, those without reliable and accessible transportation or those living in rural or remote areas are unable to easily attend necessary screenings.

Moreover, as available screening programs continue to target those who are deemed at risk based on characteristics such as age and smoking status, those who do not meet the criteria are still left disadvantaged. Given that about 25% of lung cancer cases are from never smokers, it is important to continue to work towards reaching these segments of the population.<sup>6,7</sup>

## KEY POLICY TAKEAWAYS

### 1. All Canadian jurisdictions must adopt a comprehensive lung cancer screening programs with an equity-oriented approach.

The most important action that we can take to increase lung cancer survival rates is to implement comprehensive screening programs across the country. Given that screening programs can be hard to reach for certain demographics, we must establish an equity-oriented approach to screening. Working with navigators with lived experience and setting up satellite sites in rural locations are some of the actions that could be taken. Without addressing access barriers to screening we will continue to fail to reach and support the populations that can benefit from these programs the most.

### 2. Continue to support awareness and de-stigmatization campaigns.

Lung cancer continues to be heavily stigmatized. This stigma can lead to a reluctance to ask for help, affect the quality of treatment lung cancer patients receive, or negatively affect a person's mental health.<sup>4</sup> As such, stigma has significant health consequences, negatively affecting health outcomes and contributing to population health inequities. This is especially impactful for low income demographics, racialized minorities, and Indigenous communities, as they often face intersectional layers of stigma that hinder their ability to access health care.<sup>4</sup>

In order to support these populations, system-wide interventions including education, training, practice and policy are necessary. Actions such as implementing culturally-safe and trauma-and violence-informed training for health care providers, integrating culturally representative navigators in cancer care and treatment, and tailoring programs to ensure that those who need it the most can access them will help create an inclusive and responsive health system.

### 3. Improve treatment affordability and access.

In Canada, lung cancer medication is not always publicly covered. Different jurisdictions have differing levels of coverage, limiting the treatment options that some Canadians have access to. Notably, Ontario and the Atlantic provinces are lagging behind in their coverage of important cancer medications compared to all Western provinces, Quebec, and the territories.<sup>5</sup>

Given that people with low income are disproportionately burdened by this disease, improved public coverage can significantly alleviate the burden of cost felt by this population. While some provinces cover the cost of cancer medications, most do not. This fragmented system leaves many Canadians without access to the treatment best suited to fight their disease. Undoubtedly, increasing treatment affordability and access will improve the quality of life of those affected by this disease.

## References

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