National Bowel Cancer Working Group Equity Statement

The National Bowel Cancer Working Group (NBCWG) is concerned that there are differences in bowel cancer survival between groups of New Zealanders which are inequitable. Inequities, by definition, are unfair, avoidable and remediable. Our approach to addressing inequities in bowel cancer survival is to standardise care in the areas along the diagnosis to treatment pathway, where inequities are most likely to occur.

There are differences in bowel cancer survival in New Zealand by ethnicity, age, and place of residence (rural/urban). Apart from age, ethnicity is the strongest of those influences on survival with the largest difference between Maori and non-Maori New Zealanders (Jeffreys and Sarfati 2009), (Hill et al 2010), (Robson et al 2010).

Pacific and Asian New Zealanders have substantially lower incidence and mortality from bowel cancer than other New Zealanders (Blakely et al 2007), Blakely et al 2010). There are some data on cancer survival for Pacific people which suggests that survival rates are intermediate between Maori and European New Zealanders (Soeberg et al 2012).

Our approach is that by addressing the worst area of inequities we will most likely reduce inequities between rich and poor and between Pacific and European New Zealanders. Adopting a total population or ‘get it right for all’ approach may not improve current inequities and may worsen them. Hence our focus is to ‘get it right for Maori, get it right for all’.

Bowel cancer in Maori is an important health issue

- Bowel cancer is the third most common cause of death from cancer for Maori (Robson and Harris 2007).
- Bowel cancer is currently more common amongst non-Maori, but Maori incidence and mortality rates are increasing more rapidly than for non-Maori (Shaw et al 2006), Shah et al 2012).

Maori bowel cancer survival is low compared to non-Maori

- Maori are 30 percent less likely than non-Maori to get bowel cancer but once diagnosed are 30 percent more likely to die from bowel cancer.
- Maori are more likely than non-Maori to be diagnosed with bowel cancer at an advanced stage (Robson 2010).
- Poorer survival for Maori is not all due to later stage at diagnosis (Hill et al 2010).
- Health system processes after diagnosis account for about a third of the bowel cancer survival inequity between Maori and non-Maori (Hill 2010). Maori have been found to be less likely to receive some care and to receive lower quality of care compared with non-Maori (Hill et al 2010).

Maori bowel cancer patients with comorbidities may be under treated

- Differences in co-morbidity rates between Maori and non-Maori account for about a third of the survival difference (Hill 2010). Chemotherapy may be underutilised for people with bowel cancer who have co-morbidities (Sarfati et al 2009).
Health care providers will need to play a role in eliminating inequities in bowel cancer survival between Maori and non-Maori

- Ensuring fair access to quality treatment is central to reducing inequities in bowel cancer survival between Maori and non-Maori.

- Identifying and removing inequities along the bowel cancer treatment pathway could address up to a third of the bowel cancer survival inequity between Maori and non-Maori.

- Some of the co-morbidity related excess in mortality is probably due to under treatment (and therefore can be addressed by health professionals).

- Developing a screening programme that has equal screening and follow-up rates for Maori and non-Maori could reduce inequities in stage at diagnosis.

- Health care providers could reduce the impact that poverty and other health and social inequities exert over Maori with bowel cancer. Transport and smoking are two important issues that health professionals need to address, particularly for Maori.

Quick notes for clinicians

Younger
Your Maori patients are approximately nine years younger at diagnosis than your non-Maori patients. The average age of diagnosis for Maori is 61.3 years, and for non-Maori is 70.6 years. This is most likely due to the relatively younger age of the Maori population.

Poorer care
You will need to advocate for your Maori patients to ensure they get equitable care. Compared to your non-Maori patients, your Maori patients are at greater risk of not getting access to bowel cancer care, of having to wait longer to access bowel cancer care and of receiving lower quality care.

Poorer
Your Maori patients are likely to be relatively poor compared to your non-Maori patients. Almost half of your Maori patients live in the poorest 20 percent of the country. About one third of your non-Maori patients live in the richest 20 percent of the country. Poverty is an additional stressor which can exacerbate difficulties in accessing treatment and reduce resources available for patients to manage cancer.

Discriminated
Research has shown that Maori are almost 10 times more likely to have experienced multiple types of racial discrimination compared to European New Zealanders.

What can I do as a clinician?

- **Remember to refer your Maori patients for chemotherapy**
  Maori have lower rates of referral to chemotherapy.

- **Refer your Maori patients early**
  Maori have longer waiting times.

- **Manage co-morbidities in your Maori patients and make sure your Maori patients are seeing their GP for management**
  Maori have higher rates of co-morbidity.
- **Make every effort to ensure that your Maori patients with co-morbidities get offered treatment**
  People with co-morbidities may be under treated.

- **Ask all of your patients if they smoke**
  Tobacco use is the single most preventable cause of disease, disability, and death in New Zealand. Maori smoking prevalence is over double non-Maori prevalence. Clinicians should ensure that patients are provided with intensive support to quit, including pharmacotherapy, and referred for cessation support (NZ Smoking Cessation Guidelines 2007).

- **Offer and refer your Maori patients for socioeconomic support**
  Maori have higher rates of poverty.

References


