

Social inequality in health

- equitable approaches to handling complex needs in patient care – can we use quality work strategically?

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The pattern of social inequality in cancer over the past 25 years is clear

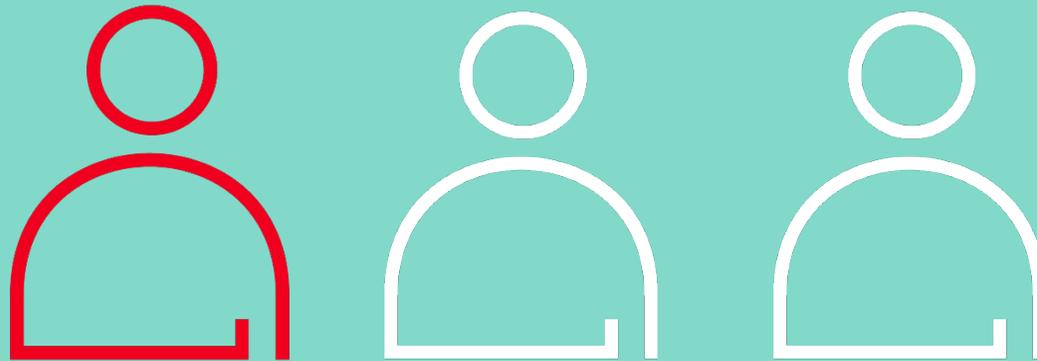
- Either stable or increasing differences in short- and long-term survival by socioeconomic position (SEP):
- Patients with high SEP are increasingly experiencing better survival
- Patients with low SEP are either experiencing less or no increase in survival

Some groups of cancer patients are systematically not benefiting from advances in diagnostics and treatment!

Large potential

If... we (theoretically) assume survival at same level as high SEP patients in all Danish patients...

1/3 more 5-year survivors*



***Among patients diagnosed 2011-2014**

5-års relative survival, . Kræft I Danmark, 2022

Social inequality is observed throughout the cancer trajectory

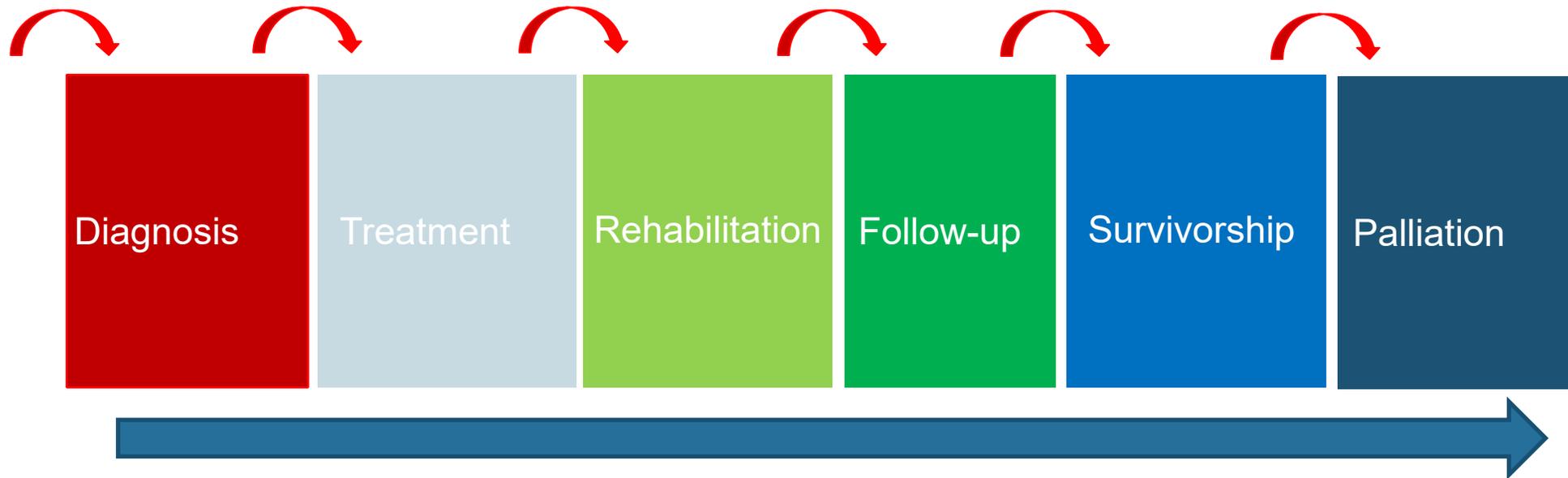
Persons with fewer social resources:

- Screen **less**
- Present **later**
- Have **worse** (non-cancer) health
- **Fall more out of** cancer diagnostic/care packages
- **Drop more out of** or receive **less** treatment
- Receive **less** rehabilitation & initiate **later and receive less** palliative care

Inequality in these factors drives inequality in **quality of life & survival**



Transitions in care create cumulative inequality



Even if inequality for the most part is not DUE to the healthcare system.....
The healthcare system can and should be a part of the solution...

Treatment disparities in a free and equal access healthcare system...?

When accounting for social disparities in stage at diagnosis and pre-existing comorbidities – treatment differences are generally limited.

BUT we still see inequalities in treatment:

- cancer forms with **bad prognosis** i.e. lung cancer (reflects grey zone for treatment choice..?)
- **transitions** between specialties – i.e. adjuvant chemotherapy after colon cancer surgery
- **complex and new** treatments – i.e. bone marrow transplants for CLL

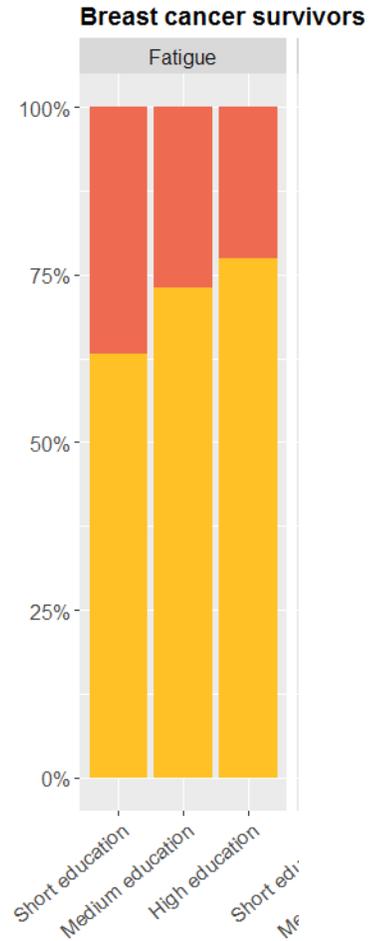
Social inequality in after-care?

Research is more sparse – as yet

But indeed we see new evidence pointing to socioeconomic differences in

- More late effects and QoL
- Less referred to rehabilitation – despite more needs
- Less participation in both basic and specialized palliation
- And subgroups may be overburdened by self-management in light of changes in follow-up care

So how is QoL among 2-12 years cancer survivors according to SEP? (Levinsen et al 2023, in review)



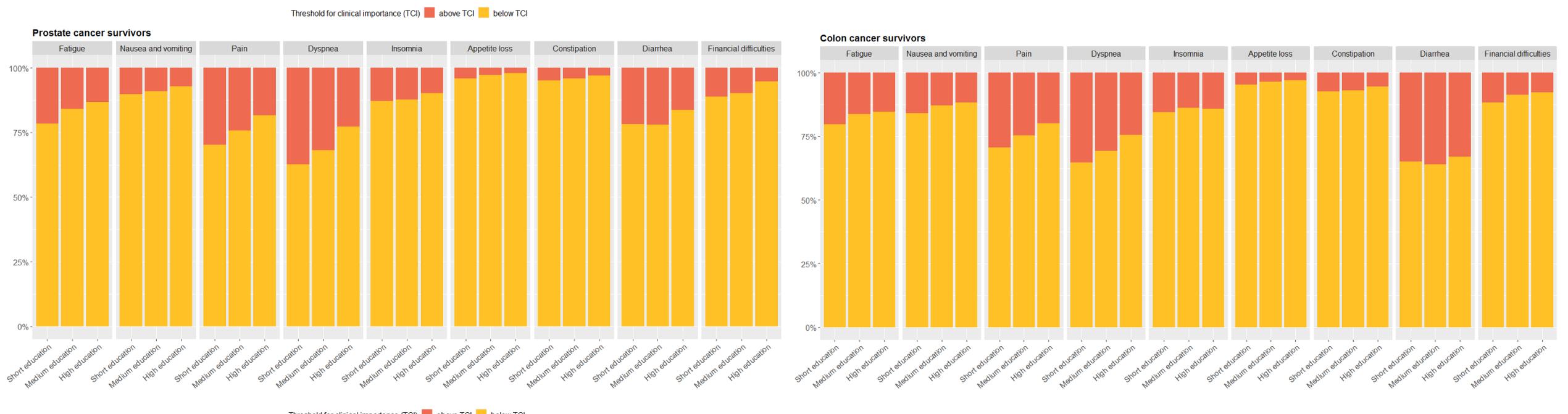
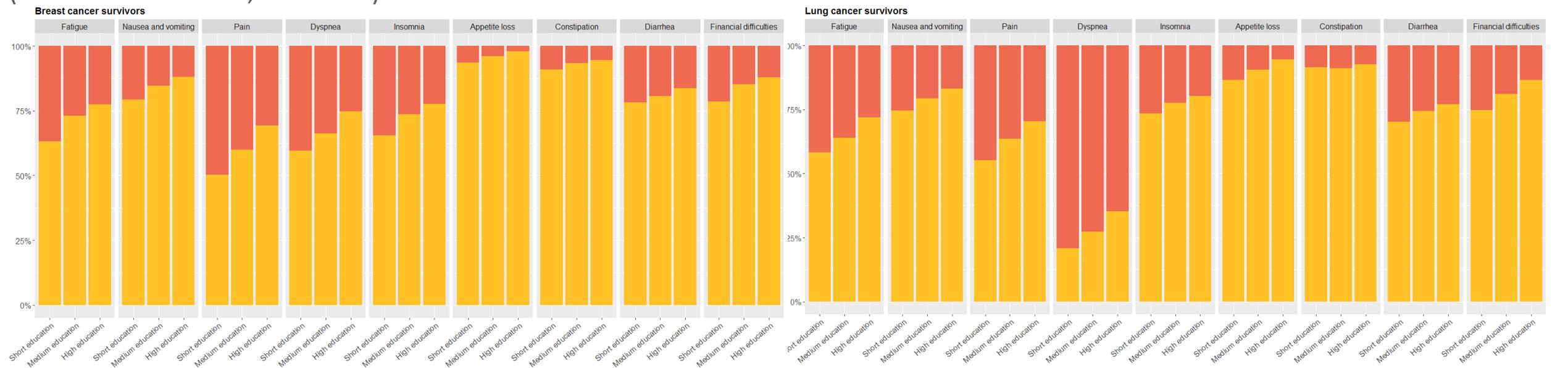
Threshold for clinical importance (TCI) ■ above TCI ■ below TCI

QoL among 2-12 years cancer survivors according to SEP? (Levinsen et al 2023, in review)

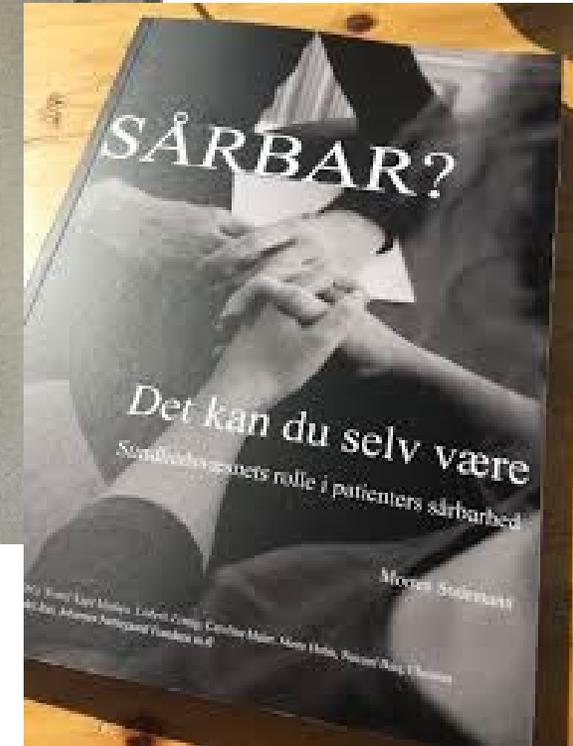


Clear inequality in clinically important symptoms in 41,000 2-12 years cancer survivors

(Levensen et al 2023, in review)



WHO exactly is the vulnerable patient?



The challenge is to go from group level to individual level

There are vulnerable patients in all social groups – with different prevalence

Vulnerable persons exist in all social groups

Inequality is present before, during and after care in cancer

Inequality widens through the cancer trajectory

Inequality happens in the meeting between patient and health system

Resources are important when disease hits...

Health literacy is a **main driver** for social inequality in health (WHO)

Patients with fewer resources find it **harder to**:

- interpret signals and symptoms from their body
- interact with healthcare staff
- manage own health and self-care
- access and navigate health services

- and the same patients are more likely to have complex health issues to deal with

In reality – what happens....?

Patients with

- short education, low income, live alone, etc...
- multidisease (physically and/or psychiatric), older, frail, etc....
- limited health literacy, worse health, life style, social support, etc...

...meet...

Structural barriers (the SYSTEM)

- complex treatment across departments and care sectors
- busy clinical reality – with time pressure, lack of staff etc...

Patients need personalized care... but how to meet that challenge?

Tailored solutions
Adapted time and language
Repetitions
Preparation for next step
Time for reflection
Trust, empathy, presence
Be seen, heard & understood
Appreciation
Care, compassion

Patience
Not to be 'told off'
Social counselling
Decision support
Professional "relative": Those who lack relatives
need them most
Professional navigation
Accessibility

Vulnerable patients: All of this at once

Kilde: Morten Sodemann 2017

Sounds costly - but can we afford not to invest in this....?



Concerted efforts have brought Danish cancer management on the right track

- Since 2000, the Danish Cancer Plans I-IV have resulted in considerable investment in infrastructure, equipment and staff for cancer management
- The cancer plans have promoted a strong patient-centric multidisciplinary approach to cancer treatment. The efforts are coordinated on a national scale (DMCG.dk, DCCC)
- Patients are now much more involved in clinical decisions and in research
- Outcomes, including survival and patient satisfaction, have greatly improved

Current (and coming) challenges



Predictions for 2020-2040

10,000 more incident cancer cases in 2040 - 23% increase from now

Only 1500 more cancer deaths in 2040 → large increase in population of patients living with and after cancer

Source: NORDCAN – NORDPRED (see www.cancer.dk)

So we will see

- More patients (and survivors) with complex health needs
- Increasing healthcare costs
- Scarcity of health staff
- Disparities in screening, diagnosis and access to cancer care – and in disease burden

TOWARDS EQUITABLE CARE IN CANCER

Improve implementation of National Guidelines i.e.:

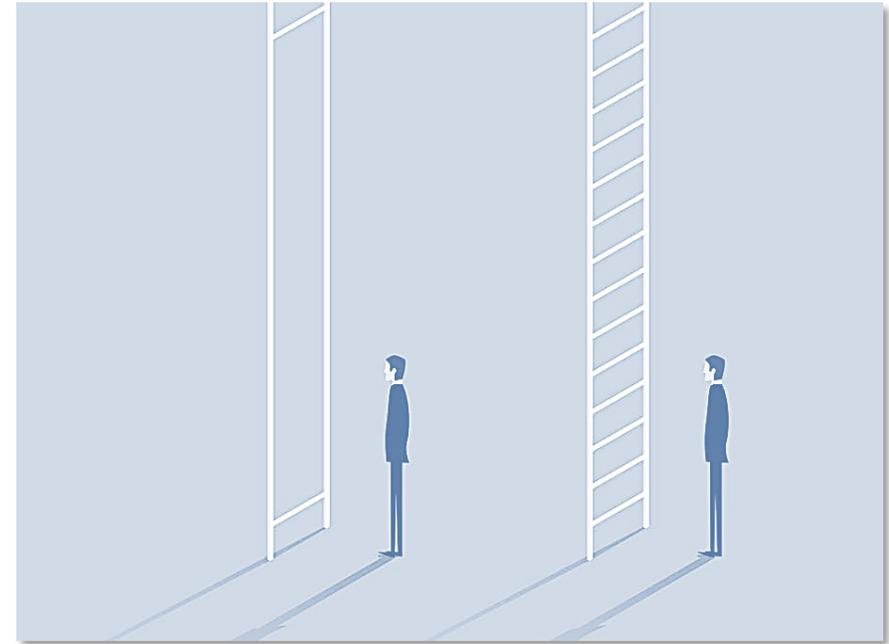
- MDT conferences – systematically include **patients resources and preferences** in assessment/planning
- Systematic **needs assessment** and **cross-sectoral collaboration** to guide rehabilitation and palliation
- **Patient-responsible** physician and nurse if not for all – then for the **vulnerable patients (at least...)** – i.e. multimorbidity, polypharmacy, help for ADL for at start



TOWARDS EQUITABLE CARE IN CANCER....(cont.)

Development of our clinical practice, e.g.

- Shared decision making – make sure NOT to increase inequality
- Digital consultations/telemedicine:
 - **STRONG** patients (free time for vulnerable patients)
 - (some) **VULNERABLE** patients (transport/time)
- Follow-up – tailor to patients' **vulnerability and needs**, as well as recurrence risk
- **Prehabilitation**/physical fitness **optimization** – improve tx adherence, fewer complications

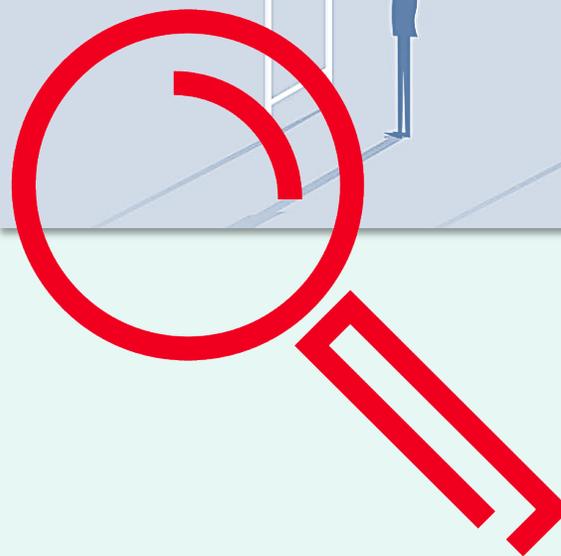
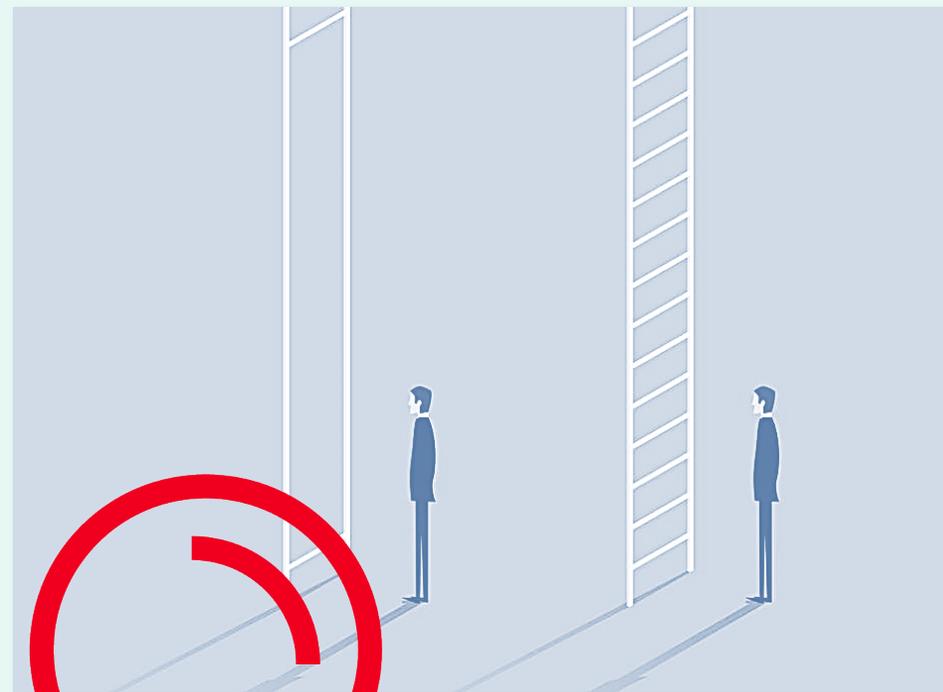


To address social inequality in cancer

...we need to be able to identify vulnerable cancer patients, no matter their social position

Ensure

- Inclusion of patient needs and preferences in treatment planning
- Needs-based supportive interventions
- Delegation of system responsibility in transitions of care



One way forward....

A generic screening tool to identify potentially vulnerable patients (physical status/frailty & psychosocial resources)

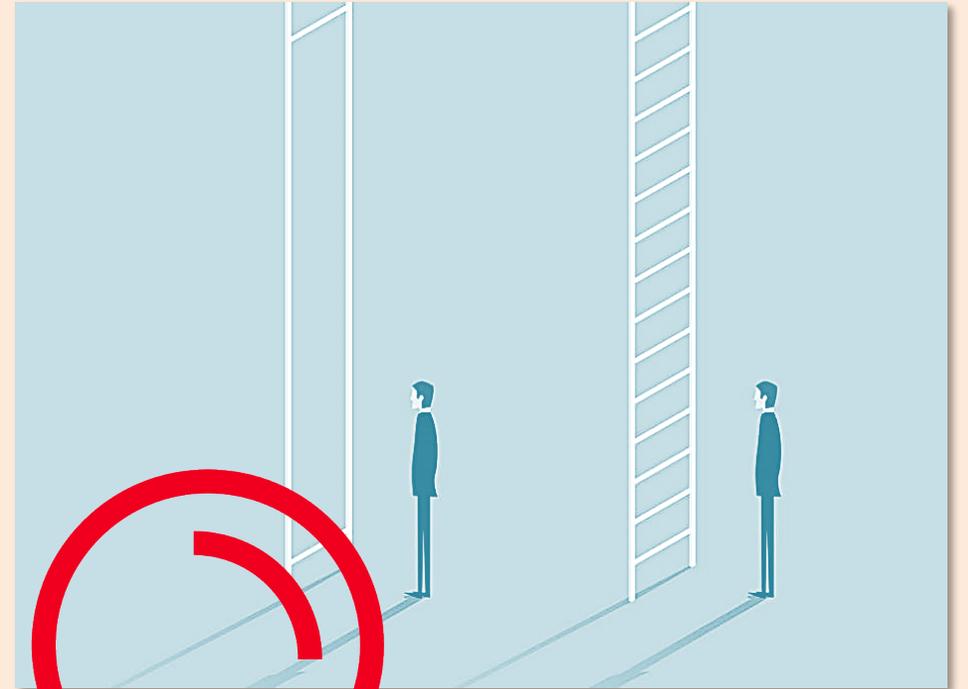
-> the (next) challenge is how to manage and support vulnerable patients through diagnosis, treatment and aftercare

The research: (again) sparse.....

The reality: busy and efficient cancer setting with challenges in staffing and "hard" deadlines for treatment...

If you give some **more** – who should have **less**???

COMPAS



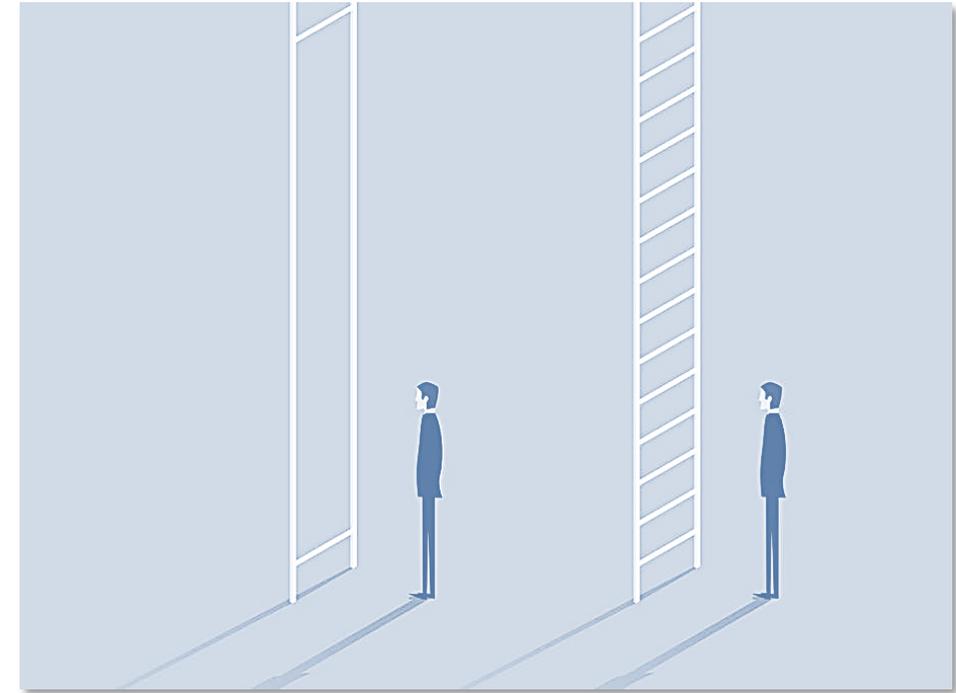
Implementation does not happen by itself

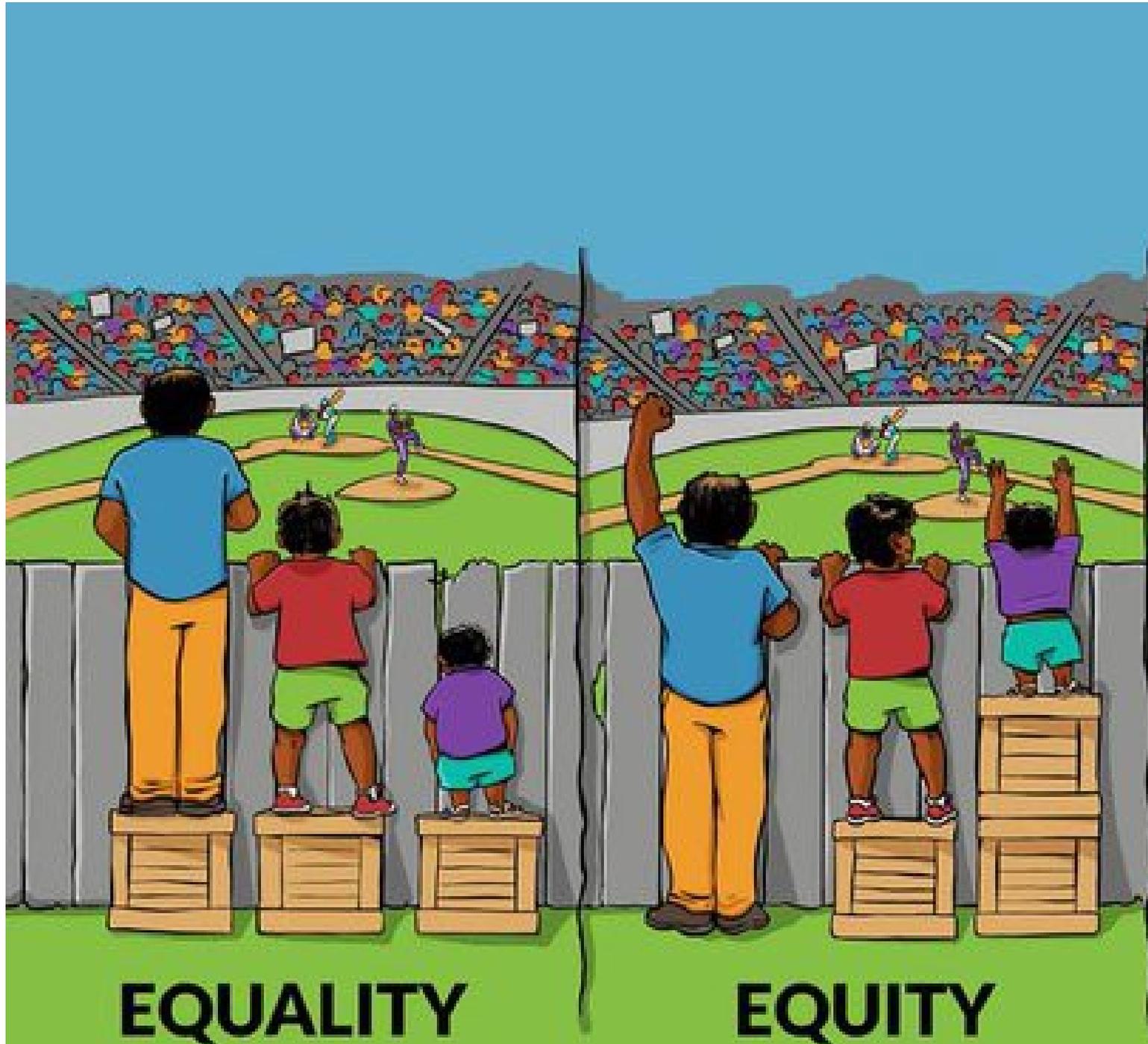
Although never systematically investigated it seems like all new treatments and practices introduce new disparity in treatment

suboptimal implementation creates inequality in care

Think about equity from the test phase....

- Explore barriers for inclusion in patients and in HCPs
- Make the test-setting as close to real-world as possible
- Measure indicators – something to work with?





EQUALITY

EQUITY