

The Social Determinants of Health and Cancer



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WHAT ARE THE SOCIAL DETERMINANTS OF HEALTH?

Over the past decades, the world has seen drastic improvements in health with life expectancy rising in most countries. However, the differences in health outcomes between the most privileged and most disadvantaged populations persist and are growing. These inequities exist in all countries and regions and are influenced by the social determinants of health, i.e. the circumstances in which people are born, grow up, live, work and age. Social, environmental and economic circumstances negatively affect people's risk of developing poor health and their ability to access health services, thereby resulting in health inequities – avoidable and unfair differences in health status between groups of people or communities. The inequitable distribution of health and illness follows what is known as the 'social gradient' – the relationship between an individual's socio-economic status and their health status (the lower a person's socio-economic status is, the worse is their health status). The social gradient steepens depending on the extent of differences in health among different groups in society – the steeper the social gradient, the greater the inequity. Health outcomes are influenced by factors such as income, employment and education as well as social norms and attitudes related to gender, sexual orientation, ethnicity, disability and old age. The social gradient applies equally to all countries, both rich and poor.

Addressing the factors that cause ill health and result in health inequities is crucial in order for everyone to attain the highest standard of health, regardless of race, religion, political beliefs, social or economic situation, a right that is enshrined in both the WHO Constitution and the UN Declaration of Human Rights.[1]

Inequity vs Inequality in health – quick definitions

- Inequality refers to the uneven distribution of health or health resources
- Inequity refers to unfair, avoidable differences in health care or health outcomes

The Social Determinants of Health and Cancer

There is a growing body of research on cancer and equity.[2, 3 ,4] These studies show how the social determinants of health impact the cancer continuum through differential exposure to cancer risk factors, including tobacco; chronic infections; reproductive, occupational and environmental factors; limited knowledge and awareness of cancer; and limited access to and use of cancer services, where these risk factors often lead to poorer outcomes.[5, 6, 7, 8] In addition, there are huge disparities around the world in the ability of people to access cancer information and prevention services, early detection and screening programmes, cancer medicines and therapy, pain medicines and palliative care. [9, 10, 11] For many people, appropriate diagnosis and treatment for cancer occurs too late and frequently not at all.[12, 13, 14, 15] Poverty, lack of access to information and services, misinformation and misconceptions, stigma and discrimination are deeply intertwined with the social determinants of health and exert important influences on the way cancer is understood and lived.

It is becoming increasingly clear that understanding and addressing the social determinants of health and their impact on cancer can improve outcomes for at-risk populations particularly for cancers that can be more easily detected and treated such as cervical, breast, colorectal and childhood cancers. The design and implementation of laws and policies that can support access to quality cancer treatment and care can also create an enabling environment for change.[16, 17, 18]

COVID-19 has exacerbated inequities

Underlying and systemic causes of inequity have left people around the world especially vulnerable to the impact of the COVID-19 pandemic. People in precarious working situations, with low wages and limited access to health facilities, have been disproportionately exposed to coronavirus infection with frequently worse outcomes for COVID-19 and for other health conditions. The COVID-19 pandemic and its repercussions in deepening health inequities has created an even greater need for action. Inequitable vaccine production and distribution compounds the challenges that low- and middle-income countries face in accessing and delivering COVID-19 vaccines and requires a concerted global response to support the COVAX facility to ensure people worldwide have equitable access to COVID-19 vaccines. Within countries, even where a national roll-out is being undertaken, attention must be paid to reaching individuals and communities that are particularly at risk of severe COVID-19 illness and death, and who may have greater barriers to health care and vaccine access.

Addressing inequity: an advocacy imperative for UICC

For World Cancer Day 2020, UICC commissioned a global survey across 20 countries to better understand the public's experiences, views, and behaviours around cancer. Conducted by Ipsos, the survey revealed that that irrespective of where people live in the world, those surveyed with a lower education and those on lower incomes appear less aware of the main risk factors associated with cancer and appear less likely to proactively take the steps needed to reduce their cancer risk than those from a high-income household or with a university education.[19]

The UICC has also conducted a desk review and stakeholder interviews to map out research studies and initiatives that address the social determinants of health (SDOH) and cancer, in order to identify gaps in the current knowledge base and to understand the key social determinants that impact cancer treatment and care. Key informant interviews were conducted with more than 30 individuals representing academia, civil society, global health policy, national cancer control institutes and local programme implementers, to elicit their views and perspectives on the key social determinants of health that affect access to cancer services in their settings.

The review found that, despite increased attention on the impact of social determinants on health outcomes and health equity in the last decade, studies have overwhelmingly been focused on Europe and North America, with far less research on the impact of social inequalities on cancer outcomes in other regions. In terms of topics addressed, studies tend to focus on differential outcomes in breast cancer predominantly, followed by paediatric and cervical cancers. The literature review and key informant interviews identified several cross cutting social determinants that need to be addressed in national cancer control planning efforts. These include the following:

Gender norms and discrimination

Around the world, women and girls are impacted by gender norms and economic and cultural factors that hinder their access to prevention, early detection and timely treatment – all of which are critical to surviving cancer and leading healthy, productive lives. Women may have to seek permission to access health facilities and frequently experience stigma and social isolation related to cancer. For breast and cervical cancers, misconceptions may lead to women being blamed for their cancer diagnosis. Fear of stigma and discrimination following a potential cancer diagnosis has also been found to be a barrier to accessing cancer screening.[20] Gender norms can also affect men's health-seeking behaviour. Men may underutilise health services, including for cancer screening, and social norms surrounding masculinity may make them less willing to discuss health concerns.[21]

Low socio-economic status

Low socio-economic status can impact access to cancer services (including prevention and screening), timely diagnosis and receiving quality care, both for individuals and populations between countries and within countries. Low socio-economic status has been found to affect treatment adherence for several cancers including ovarian, breast and childhood cancers.[22, 23, 24] Factors that put low-income individuals particularly at risk of underutilising cancer services

include the costs of cancer care, not having health insurance, employment conditions that make it difficult for patients or their caregivers to take time off work, limited or no public transportation and a lack of accommodation facilities in or near treatment centres. A multi-country study in Asia found that participants in the low-income category within each country were more than 5 times more likely to experience financial catastrophe than participants from high-income backgrounds. Across the countries, patients diagnosed with advanced stages of cancer and socioeconomically disadvantaged cancer patients were more likely to experience financial catastrophe or die within 12 months of their cancer diagnosis.[25] This includes low-income patients, those with primary education only, and those with no health insurance. Due to the often very high costs of cancer treatment, when cancer care is predominantly financed from out-of-pocket payments, this can push households below the poverty line.

Structural and societal barriers for indigenous and minority populations

The majority of research on indigenous and minority populations has been undertaken in high-income countries (HICS), particularly Canada, USA and Australia, given concerns over the higher cancer mortality in these groups.[26] Indigenous populations are historically underserved by health and other services, and there are several interconnecting factors that have made cancer a leading cause of illness and death among indigenous people. These include significant disparities in relation to risk factor prevalence (particularly tobacco and alcohol use), cancer incidence, stage at diagnosis, quality of care received and disease outcomes.[27] Limited research has been published about the factors affecting cancer outcomes among indigenous people in low- and middle-income countries (LMICs). However, most national NGOs interviewed noted how disparities in cancer outcomes are even more stark for indigenous and minority communities in their countries than the non-indigenous population, and that there is a lack of funding to be able to access these communities in order to provide adequate outreach, education and service provision.

Limited access to health promotion, early diagnosis, treatment and care among rural populations

Key informants from both HICs and LMICs across sectors noted that rural populations (those residing outside metropolitan areas) face several barriers that have an impact on health outcomes. These include the long distances often required to travel to primary care facilities and specialised clinics, a lack of screening and prevention programmes available in these areas, the impact of distance on chronic patients who need multiple treatments or have co-morbidities, and the financial impact of additional time away from jobs to access treatment in urban areas. Studies have found that patients living in rural areas are often diagnosed at later stages; are less likely to receive standard-of-care treatment, follow-up or supportive services; and have worse health outcomes during survivorship than nonrural patients. They are also less likely to be recruited into clinical trials.[28] Indigenous populations, older populations and populations with greater levels of social disadvantage also more frequently live in rural areas, thereby interacting with other key social determinants of health.

Lack of attention to older adults

Cancer is more prevalent in older adults, with cases amongst the over-65s accounting for over 50% of the global cancer burden.[29] Many cancers in older people are diagnosed at a later stage, as early cancer symptoms can be mistaken for everyday pain or minor illnesses associated with old age. As a result, cancer treatment often starts late, which increases the likelihood of side effects and reduces the chances of a successful treatment outcome. When combined with the unique challenges of managing cancer in older people, such as the management of co-morbidities and attention to overall levels of social support, health and wellbeing, the topic of ageing and cancer requires far greater attention within cancer control policy and planning. However, current evidence suggests there are limited programmes and services in place to respond the needs of older adults. [30] Also, while more older people are diagnosed with cancer than younger people, older patients are vastly underrepresented in the research that sets the standards for cancer treatments. Cancer therapeutics are based on clinical trials conducted in younger, healthier patients and effective strategies to improve clinical trial participation of older adults with cancer remain sparse.[31]

Structural and societal barriers among refugees and internally displaced populations

Cancer patients in conflict and post-conflict settings experience a particular set of barriers that influence cancer outcomes, including a collapsed or fragile health system, psychosocial and emotional distress, limited financial resources, language and cultural barriers in the host country, among others. Refugees and internally displaced populations in LMICs face additional barriers, given the limited availability of outreach and treatment services and lack of funding to provide additional specialised staff to serve these at-risk populations. Cancer is frequently neglected in the policy response to humanitarian crises and research on access to cancer treatment and care for these populations is limited. Weak health surveillance systems in conflict-affected countries mean that the true burden of cancer in refugees and displaced populations is not captured. However, several studies have shown that the majority of patients in war-affected settings present with advanced stage cancer and, for many of them, appropriate care is not available, particularly as affected regions become inaccessible, hospitals and health centres are damaged or destroyed, and health workers are killed, injured or displaced.[32]



Responding to the Social Determinants of Health

Understanding the ways in which the social determinants of health influence cancer risk factors, the reach and effectiveness of health promotion (including cancer prevention programmes), the provision of quality and timely early detection, treatment and supportive care, is essential to reducing the huge disparities in cancer that can be observed around the world today. A fundamental step in addressing the social determinants is through cancer surveillance. The collection and use of data by population-based cancer registries is important to inform policymaking and track the national cancer burden over time, understanding where there are disparities in the cancer burden among populations and monitoring these, including the success or failure of programmes to reduce incidence, decrease mortality and improve survival.

In addition, a key strategic tool for countries in their national cancer response is the development and implementation of a national cancer control plan (NCCP). This sets out the cancer burden in a country, the priority actions and interventions that will reduce the burden and the resources required for the plan's implementation. Attention to equity must be included in NCCPs through an analysis of underserved and vulnerable populations and strategies to address the needs of these populations comprehensively through cancer control programmes and services must be identified. A starting point for this is by adopting a community-based, participatory approach that seeks to understand and address the barriers facing different populations and engaging community representatives to ensure feasibility, acceptance and uptake of key interventions.

As discussed in this brief, the social determinants of health cut across population groups and there are common themes and opportunities that can be addressed within the global push to achieve Universal Health Coverage (UHC). Central to UHC is the recognition that “the enjoyment of the highest attainable standard of [physical and mental] health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.^[33] The focus on the right to health is driving calls for governments and other stakeholders to ensure that UHC planning and implementation prioritise the needs of the poor, underserved and most vulnerable first, in order to address longstanding barriers to accessing essential health services. Recognising this, the objectives of UHC are to ensure: **1.** Equitable access – access to a service should be determined by need, regardless of a person's ability to pay **2.** Quality care – services available should promote or improve the health of those using them. **3.** Financial risk-protection – providing mechanisms to protect against financial risks so that people using health services are not pushed into poverty.

These objectives are key to promoting more equitable cancer outcomes and UICC will continue to work with and support its members around the world to address the social determinants of health, to reduce disparities in cancer care and achieve the vision of 'Health for All'.

Further reading: [Addressing cancer within Universal Health Coverage: UICC and Cancer Council Australia.](#)

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