

## CHAPTER 23 SOCIO-ECONOMIC ASPECTS IN COLORECTAL CANCER

### 23.1 Socio-economics

Socio-economics are now being considered more widely in guideline development as they play a significant role in health care. Even in an affluent setting, ignorance can produce inequalities that need to be addressed.

The overall effect of socio-economics research is that deprivation has been well documented in Australia and is recognised as a factor in developing clinical practice guidelines.<sup>1</sup>

In Colorectal Cancer, there is a paucity of randomised clinical trials involving socio-economic background. They relate largely to screening factors, compliance with treatment, and the outcomes of treatment.

Pilot screening programs using faecal occult blood testing (FOBT) have been carried out in Australia (see Chapter 3) and it is planned to extend them. While such programs should allow greater access to screening for all levels of the population, they will not reduce the need to maintain education and persuasive advertising to participate in screening.

Whynes et al<sup>2</sup> aimed to determine the effects and extent of socioeconomic deprivation, analysing clinical data from a large randomised control trial augmented by geographically-based indices of deprivation. While deprivation had no significant effect on prevalence of Colorectal Cancer, it had a significant effect on participation in screening. People from more economically deprived areas have less interest than economically replete people in accepting an invitation to be screened. A similar observation has been made in other trials. In Glasgow,<sup>3</sup> a randomised controlled trial in people aged 55–65 years noted that lower socio-economic or deprived groups expressed lower levels of interest in screening tests. In a study in France<sup>4</sup> on the offering of FOBT, 1129 persons were circularised with a questionnaire and 645 (57.1%) returned it. However, review revealed that actually undertaking the test cannot be assumed from intention to do so. The authors suggest that this type of study based on questionnaires should be avoided in determining underlying behaviour towards secondary prevention.

In aiming to increase FOBT in the USA, a national priority is to increase participation by African Americans.<sup>5,6</sup> Fatalism is believed to be a barrier to FOBT screening in this population. In this study of elderly white and African Americans, the latter were the larger number but even when factors such as age, poverty and education were controlled, fatalism remained the only significant barrier to FOBT. Fatalism deserves significant attention in some ethnic groups, to derive interventions to reduce its effectiveness.

A cohort study of white and African Americans with advanced lung and colon cancer and who had not had previous chemotherapy, had their socioeconomic and biological data collected prospectively in twelve medical centres in the U.S. Veterans Administration System (May 1981–May 1986).<sup>7</sup> The essential findings of the study were that lung and colon cancer outcomes ‘may be similar among black and white patients who have equal access to comparable medical care in spite of socioeconomic differences’. This study puts equal access to care as a necessary accompaniment to good clinical care.

Based on a randomised study after mailing FOBT kits, Myers et al<sup>8</sup> recommended that health professionals raise awareness of risk factors and curability of Colorectal Cancer to encourage potential screenees to commit to recommended behaviour patterns. They also recommended that messages be tailored to keep past testers in the screening loop.

The approaches outlined are designed to maintain the educational thrust and to bring readers’ attention to advocacy for equal access as an aid for those with socio-economic deprivation.

## References

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