Migrants and refugees: Nationality and social status affect cancer care quality

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Access to quality cancer care is still a big issue in Europe, and there is great heterogeneity in the availability of drugs, screening programmes and resources among countries. Neglected cancer populations exist with lower rates of early diagnosis and treatment compliance. Migrants and refugees are one of those. As the Europe migrant crisis grows, Dr Alexandru Eniu, Head of the Day Hospital Unit, Department of Breast Tumours, Cancer Institute "I. Chiricuta", Cluj-Napoca, Romania, Chair of the ESMO Emerging Countries Committee and ESMO Executive Board member, points out possible strategies to overcome disparities in cancer care.

Does nationality and social status still affect early diagnosis, accessibility to treatment and good quality of care?

Eniu: Absolutely - there are big discrepancies among European countries which are even more pronounced outside Europe. There are multiple reasons for this, such as different healthcare systems, reimbursement, low resource environments, lack of access to trained personnel, etc. Data to support the disparities include the recent EUROCARE study, which revealed big discrepancies in 5-year relative survival and trends among Eastern Europe, Western Europe, Northern and Central Europe. The ESMO European Consortium Study on the availability of antineoplastic medicines found marked discrepancies in access to drugs - mainly for more expensive, newer drugs, but also shortages for inexpensive, old but essential medications. Access to radiotherapy was also a problem, mainly outside Europe.

The ESMO Magnitude of Clinical Benefit Scale presented earlier this year represents a first step in the critical public policy issue of value in cancer care. It is a validated approach for stratifying the magnitude of clinical benefit that can be anticipated from anti-cancer therapies. This tool provides a way to tackle disparities by promoting access to therapy, "choosing" when resources are limited and ensuring reimbursement of the most beneficial treatments.

How do migrants and refugees represent a neglected group of patients at risk for cancer development?

Eniu: Cancer can be a chronic disease requiring timely and lengthy access to a coordinated care system. Some cancers are preventable through screening. Refugees and migrants, due to their displacement, do not have access to either screening or early detection. Having limited access to the healthcare system in their adopted country, refugees and migrants neglect early signs and present only when symptoms oblige them to seek medical help. The observational, multicentric study presented by S. Jozef at ECC2015 is interesting because it targets this specific population. More than 11,000 migrants and refugees were surveyed and the distribution of tumours showed a predominance of the frequent tumour types (breast, colon, lung) which is higher than in average population. Remarkably, almost half of the patients presented at a late stage. Also important to note is that almost half did not complete the therapy - a third because they did not return to the hospital.

How would policy makers, oncologists and multidisciplinary teams deal with this emerging data, as the European refugee crisis is a hot issue today?

Eniu: More attention is clearly needed on providing cancer treatment and care to this underserved population. Efforts should be made to raise awareness amongst politicians and policy makers. Special funds for

migrants could be one solution.

Beyond neglected populations, have survival rates for any type of cancer generally improved in the last five years in Europe?

Eniu: Yes, indeed. The results of EUROCARE-5 show that in general 5-year relative survival has increased steadily over time in Europe, with the greatest gains seen in Eastern Europe. Patients with non-Hodgkin lymphoma, prostate and rectal cancers experienced the largest increases in relative survival. Relative survival increased for head and neck (excluding laryngeal) tumours, breast, cervical, liver, gallbladder and extra hepatic biliary tract cancers. In lung tumours, the increase in relative survival was higher for squamous cell carcinoma and adenocarcinoma than for small and large cell carcinoma. Relative survival slightly increased for patients with skin melanoma but remained stable for oesophageal, pancreatic, penile and testicular cancers.

Would strategies to overcome country disparities in terms of cancer care quality further improve and help to level survival rates in people living in Europe, despite their nationality?

Eniu: Yes, but in the long term. It is a difficult situation, as survival is influenced by many parameters related to the general health status of the population, the infrastructure of the healthcare system, resources, and so on. ESMO is working to tackle disparities, and is committed to promoting the best care for all cancer patients. The two projects mentioned above (Ed. antineoplastic medicine availability survey and Magnitude of Clinical Benefit Scale) are clear examples of this commitment. However, it takes time to improve survival. We are making small steps in the right direction, and the cumulative effort will hopefully reap benefits in the long term.