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EDITORIAL

Ethnicity and breast cancer stage at diagnosis: an issue of health equity

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Almost 25 years ago, prominent health researcher Margaret Whitehead, in conjunction with the World Health Organization, developed a definition of the term "health inequities," which has since become widely used in the international health literature. While health *inequality* is quite simply a difference in health between groups, health *inequity* is a normative concept. Health inequities are differences in health that "are not only unnecessary and avoidable but, in addition, are considered unfair and unjust"[1,2]. The groups affected by health inequities are typically socially defined on the basis of factors such as sex, race or ethnicity, socioeconomic status, and immigrant status[2]. Implicit in the definition is the idea that health inequities must be reduced or eliminated once identified[1].

In this issue of *Current Oncology,* the article by Ginsburg and colleagues[3], "A population-based study of ethnicity and breast cancer stage at diagnosis in Ontario," brings the issue of health inequities in oncology to the forefront. Applying a validated surname algorithm to Ontario's population-based cancer registry, the authors compared stage at diagnosis of breast cancer for South Asian (that is, Indian, Pakistani, Bangladeshi, and Sri Lankan) and Chinese women with stage for women in the remaining general population. They found that South Asian women were more likely than women in the remaining general population to be diagnosed with later-stage breast cancer. Conversely, Chinese women were less likely than women in the remaining general population to be diagnosed with later-stage disease. Compared with the remaining general population, both ethnocultural groups made more primary care visits, and yet fewer South Asian women had a recent history of breast cancer screening. Both ethnocultural groups were also less likely than the remaining general population to be in the highest income quintile. In sensitivity analyses, diabetes (more common among South Asian populations) did not act as an effect modifier. Taken together, the findings suggest that the authors have identified a health inequity among South Asian women that clinicians, researchers, and policymakers in Ontario must address.

The findings are especially important in the Canadian context for several reasons. First, South Asians constitute the largest visible minority group in both Canada and Ontario (people of Chinese ethnicity constitute the second largest)[4]. In 2013, 20% of immigrant permanent residents in Canada came from a South Asian country[5]. Although the study results would represent a call to action regardless of the size of the group affected, the prevalence of South Asian people in Canada makes the matter particularly compelling. Second, data about race or ethnicity are rarely collected in a systematic manner in Canadian health care settings[6]. That data deficiency certainly does not mean that ethno-racial inequalities do not exist in Canada; indeed, lack of data often limits the ability to accurately and adequately identify health inequalities and inequities. The article authors were able to circumvent that issue by using a method (a surname algorithm) that was both innovative and validated.

A substantial amount of research in Canada has documented and explored inequities in cancer screening for immigrants[7–13], but comparatively little Canadian literature has addressed the steps that should logically follow: cancer diagnosis and treatment for immigrants and the potential delays therein. Hopefully, Ginsburg and colleagues have opened a door through which many others will pass.

Research always begets further research, and this study is no exception, because the reasons behind the current findings must be actively pursued. Cancer researchers are beginning to explore the peri-diagnostic period for immigrant and Canadian-born patients to identify potential important differences, such as in patterns of health care use or the length of the diagnostic interval[14]. Qualitative studies conducted with patients and providers could be particularly beneficial in determining the roles that patient-level, physician-level, and system-level factors play in facilitating inequities. Such research will be particularly crucial in the context of the finding that, compared with patients in the remaining general population, South Asian women have more primary care contacts. Ginsburg *et al.*[3] found Chinese women to be at an advantage when it came to stage at breast cancer diagnosis, and determining whether previous health promotion efforts, cultural differences, or some other factors influenced that finding will be informative. Finally, differences in stage at diagnosis have to be explored for other common cancers in which stage is a predictor for recurrence and survival, and for other immigrant and ethno-racial groups.

The authors have described a health inequality in stage at breast cancer diagnosis for South Asian women in Ontario—an inequality that certainly has the potential to be unnecessary and avoidable, unfair and unjust. Now it falls to the oncology community—that is, to clinicians, researchers, and policymakers—to act.

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CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology*'s policy on disclosing conflicts of interest and I declare that I have none.

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