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Addressing the Impact of Lung Cancer in Canada: A Focus on Cancer Control Strategies

Leo Lin*

Department of Medical Oncology, Sun Yat Sen University, Guangdong, China

Corresponding author: Leo Lin, Department of Medical Oncology, Sun Yat Sen University, Guangdong, China, E-mail: lelio8451@hotmail.com

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Description

Lung cancer is the most prevalent cancer in Canada, with one in every fifteen Canadians being afflicted with it during their lifespan. Lung cancer is typically discovered at an advanced state (stage III or stage IV), when the chances of cure is less. Lung cancer accounts for one-quarter of all cancer-related fatalities in Canada. Lung cancer incidence and mortality rates closely track trends in the smoking epidemic, such that a rise or fall in smoking consumption rates precedes the following rise or fall in lung cancer incidence and mortality by about 20 years. As a result, smoking reduction initiatives, as well as novel techniques for detecting early stage lung cancer, have been designated as a national priority in the Canadian Strategy for Cancer Control, 2019-2029.

Lung Cancer Screening (LCS) will be available in Ontario through an organized public health program named the Ontario Lung Screening Program beginning in April 2021. Currently, screening is available at four locations across the province: The Ottawa Hospital, Health Sciences North in Sudbury, Lake ridge Health in Oshawa, and the University Health Network in Toronto. The program's goal is to identify asymptomatic lung tumours that are possibly curable, decreasing lung cancer-related death.

As with any cancer screening, it is critical to evaluate disease distribution in the community so that individuals who are most at risk of developing lung cancer are particularly targeted for the LCS intervention. Individuals between the ages of 55 and 74 who have smoked daily for the past 20 years are presently qualified for referral. The present inclusion requirements make the implicit presumption that age-eligible people who have smoked or are currently smoking will be able to access the screening program and be prepared to engage in lung cancer screening. Individuals with lower levels of education, lower income, and lower occupational class are more likely to smoke and less likely to be successful at smoking cessation. Furthermore, there are well-documented and substantial disparities in cancer screening availability across groups based on gender, race, ableism, socioeconomic status, and rural location.

To avoid further widening of health disparities as a consequence of unequal uptake of lung cancer screening measures, it is critical to reallocate resources to satisfy the needs and goals of the most inequitable groups. This strategy, known as a "priority population" approach, is "regardful" of systemic disparities that influence disease risk and access to treatment and "responsive" to patient requirements.

Clinical encounters that are equity-oriented, trauma and violence-informed, can favorably impact people's choice to engage in LCS. On the other hand, stigmatizing acare lacks self-reflexivity and promotes personal and institutional prejudices, creating dangerous places that deter involvement in LCS. Community and peer support workers, health promoters, and occupational therapists are strategically placed to provide wrap-around support services that allow physicians to make timely referrals.

A crucial type of practice-focused knowledge mobilization is the use of learning tools to support initial and on-going professional growth. Interventions that use a combination of e-learning components and organizational methods to increase equity at the point of care, for example, have been shown to boost care workers' trust and skills to provide Equity-Oriented Health Care (EOHC) in primary care environments. An approach to EOHC used in the "EQUIP" health equity study program contains three important dimensions, which are outlined below: Trauma and Violence-Informed Care (TVIC), cultural safety, and harm reduction through substance use health-emphasizing knowledge about trauma, understanding of the context of people's lives, and explicit attempts to build trust-both at the point of care and at the level of organizational practices.

It is recognized that the learning modules alone will have little impact on the structural barriers to treatment that patients do not face as a consequence of societal inequities, nor will learning modules alone question the fundamental economic systems that shape smoking behavior and lung cancer risk. Learning modules, on the other hand, can promote equity-oriented care at the point of care, resulting in a safer clinical encounter, assist PCPs in contributing to systemic changes in how LCS is organized and provided, and promote advocating for equity-oriented policies across sectors.

These, in turn, can have an impact on the decision to engage in LCS. The work on equity-oriented cancer care will lay the groundwork for the formation of a joint and multidisciplinary network of partners developing organizational processes to support equitable access to cancer care and pushing for system-level policy change.