Health Disparities in Cancer Facts

FROM THE DIVISION OF CANCER PREVENTION AND CONTROL 2008 / 2009

Racial and ethnic minorities suffer disproportionately from cancer compared to the entire United States population. Enhanced effort is required to eliminate racial and ethnic disparities in cancer prevention, early detection, and delivery of care.

The Centers for Disease Control and Prevention (CDC) works through its national programs and many partnerships with state health departments, academic institutions, and other public and private organizations and with the Office of Health Equity to promote cancer education, prevention, treatment, and screening among all populations.

Health Disparities in Cancer

Health disparities are differences in the incidence, prevalence, and mortality of a disease and the related adverse health conditions that exist among specific population groups. These groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location, or sexual orientation.[1]

According to CDC's Office of Minority Health and Health Disparities, life expectancy and overall health have improved in recent years for most Americans. Despite this, not all Americans are benefiting equally. CDC monitors trends and patterns in cancer incidence and mortality and identifies which populations are disproportionately affected by the disease.

United States Cancer Statistics: 2004 Incidence and Mortality[2] reports the following trends by race/ethnicity for all cancers combined (rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population).

For men, for all cancers combined:

- Incidence rates are highest among black (607.3), followed by white (527.2), Hispanic* (415.5), Asian/Pacific Islander (325.8), and American Indian/Alaska Native (288.6) men.
- Death rates are highest among black (303.5), followed by white (224.8), Hispanic* (152.8), American Indian/Alaska Native (151.2), and Asian/Pacific Islander (137.0) men.

For women, for all cancers combined:

- Incidence rates are highest among white (405.9), followed by black (379.7), Hispanic* (318.6), Asian/Pacific Islander (267.4), and American Indian/Alaska Native (242.2) women.
- Death rates are highest among black (182.8), followed by white (156.4), American Indian/Alaska Native (110.7), Hispanic* (101.9), and Asian/Pacific Islander (92.3) women.

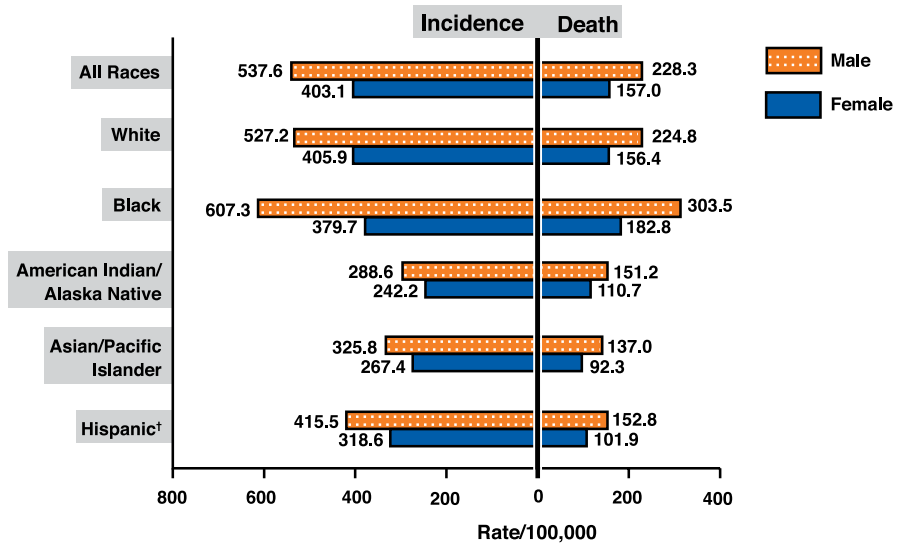
* *Hispanics may be of any race.*

In addition to differences between racial and ethnic groups, important disparities also exist within these groups by geography, national origin, economic status, and other factors. For example, the *Annual Report to the Nation on the Status of Cancer, 1975–2004, Featuring Cancer in American Indians and Alaska Natives*[3] reports the following trends:

- Overall, cancer incidence rates for American Indian/Alaska Native persons were lower than for whites, but they were higher for cancers of the stomach, liver, cervix, kidney, and gallbladder.

- Cancer incidence rates among American Indian/Alaska Native persons vary a great deal from one region to another, and are highest in Alaska and the Northern and Southern Plains, and lowest in the Southwest.
- For cancers of the breast and cervix, American Indian/Alaska Native women are less likely than white women to have their cancer found early.

Cancer Incidence and Death Rates* for All Cancer Sites Combined, by Race/Ethnicity and Sex, United States, 2004



*Rates are age-adjusted to the 2000 U.S. standard population (19 age groups - Census P25-1130). Incidence rates cover 98% of the U.S. population. Death rates cover 100% of the U.S. population.
†Hispanic is not mutually exclusive from white, black, Asian/Pacific Islander, and American Indian/Alaska Native.
Source: *United States Cancer Statistics: 2004 Incidence and Mortality.*

Factors That Contribute to Health Disparities in Cancer

Socioeconomic Status *(e.g., education, income, and employment)*
Research reveals a link between poverty and low educational achievement with increased cancer deaths among minority populations.[4]

Access to and Utilization of Health Care Services *(cancer screening)*
Research documents inequalities in the use of preventive and primary care services. Additionally, minorities are far less likely than whites to have insurance and are more likely to be uninsured or underinsured.[4]

Behaviors *(e.g., physical activity, diet, and tobacco use)*
Physical inactivity and unhealthy eating contribute to a number of chronic diseases, including some cancers.[5] Tobacco use is a well established risk factor for cancer of the lung and a number of other sites.[6] The prevalence of cigarette smoking is higher among some racial and ethnic minorities than whites.[7]

Social Environment *(e.g., educational and economic opportunities, racial/ethnic discrimination, and neighborhood and work conditions)*[4]
Some communities lack the basic resources that everyone needs for a healthy life. These include healthy food, safe housing, living-wage jobs, decent schools, supportive social networks, and access to health care. Social environments lacking basic resources present the highest public health risk for serious illness and premature death.

Exposure to Carcinogens *(substances that are known or appear likely to cause cancer)*[8]
A person's physical environment, workplace, socioeconomic status, and other factors can affect the likelihood of being exposed to these substances.

Treatment
Because minorities often do not receive timely treatment or receive treatment for later-stage disease,[9] their survival rates are lower than those of whites.[10]

Reducing Health Disparities in Cancer

CDC and other public health agencies, health care providers, and communities of all racial and ethnic groups must become partners in a national effort to:

- Improve early detection of cancer through routine mammography, Pap tests, and colorectal cancer screening.
- Implement evidence-based community interventions to increase screening and modify risk behaviors.
- Develop research projects that will encourage minority groups to participate in clinical trials for cancer prevention to ensure that significant differences between minority and ethnic groups are identified.
- Undertake research that will inform decisions about interventions to reduce cancer disparities and improve health. Currently, there is a shortage of data on interventions that are available to people regardless of socioeconomic status or behavior and that address the social environment.
- Use a variety of media and channels to "market" cancer information to diverse populations in a variety of settings.

Access to quality cancer care and clinical trials needs to be expanded to ensure that minority groups are provided the same care and access to state-of-the-art technology that patients in major care centers receive.

Fear of cancer, perceived cost of care, and lack of physician referral are common barriers to cancer screening and other preventive services. Health care providers play a critical role in recommending and increasing use of preventive services. Research shows that physician recommendation is a major correlate of receipt of screening.

Ongoing Work

CDC provides funding and technical assistance to help states, tribes/tribal organizations, and territories collect data on cancer incidence and death, cancer risk factors, and the use of cancer screening tests. Public health professionals use the data to identify and track cancer trends, strengthen cancer prevention and control activities, and prioritize the use of resources.

CDC's National Program of Cancer Registries (NPCR). By documenting new cancer cases within each state, the NPCR identifies minority groups that experience health disparities in cancer and aids in state cancer planning.

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The NBCCEDP provides breast and cervical cancer screening, diagnosis, and treatment to low-income, medically underserved, and uninsured women (emphasizing recruitment of minority women) through states, tribes, and territories.

CDC's National Comprehensive Cancer Control Program (NCCCP). The NCCCP provides seed money, structure, and support for developing and implementing Comprehensive Cancer Control (CCC) plans in all 50 states, and in several tribes and U.S. Associated Pacific Islands and territories. CCC is a collaborative process through which a community pools resources to reduce the burden of cancer that results in risk reduction, early detection, better treatment, and enhanced survivorship.

CDC's Colorectal Cancer Screening Demonstration Program. The program, underway in five pilot areas around the nation, is aimed at increasing colorectal cancer screening among low-income adults aged 50 and over who have little or no health insurance coverage for regular screenings.

CDC's Racial and Ethnic Approaches to Community Health 2010 (REACH 2010). This program is a cornerstone of CDC's efforts to eliminate racial and ethnic disparities in health. Launched in 1999, REACH 2010 is designed to eliminate disparities in six priority areas in which racial and ethnic minorities experience serious disparities in health access and outcomes.

Cancer Prevention and Control Research Network (CPCRN). The CPCRN was established under the CDC-funded Prevention Research Center program to support academic and community partnerships for cancer prevention and control intervention and dissemination research. Its mission is to accelerate the adoption of evidence-based cancer prevention and control in communities through advancing the *science* of cancer prevention and control and influencing public health and primary care *practice*. In particular, it is engaged in enhancing large-scale efforts to reach underserved populations and reduce their burden of cancer.

Future Directions

CDC plans to conduct research and surveillance activities that will develop and evaluate comprehensive approaches to cancer prevention and control. Results will guide interventions designed to address health disparities in cancer among racial and ethnic groups.

References

1. National Cancer Institute. *Health Disparities Defined*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. Available at http://crchd.cancer.gov/definitions/defined.html.
2. U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 2004 Incidence and Mortality.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; Washington, DC: National Cancer Institute; 2007.
3. Espey DK, Wu X, Swan J, Wiggins C, Jim M, Ward E, Wingo PA, Howe HL, Ries LAG, Miller BA, Jemal A, Ahmed F, Cobb N, Kaur JS, Edwards BK. Annual report to the nation on the status of cancer, 1975–2004, featuring cancer in American Indians and Alaska natives. *Cancer* 2007;110(10):2119–2152.

4. Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health* 2003;93(2):200–208.

5. Centers for Disease Control and Prevention. *Physical Activity and Good Nutrition: Essential Elements to Prevent Chronic Diseases and Obesity: At A Glance 2008*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion; 2008. Available at www.cdc.gov/nccdphp/publications/aag/dnpa.htm.

6. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. *The Health Consequences of Smoking: A Report of the Surgeon General*. Available at www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/.

7. Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 2006. *MMWR* 2007;56(44):1157–1161.

8. National Toxicology Program. *11th Report on Carcinogens*. Research Triangle Park, NC: U.S. Department of Health and Human Services; 2004.

9. Shavers VL, Brown ML. Racial and ethnic disparities in the receipt of cancer treatment. *Journal of the National Cancer Institute* 2002;94(5):334–357.

10. Clegg LX, Li FP, Hankey BF, Chu K, Edwards BK. Cancer survival among US whites and minorities: A SEER (Surveillance, Epidemiology, and End Results) Program population-based study. *Archives of Internal Medicine* 2002;162(17):1985–1993.

Contact Information

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control

Mail Stop K–64
4770 Buford Highway, NE
Atlanta, GA 30341-3717

1 (800) CDC-INFO ▪ Fax (770) 488-4760
CDCINFO@cdc.gov ▪ www.cdc.gov/cancer