

The harsh truths of cancer health disparities

A troubling gap exists between cancer treatment and cancer outcomes based on race, ethnicity, socioeconomic status, sexual orientation, and other characteristics.¹ What have we most recently learned, and how can we imperatively close this gap?

Some shocking statistics¹

- African American men have a 111% higher risk of dying from prostate cancer than white men.
- African American women are 39% more likely to die from breast cancer compared to white women.
- Asian/Pacific Islander adults are twice as likely to die of stomach cancer than white adults.
- Native American and native Alaskan individuals are twice as likely to develop liver and bile duct cancer than white individuals.
- Men living in Kentucky are 3.5x more likely to have and die from lung cancer than men living in Utah.
- The survival rate for uninsured people with liver cancer is less than half as long as it is for those with insurance.
- Men with colorectal cancer in the poorest U.S. counties have a 35% higher death rate than men in the most affluent counties.
- Bisexual women are 70% more likely to be diagnosed with cancer than heterosexual women.

Much room for needed progress

While certain statistics may reflect progress—e.g., the cancer death rate for African American individuals was 33% higher than for white individuals in 1990 but 16% higher in 2016—a huge discrepancy persists. The contributing factors to cancer are complex, such as genetics, a lack of medical research across diverse study subjects, and differences in access to care.¹



Prevention may be possible

More than 4 in 10 cancers and cancer deaths are linked to modifiable risk factors, such as smoking, excess body weight, physical inactivity, dietary deficiencies, alcohol consumption, and sun exposure.²

However, certain segments of the U.S. population are less likely to modify these kinds of behaviors. For example, the incidence of lung cancer from tobacco use is 40% higher in the South than it is in the West, and the prevalence of physical inactivity in Hispanic individuals is 32% compared to 23% in non-Hispanic white people.

Additionally, regular cancer screenings can help detect breast, cervical, colorectal, and prostate cancer, as well as certain strains of cancer-related human papillomavirus (HPV). Yet, people with long travel distances to screening sites, low incomes, or low health literacy are less likely to undergo recommended cancer screening tests than those not facing these obstacles. Those without health insurance, transportation to a medical facility, or paid medical leave are also less likely than their counterparts to get screened.³

To address these cancer risk factors, new strategies in public education and evidence-based intervention must be implemented to reduce the incidence of cancer across all populations.¹

The impact of socioeconomic status

Socioeconomic status, high-poverty neighborhoods, and low educational levels are all linked to higher death rates from certain types of cancers. Those living in disadvantaged neighborhoods are more likely to be diagnosed with late-stage cancer and face poorer survival rates compared to those in more advantaged neighborhoods. If socioeconomic disparities were eliminated, 34% of deaths from cancer could be prevented.¹

The social imprecision of precision medicine

Precision medicine uses individuals' personal and cancer profiles—which include biological, environmental, and lifestyle factors—to predict optimal cancer prevention and treatment strategies. A social barrier to using these profiles, however, is that they don't usually consider the genetic differences of racial and ethnic minorities. Without data on cancer-associated mutations from all types of people, the breakthrough treatments may not be as effective for minorities.¹

The economics of health disparities

To reduce cancer health disparities, federal agencies must substantially increase funding in related programs, which would generate notable fiscal savings over time. It's projected that eliminating all

health disparities for racial and ethnic minorities would have reduced direct medical costs by about \$230 billion and indirect costs associated with illness and premature death by more than \$1 trillion from 2003 to 2006.¹

A national priority

By nationally prioritizing cancer health disparities research, Congress can help transform cancer care for people of all races, ethnicities, genders, sexual orientations, and socioeconomic statuses. With collaboration from all stakeholders, closing the gap across the country for the social justice of health equity is possible.

AccessHope is working to reduce cancer health disparities in underserved populations by offering leading cancer expertise and support to employees nationwide, regardless of their job level and ZIP code.



References

¹ American Association for Cancer Research. AACR Cancer Disparities Progress Report 2020. https://cancerprogressreport.aacr.org/wp-content/uploads/sites/2/2020/09/AACR_CDPR_2020.pdf. Published 2020. Accessed October 6, 2020.

² Mendes E. More than 4 in 10 cancers and cancer deaths linked to modifiable risk factors. American Cancer Society News. November 21, 2017. <https://www.cancer.org/latest-news/more-than-4-in-10-cancers-and-cancer-deaths-linked-to-modifiable-risk-factors.html>. Accessed February 22, 2021.

³ Cancer disparities. National Cancer Institute Web site. <https://www.cancer.gov/about-cancer/understanding/disparities>. Updated November 17, 2020. Accessed February 22, 2021.

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