CANCER DISPARITIES
A CHARTBOOK

Cancer Action Network℠

American Cancer Society®

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CANCER DISPARITIES
A CHARTBOOK

INTRODUCTION

This Chartbook provides an overview of cancer disparities. It includes information on cancer incidence and deaths by age and type of cancer, including differences by race/ethnicity and use of recommended cancer screening services. Information on how the American Cancer Society Cancer Action Network (ACS CAN) is addressing disparities through our legislative work.

HIGHLIGHTS

Despite notable advances in cancer prevention, screening, and treatment, a disproportionate number of the uninsured, minorities, and other medically underserved populations are still not benefiting from such important progress. Eliminating disparities in cancer screening, diagnosis, treatment, and mortality is an essential step toward improved health outcomes for all Americans with cancer.

Underlying causes of cancer disparities are interrelated and complex. Causes of cancer disparities can be linked to social, behavioral, and economic factors such as persistent inequalities in access to care, language barriers, unhealthy environments, and racial discrimination. The consequences of such fundamental causes of disparities are that diseases like cancer are more often diagnosed at later stages when the severity is likely to be greater and options for treatment, as well as the odds of survival, are decreased.

Eliminating disparities in cancer screening, diagnosis, treatment, and mortality is an essential step toward improved health outcomes for all Americans with cancer. We cannot hope to address the differences in the burden of cancer in these populations without creative public health interventions that seek to overcome the financial, cultural, geographic and educational barriers to care.

DISPARITIES IN CANCER PREVENTION AND SCREENING

Racial and ethnic minorities and persons of lower socioeconomic status are more likely to engage in high risk health behaviors and less likely to receive timely cancer screenings. Tobacco provides an excellent illustration of the disparities in cancer prevention.

Persons with private insurance, higher income and education are less likely to smoke (Slide 1-1). While tobacco use has declined significantly overall, these reductions in tobacco use and exposure have not benefited racial and ethnic minorities equally. Among high school students, while whites are more likely to smoke, racial and ethnic minorities have seen a smaller absolute decline in smoking rates (Slide 1-2). Recent research finds that while exposure to second hand smoke has decreased, the relative decline was nearly twice as large for non-Hispanic whites compared with non-Hispanic blacks (Slide 1-3).

Provider behavior contributes to disparities by creating differences in the physician-patient encounter. Black and Hispanics are less likely than whites to be screened for tobacco use during a medical visit. As a result, they are also less likely to be counseled to quit smoking or use tobacco cessation treatments during an attempt to quit smoking (Slide 1-4). The affordability of health care also contributes to disparities in access to cancer screenings. Persons of low socioeconomic status and racial and ethnic minorities are less likely to receive timely cancer screenings. Insurance plays a key role. Persons with private insurance are much more likely to receive timely cancer screenings than uninsured persons (Slide 1-5). However, income can also play a role. Persons of lower income are less likely to receive timely cancer screenings (Slide 1-6). This may be due in part by the financial costs associated with cancer screenings. Research has shown that even small co-pays can deter lower income women from receiving a mammogram.

Similar to trends in smoking, while some cancer screening rates have improved overall, racial and ethnic disparities have persisted and in some cases, increased. Since the late 1990s, colonoscopy screening rates have dramatically increased. However, overall racial disparities have also increased since that time. In 1998, the difference in screening rates among racial and ethnic groups was 12 percentage points, this increased to 21 percentage points in 2005 (Slide 1-7).

Barriers to preventive care for racial and ethnic minorities and lower socioeconomic groups can include structural and cultural barriers. From a structural standpoint, financial costs, lack of transportation, low health literacy, and lack of a provider referral are all barriers frequently encountered by minority and low income populations as they seek cancer screenings. For example, even minimal copays can deter women from receiving timely mammograms. Further, such copays are more likely to deter lower educated women than higher educated women (Slide 1-8).

From a cultural standpoint, lack of language services, beliefs about disease and screenings, lack of knowledge about screenings, trust of the medical institution and poor physician-patient communication can delay or cause individuals to forego cancer screenings. Spanish speaking women who had access to prevention care management services that spoke spanish were 2 times more likely to be up to date with all their cancer screenings than women who did not have access to these language services (Slide 1-9). Culture can affect how one processes information. Racial and ethnic minorities are also more likely to hold false beliefs about cancer prevention which may deter them from obtaining timely screenings. For example, African Americans are 2 times more likely than whites to believe that mammograms can cause breast cancer. Hispanics are more likely to believe that quitting smoking will not reduce a smoker's cancer risk (Slide 1-10).

DISPARITIES IN CANCER INCIDENCE AND MORTALITY
Racial and ethnic minorities, persons of lower socioeconomic status, and the uninsured are more likely to be diagnosed with some cancers often at later stages when the severity is likely to be greater and the odds of survival are decreased.

Access to adequate healthcare coverage can make a difference in the fight against cancer. Uninsured persons and persons enrolled in Medicaid are more likely to be diagnosed with later stage cancer and less likely to survive. Recent research from the Society finds that uninsured persons or those enrolled in Medicaid are more than two times more likely to be diagnosed with late stage breast cancer than privately insured persons (Slide 2-1).   Regardless of stage of diagnosis, uninsured and Medicaid persons are less likely to survive cancer. Among colorectal cancer patients, persons diagnosed with stage I cancer that are uninsured or on Medicaid have worse survival rates than stage II privately insured persons (Slide 2-2).

While this research suggests that Medicaid enrollees fare poorly in comparison to the privately insured, this doesn't necessarily mean that Medicaid is an ineffective program. In some cases, people who are classified as having Medicaid insurance are actually uninsured at the time of their cancer diagnosis and are retroactively enrolled in the program. Medicaid enrollees may be more likely than other populations to face barriers to care, such as inadequate transportation or difficulty in finding physicians that accept Medicaid. High rates of co-morbidities may also contribute to poor results among Medicaid cancer patients, by complicating treatment options and decreasing adherence to screening and treatment. Medicaid policies regarding eligibility and enrollment vary considerably among states, and are often complex leading to delays in treatment, interruptions in care, and worse outcomes.

Race and ethnicity status also plays an important role in the risk of being diagnosed with and surviving cancer. Some racial and ethnic minorities have a higher risk of being diagnosed with cancer, particularly at later stages, and are less likely to survive (Slides 2-3, 2-4). Certain cancers show particularly large disparities. African American men are 50 percent more likely than whites to be diagnosed with prostate cancer and 200 percent more likely to die of prostate cancer (Slides 2-5, 2-6). However, the racial/ethnic disparity pattern is not consistent across all cancers. White women are more likely to be diagnosed with breast cancer, though Black women are more likely to die of breast cancer (Slides 2-7, 2-8).

In part, racial/ethnic disparities in some cancer death rates can be explained by the higher rate of late stage diagnosis among racial and ethnic minorities. Regardless of insurance status, racial and ethnic minorities are more likely to be diagnosed with late stage cancers that can be detected early by screening or evaluation of symptoms, including late stage breast cancer (Slide 2-9).

The degree of cancer disparities varies dramatically across geographic areas. For example, the difference in black-white breast cancer death rates is much larger in Chicago than in New York City or nationally (Slide 2-10). Many of these geographic variations in disparities are due to differences population composition, community characteristics that facilitate or hinder healthy behaviors, as well as differences in the healthcare infrastructure.

Progress in fighting cancer has not been evenly distributed throughout the population. While in the early 1980s, there was little difference in black-white breast or colorectal cancer death rates, these differences have since grown considerably (Slide 2-11). The increase in cancer disparities can be traced to differences in access to care, such as cancer screening rates as well as differences in receipt of appropriate cancer treatment (see Section 3).

DISPARITIES IN TREATMENT AND PALLIATIVE CARE

Racial and ethnic minorities, persons of lower socioeconomic status, and the uninsured are less likely to receive recommended treatment and appropriate palliative care. Compared to whites, African Americans are 50% less likely to receive appropriate treatment for breast cancer. American Indians are 70% less likely (Slide 3-1). This includes a lower likelihood of adjuvant chemotherapy and breast conserving surgery.

However, these racial and ethnic disparities may be ameliorated by access to care. One study found that there are no disparities in the receipt of recommended cancer treatment among privately insured, but that Hispanics fare less well on Medicare and Blacks fare less well on Medicaid (Slide 3-2).

Like disparities in prevention and mortality, disparities in treatment can grow over time. As new treatment technology becomes more widely practiced, disparities may grow. One study found that disparities in the receipt of sentinel node lymph biopsy by insurance status have grown as the technology has become more popular (Slide 3-3). This can be explained in part by inequities in place of treatment. Uninsured persons and those enrolled in Medicaid are less likely to receive their treatment in centers practicing state of art technology.

Racial differences in patient beliefs and choices may explain part of the disparities in treatments. African Americans are less likely than whites to choose curative therapy for lung cancer. Consequently, they are less likely to survive 5 years following their lung cancer diagnosis (Slide 3-4). However, the beliefs underlying these choices are complex. African Americans are more likely to believe that surgery will cause the tumor to spread, be opposed to surgery in general, and less likely to trust the doctor's recommendations (Slide 3-5).

Problems in communication and coordination of care may also explain some of the disparities in treatment. Racial and ethnic minorities and non-English speakers are less likely to feel that they received excellent or very good cancer care. Regression analyses found that a lack of coordination of care was the largest explanation for these differences (Slide 3-6).

Finally, when it comes to end of life, Blacks are less likely to use hospice care, regardless of cancer type (Slide 3-7). In part, the lower hospice rate may be due to a lack of trust in physician opinions and an emphasis on treatment up until the last possible moment.

STRATEGIES FOR CLOSING THE GAP

The American Cancer Society Cancer Action Network (ACS CAN) along with its partner charitable organization, the American Cancer Society, is dedicated to reducing cancer incidence and mortality rates among minority and medically underserved populations. This goal can be achieved by instituting cost-effective, evidence-based public health programs that promote overall wellness and save lives.

The ACS CAN and the Society strive to help create, change, and influence public policies that significantly reduce such disparities and promote outreach to diverse communities. These efforts described in this chapter represent our continued commitment to address the disparate impact of cancer on minority and other medically underserved populations.

Access to health care can play an important role in reducing disparities. To that end, ACS CAN advocates for all Americans to have available, affordable, adequate, and administratively simple health insurance. Currently, 46 million Americans do not have access to health insurance. However, due to differences in state policies, some states have a greater proportion of their population that is uninsured (Slide 4-1). Many people believe that Medicaid covers all Americans living in poverty, however that is not the case. Low income adults are more likely than any other group to be uninsured. Some health care reform policies have suggested increasing the enrollment of adults living in poverty into Medicaid (Slide 4-2).

ACS CAN is specifically working to expand access to cancer screenings and treatment for the low-income, uninsured. A central effort towards this expansion is the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This Centers for Disease Control and Prevention (CDC) program provides community-based breast and cervical cancer screening and diagnosis to low-income, uninsured women. Currently, funding levels only allow less than one in five eligible women to be screened (Slide 4-3). Apart from increasing federal funding, more eligible women can be served by the program if states also increase their contributions to the NBCCEDP (Slide 4-4).

Additionally, ACS CAN is working to pass the Colorectal Cancer Early Detection, Prevention, and Treatment Act. Pending in Congress, this legislation would create a CDC program for colorectal cancer screenings and treatment. The program would focus on low-income, uninsured men and women, as well as those most at risk, such as African Americans, who are more likely to die from colorectal cancer than any other racial or ethnic group. A similar program in New York City eliminated racial disparities in colorectal cancer screening (Slide 4-5).

Patient navigators can play an important role in reducing cancer disparities. Among patients in an urban, low-income clinic, the use of patient navigators dramatically increased patient compliance with colorectal cancer screening and follow-up to abnormal mammograms (Slide 4-6). ACS CAN is working to increase funding for the Patient Navigator Outreach, and Chronic Disease Program.

Medicaid enrollees are much more likely to smoke than the general US population. Yet, access to tobacco cessation services varies significantly by state (Slide 4-7). Although Medicaid coverage of smoking cessation services is one of the most cost-effective disease prevention strategies, many states are reducing or eliminating such coverage. The Society is working in partnership with ACS CAN to maintain, if not expand, these programs.

LIST OF CHARTS

DISPARITIES IN CANCER PREVENTION AND SCREENING

1. Socioeconomic status has a large effect on cancer preventive behaviors.
2. Improvements in cancer causing behaviors are not equally shared.
3. Unequal progress can also increase disparities
4. Racial and ethnic minorities are less likely to be advised to quit smoking.
5. Uninsured persons are less likely than privately insured persons to receive timely cancer screenings.
6. Higher income adults are the most likely to receive timely cancer screenings.
7. More people are getting colorectal cancer screenings, but the disparities between racial and ethnic groups have increased.
8. Small co-pays for mammography are more likely to deter lower educated women from receiving mammograms
9. Spanish speaking women with access to language appropriate preventive care are twice as likely to be up to date with all their cancer screenings.
10. Blacks and Hispanics are more likely than whites to believe false statements about cancer prevention.

DISPARITIES IN CANCER INCIDENCE AND MORTALITY

11. Uninsured and publicly insured women are two and half times more likely to be diagnosed with a later stage of breast cancer than privately insured women.
12. Uninsured and Medicaid patients with stage I colorectal cancer fare worse than privately insured patients with stage II colorectal cancer.
13. Blacks are more likely than other racial/ethnic groups to be diagnosed with cancer
14. Blacks are more likely than other racial/ethnic groups to die of cancer
15. Blacks are more than 50% more likely than whites to be diagnosed with prostate cancer
16. Black men are twice as likely as white men to die of prostate cancer
17. Incidence rates of breast cancer are highest in white women
18. Death rates from breast cancer are highest in black women
19. Minority women are almost twice as likely to be diagnosed with a later stage breast cancer than white women, regardless of insurance status
20. Black to white cancer mortality disparities vary greatly by region
21. Despite progress in fighting cancer, racial disparities continue to grow

DISPARITIES IN TREATMENT AND PALLIATIVE CARE

22. Racial and ethnic minorities are less likely to receive appropriate treatment for breast cancer
23. Privately insured patients are equally likely to receive recommended cancer treatment, regardless of race.
24. As new technology is introduced, cancer disparities in treatment may grow.
25. Blacks are less likely to receive curative surgery for lung cancer, and consequently are less likely to survive.
26. Inequities in cancer treatment may be linked to cultural beliefs.
27. Racial/ethnic minorities and non-English speakers are less likely to rate their cancer care as excellent or very good.
28. Blacks are less likely than whites to use hospice services prior to their deaths from cancer.

STRATEGIES FOR CLOSING THE GAP

29. Ensure that affordable, available, adequate, and administratively simple health insurance is available for all.
30. Fully fund the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
31. Provide state appropriations for Breast and Cervical Cancer Screening Programs.
32. Pass the Colorectal Cancer Early Detection and Treatment Act
33. Fund the Patient Navigator Outreach and Chronic Disease Prevention Act.
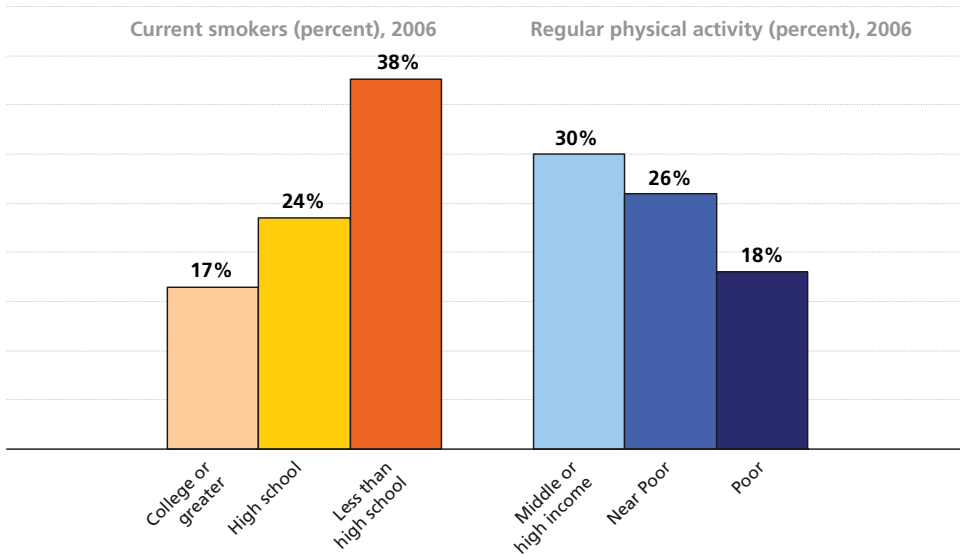34. Increase Medicaid coverage of tobacco cessation treatment.

Chart 1-1.

Socioeconomic status has a large effect on cancer preventive behaviors.

More educated, higher income persons are less likely to smoke and more likely to engage in physical activity.*

Current smokers (percent), 2006   Regular physical activity (percent), 2006

*Smoked cigarette(s) on one or more days of the 30 days preceding the survey.
Sources: National Health Interview Survey (NHIS),NCHS, CDC.

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Chart 1-2.

Improvements in cancer causing behaviors are not equally shared.

While white high school students are more likely to smoke, minority students have seen the smallest absolute decline in smoking.

Age-adjusted percent of current smokers
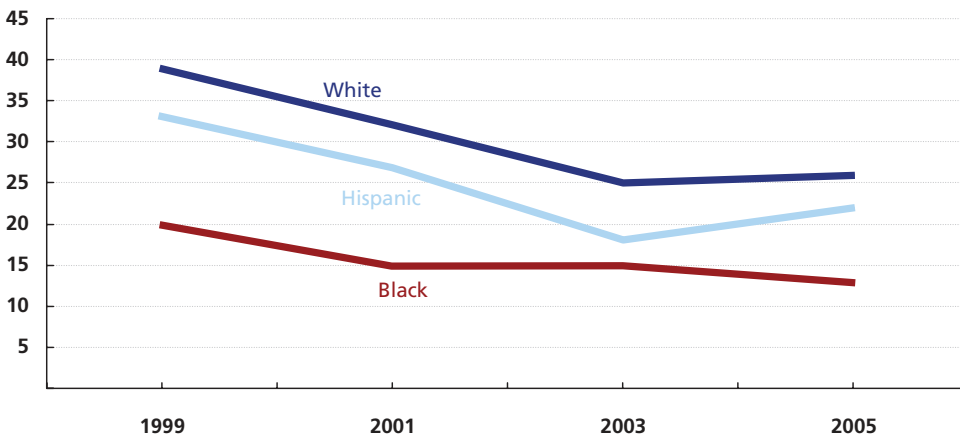
I 95% confidence interval
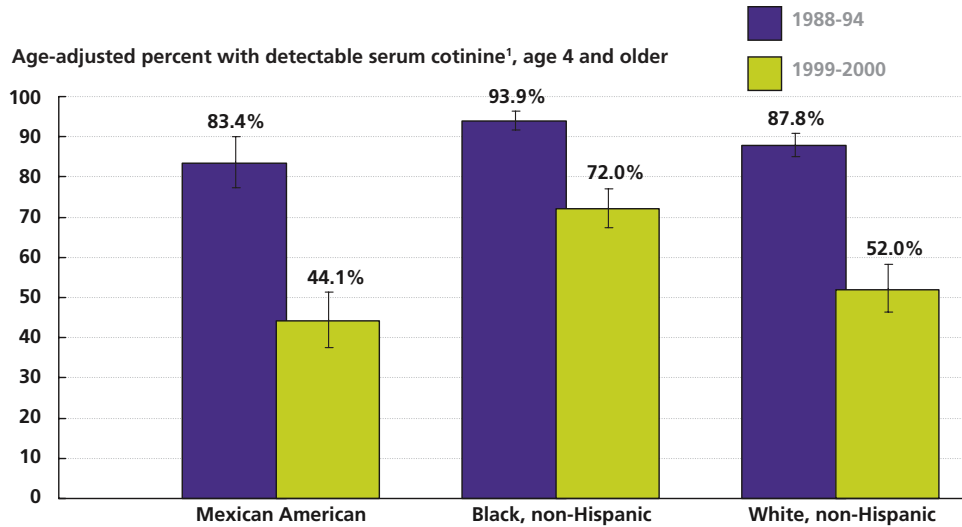*Smoked cigarette(s) on one or more days of the 30 days preceding the survey.
Note: Data for American Indians/ Alaska Natives, and Asians/Pacific Islanders are not reliable.
Sources: Youth Risk Behavior Surveillance System (YRBSS), NCCDPHP, CDC.

Chart 1-3.

At the same time that exposure to environmental tobacco smoke decreased, disparities have increased.

Age-adjusted percent with detectable serum cotinine[1], age 4 and older

Legend: 1988-94, 1999-2000

Mexican American: 83.4%, 44.1%
Black, non-Hispanic: 93.9%, 72.0%
White, non-Hispanic: 87.8%, 52.0%

I 95% confidence interval

[1] Serum continine levels can be used to estimate the exposure to nicotine over the past 2 to 3 days.
Nonsmokers defined by serum cotinine levels < 11 ng/mL.
Notes: Age-adjusted to the 2000 standard population.
Data for other Hispanics, American Indians,/Alaska Natives, Asians/Pacific Islanders are unreliable.
Source: National Health and Nutrition Examination Survey (NHANES), NCHS, CDC.

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Chart 1-4.

Racial and ethnic minorities are less likely to be advised to quit smoking.

Likelihood

Legend: Hispanic, Black, White

Screened for tobacco use: 0.69, 0.70, 1.00
Advised to quit smoking: 0.64, 0.72, 1.00
Used tobacco cessation treatments in the past year: 0.59, 0.60, 1.00
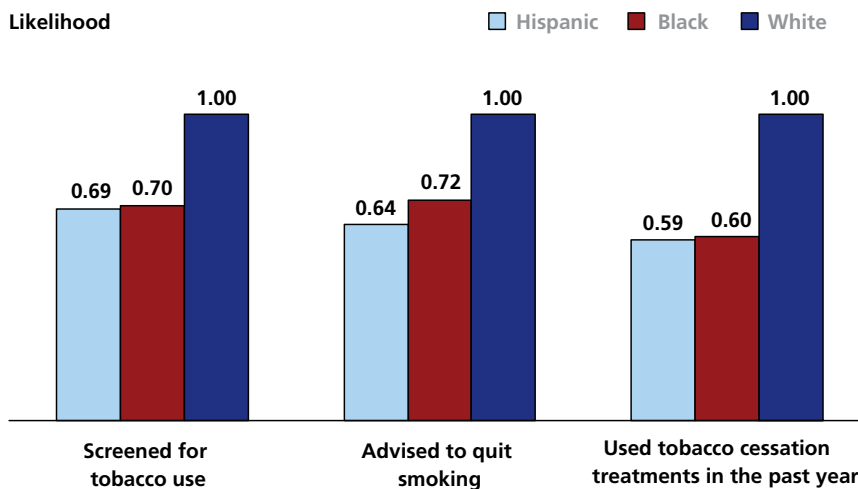
SOURCES: Cokkinides, Vilma et al. 2008. "Racial and Ethnic Disparities in Smoking Cessation Interventions: Analysis of the 2005 National Health Interview Survey." American Journal of Preventive Medicine. 34(5): 404-412.

Chart 1-5.

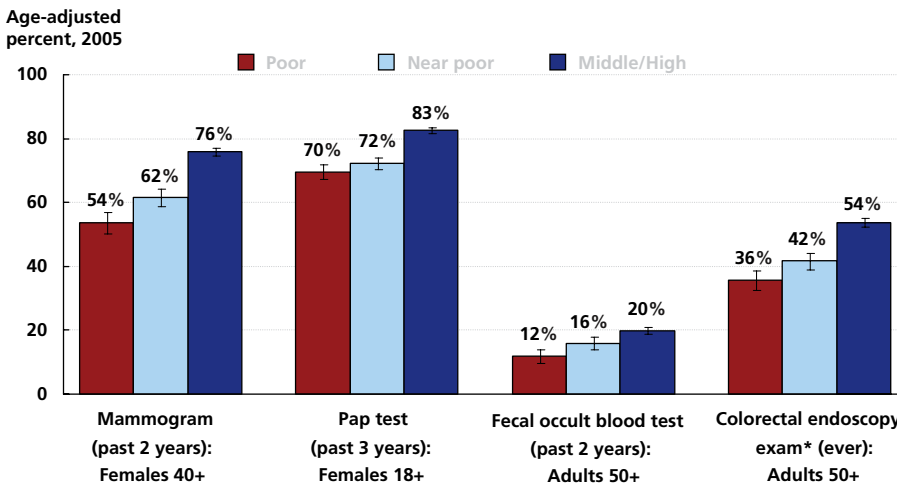Uninsured persons are less likely than privately insured persons to receive timely cancer screenings.

Percent

Legend: **Uninsured** | **Medicaid** | **Private**

Category	Uninsured	Medicaid	Private
Received recommended colorectal cancer screening in past 10 years, 2005 (Adults, 50-64)	19%	40%	48%
Pap Test in Past Three Years, 2005 (Women, 18-64)	68%	83%	88%
Mammogram in Past Two Years, 2005 (Women, 40-64)	38%	56%	75%
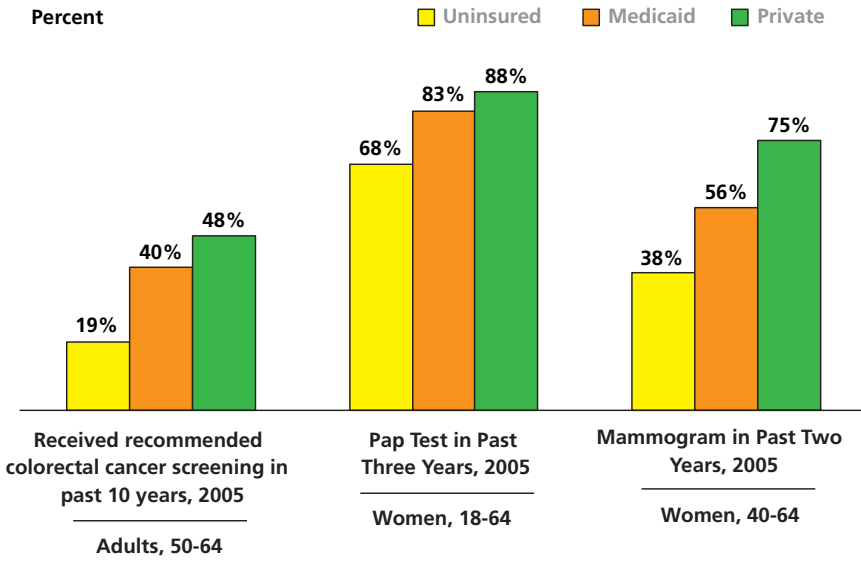
SOURCES: Ward, Elizabeth, et al. "Association of Insurance with Cancer Care Utilization and Outcomes." CA: A Cancer Journal for Clinicians 58.1 (2008): 9-31.

Chart 1-6.

Higher income adults are the most likely to receive timely cancer screenings.

Age-adjusted percent, 2005

Legend: **Poor** | **Near poor** | **Middle/High**

| Category	Poor	Near poor	Middle/High
Mammogram (past 2 years): Females 40+	54%	62%	76%
Pap test (past 3 years): Females 18+	70%	72%	83%
Fecal occult blood test (past 2 years): Adults 50+	12%	16%	20%
Colorectal endoscopy exam* (ever): Adults 50+	36%	42%	54%

*Includes sigmoidoscopy, colonoscopy, and proctoscopy Note: Data are age-adjusted to the 2000 standard population. Poor includes those below the Federal poverty level, Near poor includes those 100-199% of the Federal poverty level, and Middle/High income includes those 200% or more of the Federal poverty level.
SOURCE: National Health Interview Survey, CDC, NCHS.

Chart 1-7.

More people are getting colorectal cancer screenings, but the disparities between racial and ethnic groups has increased.
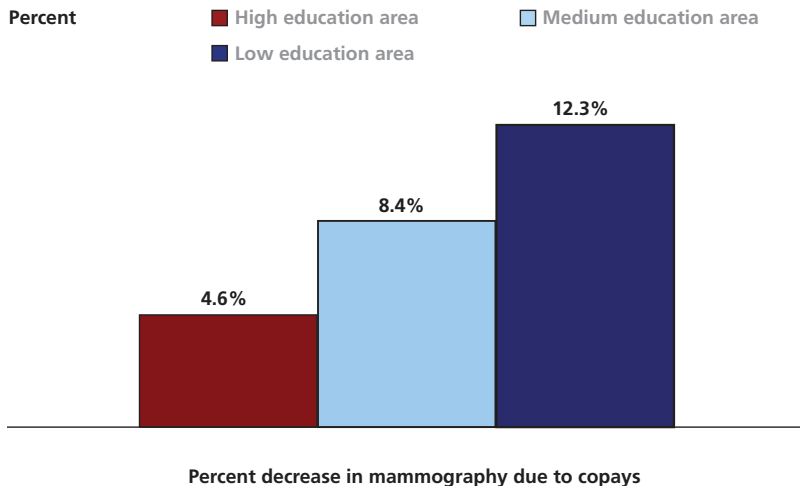
Percent
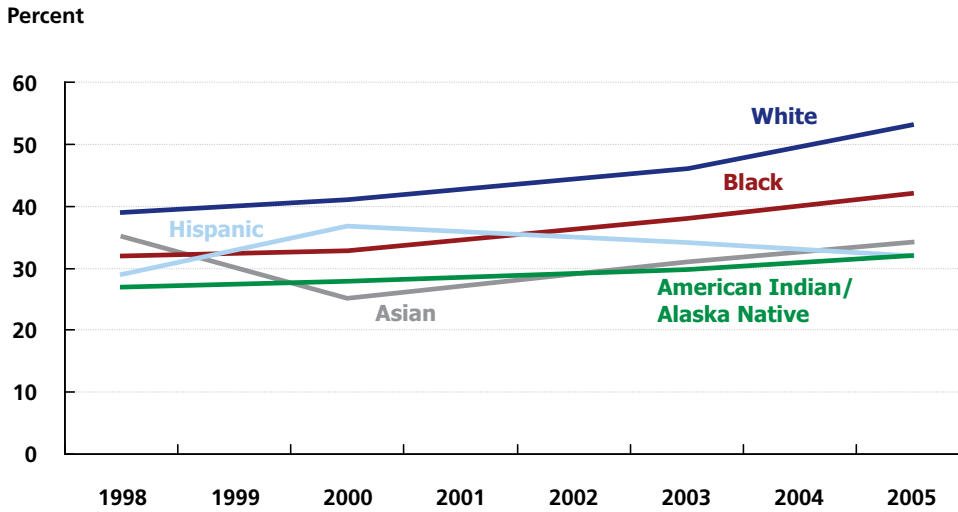
Note: The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Data for the single race categories shown are for persons who reported only one racial group. Data for Native Hawaiian and other Pacific Islanders, and 2 or more races are statistically unreliable.
SOURCE: National Health Interview Survey, NCHS, CDC.

Chart 1-8.

Even small copays[1] for mammography deter lower educated women from receiving mammograms.

Percent   ■ **High education area**   ☐ **Medium education area**
■ **Low education area**


Percent decrease in mammography due to copays

[1]$10-$20
SOURCES: Trevedi, Amal et al. 2008. "Effect of Cost-Sharing on Screening Mammography in Medicare Health Plans." NEJM. 358-375-383.
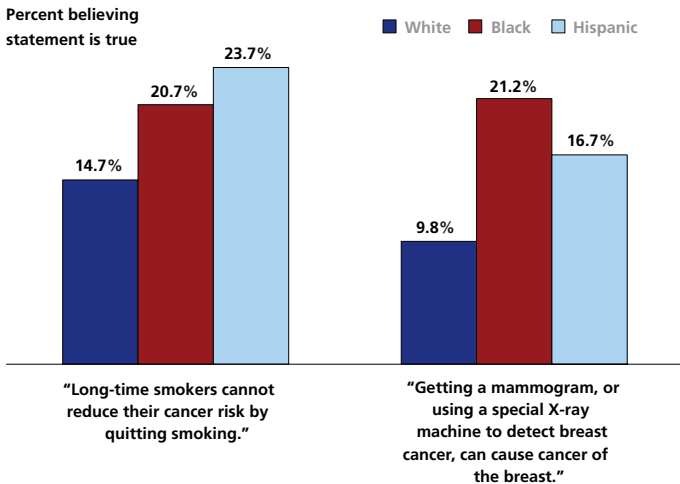
Chart 1-9.

Spanish speaking women with access to language appropriate preventive care are twice as likely to be up to date with all their cancer screenings.

Likelihood of cancer screenings

☐ **Spanish-speaking**   ■ **English-speaking**

1.98
1.89
1.46
1.00

No access to language appropriate services

Access to language appropriate preventive care management
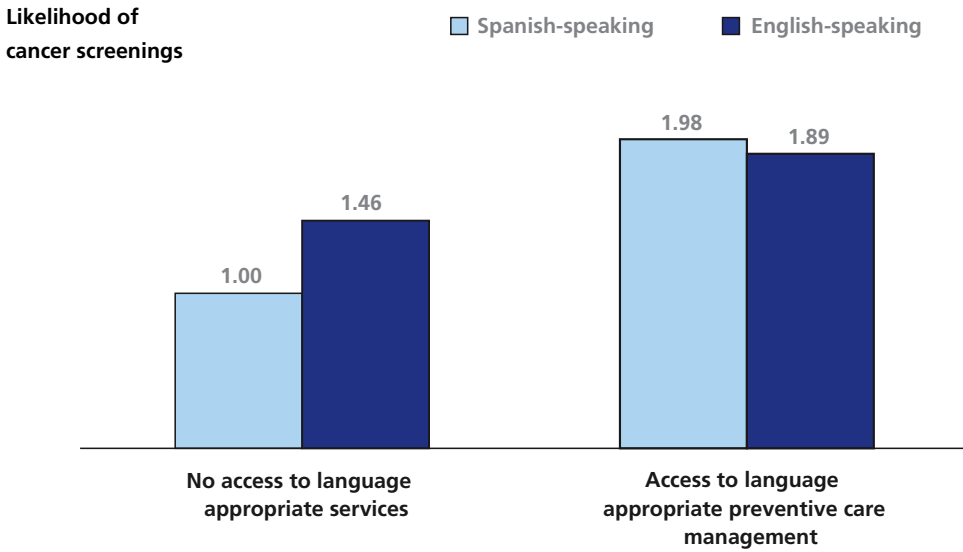
SOURCES: Beach, Michael et al. "Can Languag-Concordant Preventive Care Managers Improve Cancer Screening Rates?" 2007. Cancer Epidemiology Biomarkers Prevention. 16(10): 2058-2064.

Chart 1-10.

Blacks and Hispanics are more likely than whites to believe false statements about cancer prevention.

Percent believing statement is true

■ White   ■ Black   ☐ Hispanic

23.7%
20.7%
14.7%
9.8%
21.2%
16.7%

"Long-time smokers cannot reduce their cancer risk by quitting smoking."

"Getting a mammogram, or using a special X-ray machine to detect breast cancer, can cause cancer of the breast."

SOURCES: Stein, Kevin et al. 2007. "Prevalence and Sociodemographic Correlates of Beliefs Regarding Cancer Risks." Cancer 110: 1139-1148.

DISPARITIES IN CANCER INCIDENCE AND MORTALITY

Chart 2-1.

Uninsured and publicly insured women are two and a half times more likely to be diagnosed with a later stage of breast cancer than privately insured women.

Likelihood of being diagnosed with Stage III/IV breast cancer vs. Stage I breast cancer
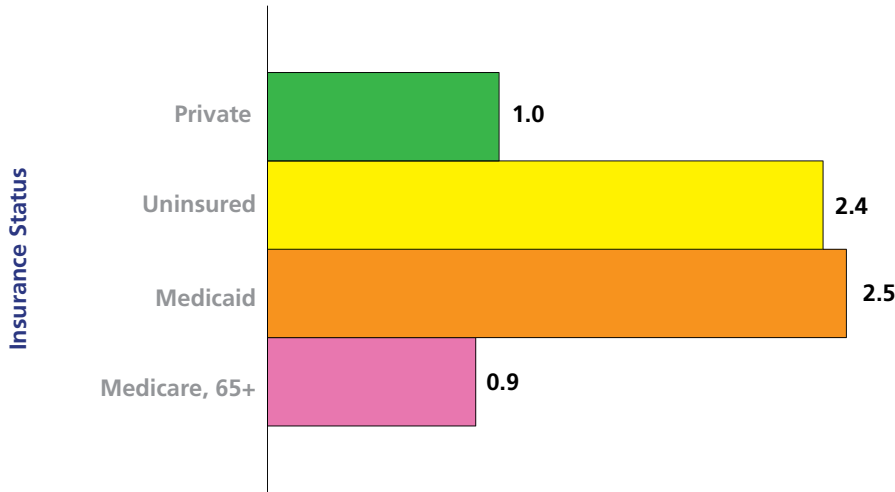
Insurance Status

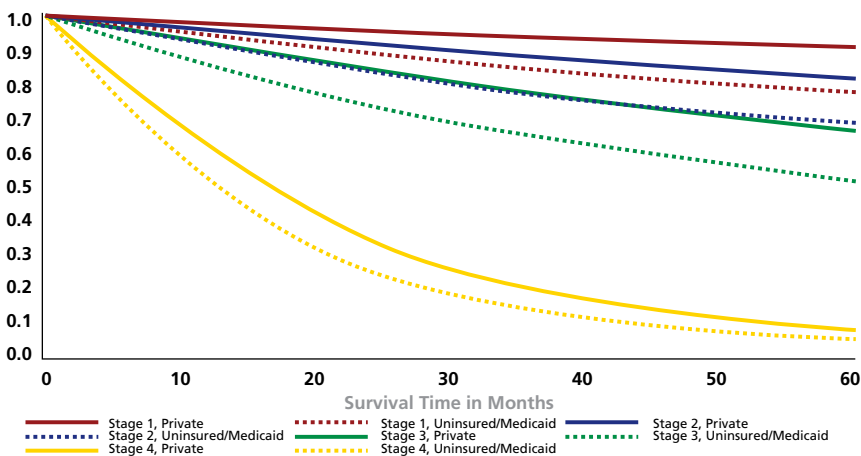| Category	Value
Private	1.0
Uninsured	2.4
Medicaid	2.5
Medicare, 65+	0.9

Note: Model adjusted for insurance type, race/ethnicity, age at diagnosis, income, proportion without high school degree, US census region, year of diagnosis, and facility type.
SOURCE: Halpern et al. "Insurance Status and Stage of Cancer at Diagnosis Among Women with Breast Cancer." Cancer. 110: 403-411. 2007

Chart 2-2.

Uninsured and Medicaid colorectal cancer patients with stage I colorectal cancer fare worse than privately insured patients with stage II colorectal cancer.

Covariate Adjusted Survival

Survival Time in Months

Legend:
- Stage 1, Private
- Stage 2, Uninsured/Medicaid
- Stage 4, Private
- Stage 1, Uninsured/Medicaid
- Stage 3, Private
- Stage 4, Uninsured/Medicaid
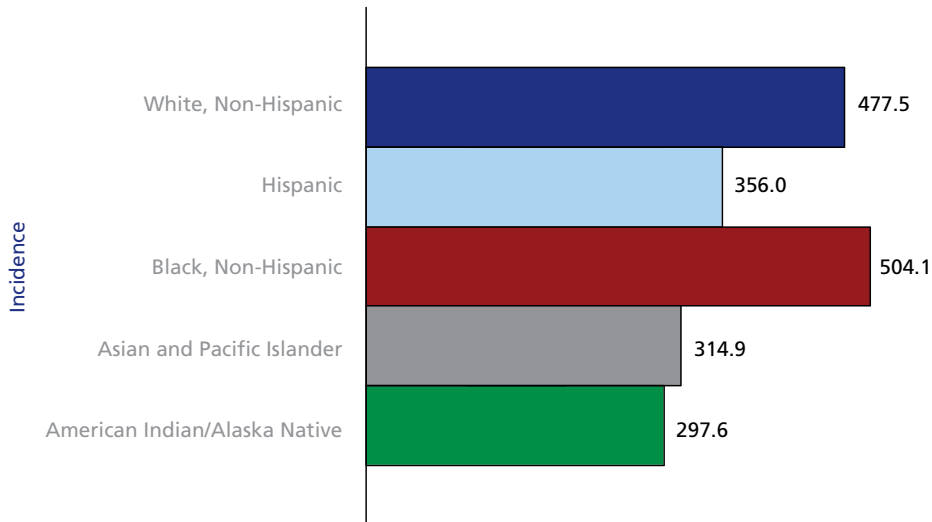- Stage 2, Private
- Stage 3, Uninsured/Medicaid

Source: Cancer Facts and Figures, 2008. American Cancer Society

Chart 2-3.

Blacks are more likely than other racial/ethnic groups to be diagnosed with cancer.

Cancer Incidence Rates, 2004

Per 100,000 population

Incidence

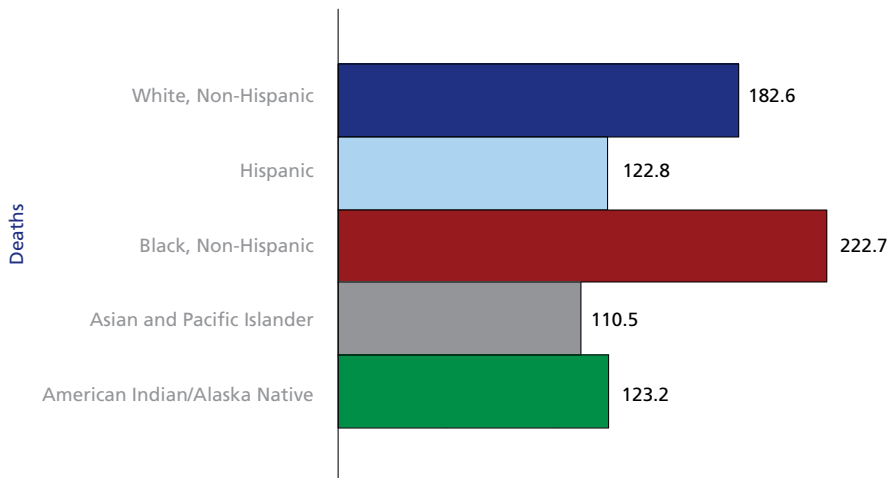| Group	Rate
White, Non-Hispanic	477.5
Hispanic	356.0
Black, Non-Hispanic	504.1
Asian and Pacific Islander	314.9
American Indian/Alaska Native	297.6

Note: Data are age-adjusted to the 2000 standard population. SOURCE: National Cancer Institute, Surveillence, Epidemiology, and End Results (SEER) Program.

Chart 2-4.

Blacks are more likely than other racial/ethnic groups to die of cancer.

Cancer Death Rates, 2005

Per 100,000 population

Deaths

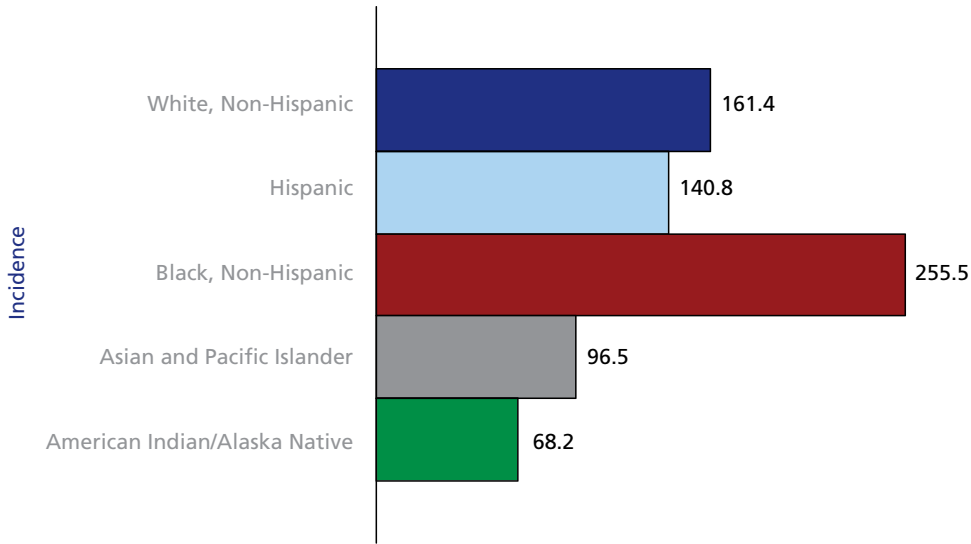| Group	Rate
White, Non-Hispanic	182.6
Hispanic	122.8
Black, Non-Hispanic	222.7
Asian and Pacific Islander	110.5
American Indian/Alaska Native	123.2

Note: Data are age-adjusted to the 2000 standard population. SOURCE: National Vital Statistics System--Mortality, NCHS, CDC.

Chart 2-5.

Blacks are more than 50% more likely than whites to be diagnosed with prostate cancer.

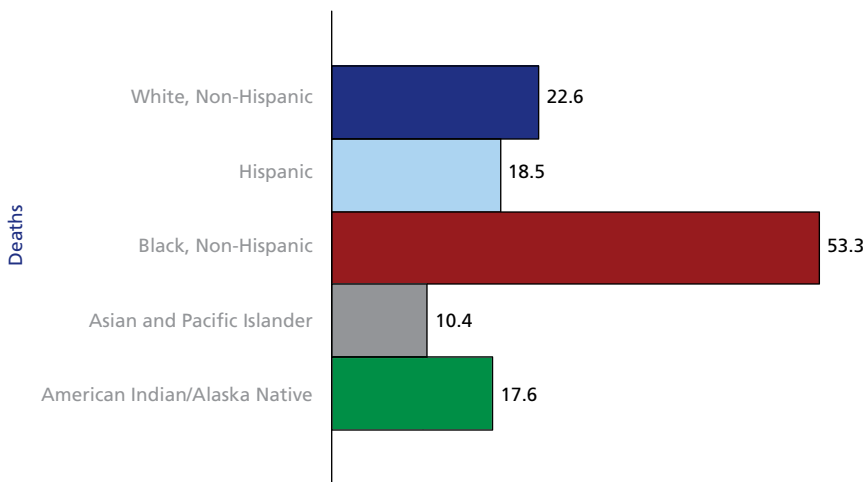**Prostate Cancer Incidence Rates, 2004**

Per 100,000 population

Incidence

- White, Non-Hispanic — 161.4
- Hispanic — 140.8
- Black, Non-Hispanic — 255.5
- Asian and Pacific Islander — 96.5
- American Indian/Alaska Native — 68.2

Note: Data are age-adjusted to the 2000 standard population. SOURCE: National Cancer Institute, Surveillence, Epidemiology, and End Results (SEER) Program;

Chart 2-6.

And blacks are twice as likely than whites to die of prostate cancer.

Prostate Cancer Death Rates, 2005

Per 100,000 population

Deaths

- White, Non-Hispanic — 22.6
- Hispanic — 18.5
- Black, Non-Hispanic — 53.3
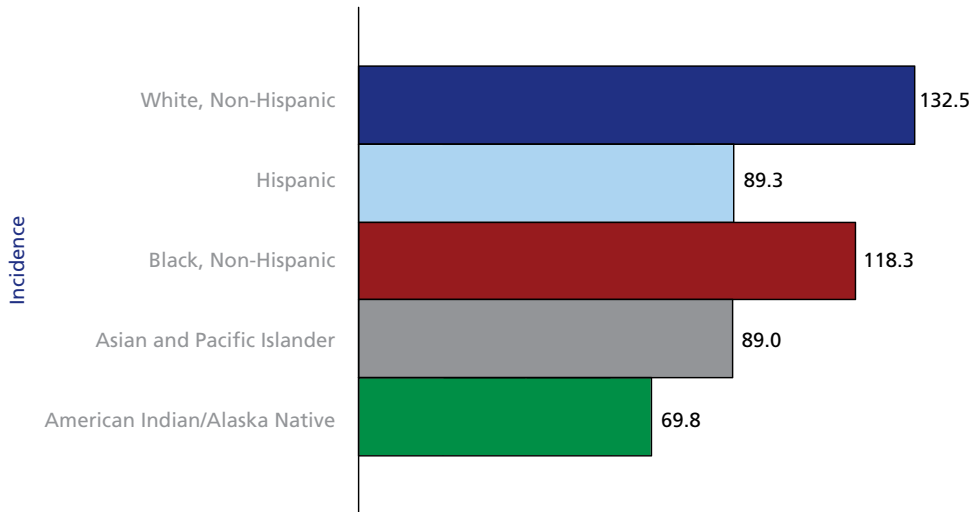- Asian and Pacific Islander — 10.4
- American Indian/Alaska Native — 17.6

Note: Data are age-adjusted to the 2000 standard population. SOURCE: National Vital Statistics System--Mortality, NCHS, CDC.

Chart 2-7.

Incidence rates of breast cancer are highest in white women.

Breast Cancer Incidence Rates, 2005

Per 100,000 population

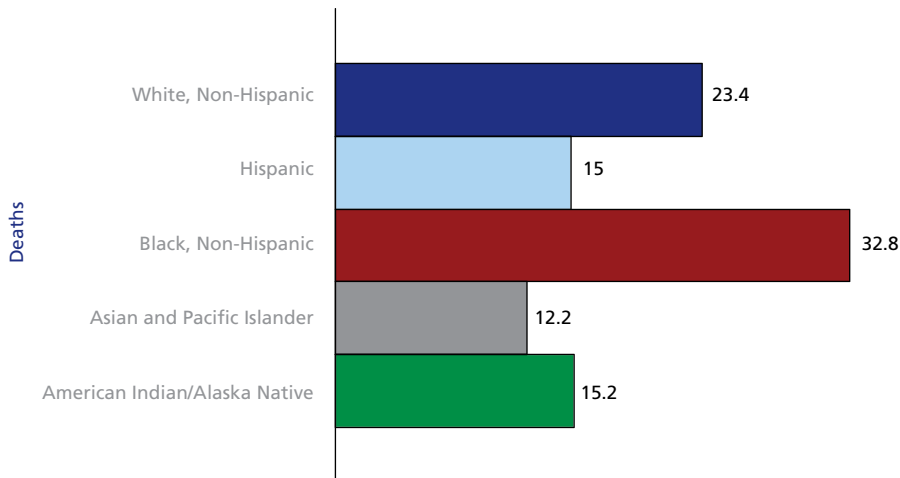Note: Data are age-adjusted to the 2000 standard population. SOURCE: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program;

Chart 2-8.

….but death rates from breast cancer are highest in African American women.

Breast Cancer Death Rates, 2005

Per 100,000 population
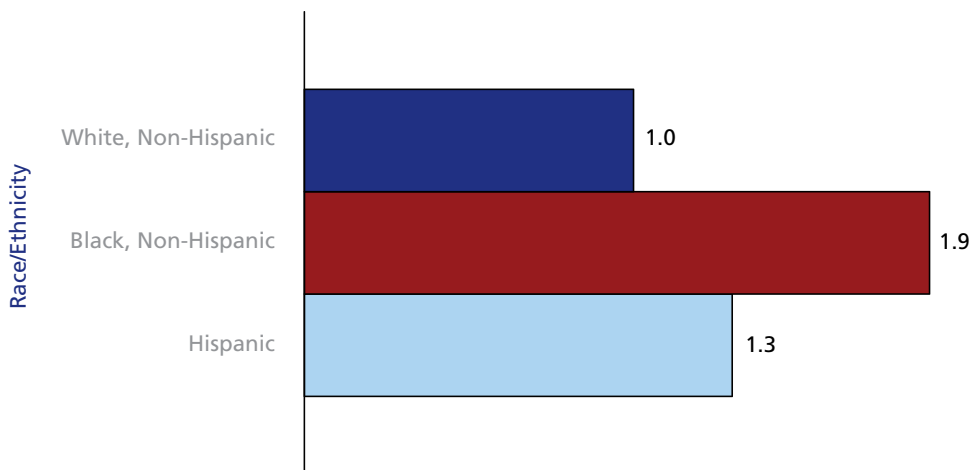

Note: Data are age-adjusted to the 2000 standard population. SOURCE: National Vital Statistics System--Mortality, NCHS, CDC.

Chart 2-9.

Minority women are almost twice as likely to be diagnosed with
a later stage of breast cancer, regardless of insurance status.

Likelihood of being diagnosed with Stage III/IV breast cancer vs. Stage I breast cancer

Race/Ethnicity

White, Non-Hispanic — 1.0

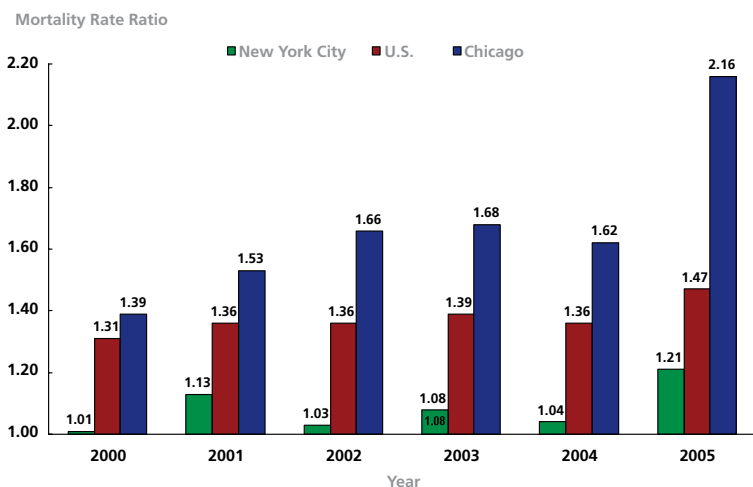Black, Non-Hispanic — 1.9

Hispanic — 1.3

Note: Model adjusted for insurance type, race/ethnicity, age at diagnosis, income, proportion without
high school degree, US census region, year of diagnosis, and facility type.
SOURCE: Halpern et al. "Insurance Status and Stage of Cancer at Diagnosis Among Women with
Breast Cancer." Cancer. 110: 403-411. 2007

Chart 2-10.

Black to white cancer mortality disparities vary greatly by region.

**For example, blacks are more likely to die of breast cancer in Chicago than in
New York City.**

Mortality Rate Ratio

Legend: ■ New York City ■ U.S. ■ Chicago

Year	New York City	U.S.	Chicago
2000	1.01	1.31	1.39
2001	1.13	1.36	1.53
2002	1.03	1.36	1.66
2003	1.08	1.39	1.68
2004	1.04	1.36	1.62
2005	1.21	1.47	2.16

Source: Hirschman, J et al. 2007. "The black:white disparity in breast cancer mortality: the example of
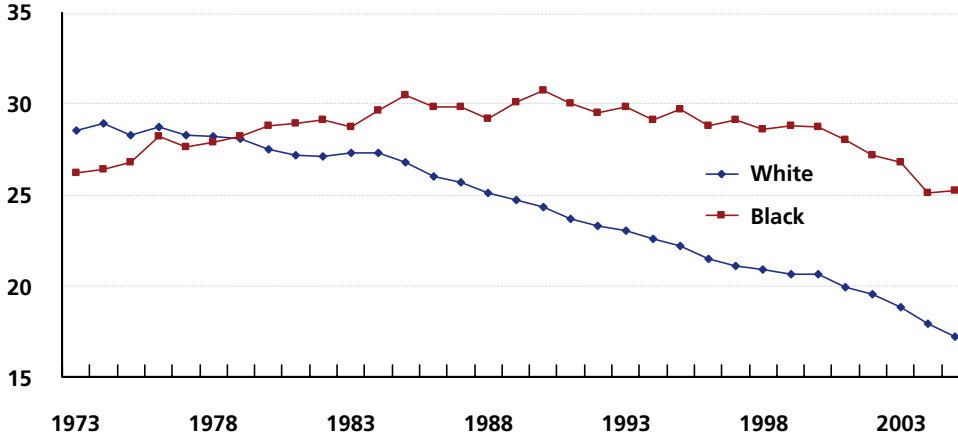Chicago." Cancer Causes Control. 18:323-333.

Chart 2-11.

Despite progress in fighting cancer, racial disparities continue to grow.

Colorectal Cancer Death Rates

Per 100,000 population

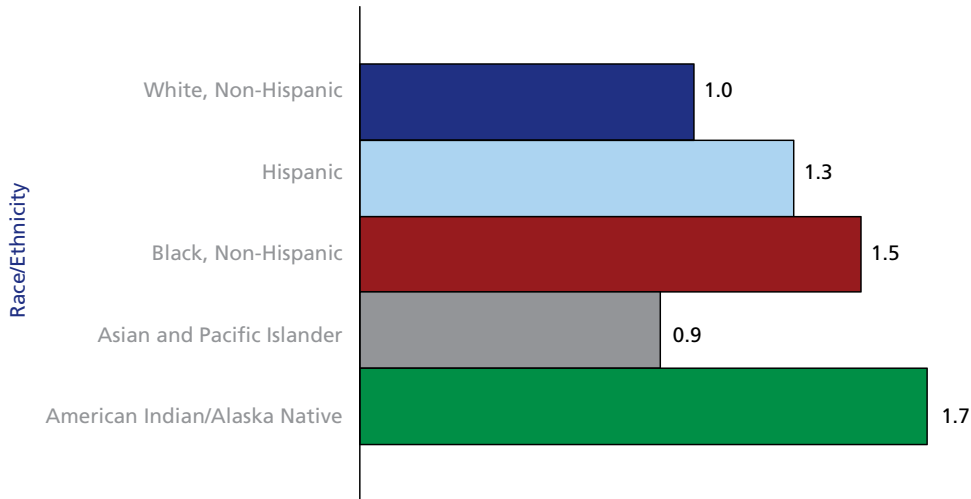Source: National Vital Statistics- Mortality, CDC, NCHS

Chart 3-1.

Racial and ethnic minorities are more likely to receive inappropriate treatment for breast cancer.

Odds ratio of receiving inappropriate treatment

Race/Ethnicity

- White, Non-Hispanic — 1.0
- Hispanic — 1.3
- Black, Non-Hispanic — 1.5
- Asian and Pacific Islander — 0.9
- American Indian/Alaska Native — 1.7

SOURCE: Li et al. 2003. "Differences in Breast Cancer Stage, Treatment, and Survival by Race and Ethnicity." Archives of Internal Medicine. 163:49-56.

Chart 3-2.

Privately insured patients are equally likely to receive recommended cancer treatment, regardless of race.

Adjusted Percent

Legend: White, Black, Hispanic

	White	Black	Hispanic
All patients	65%	58%	57%
Private	64%	60%	60%
Medicare	67%	66%	57%
Medicaid	63%	50%	60%
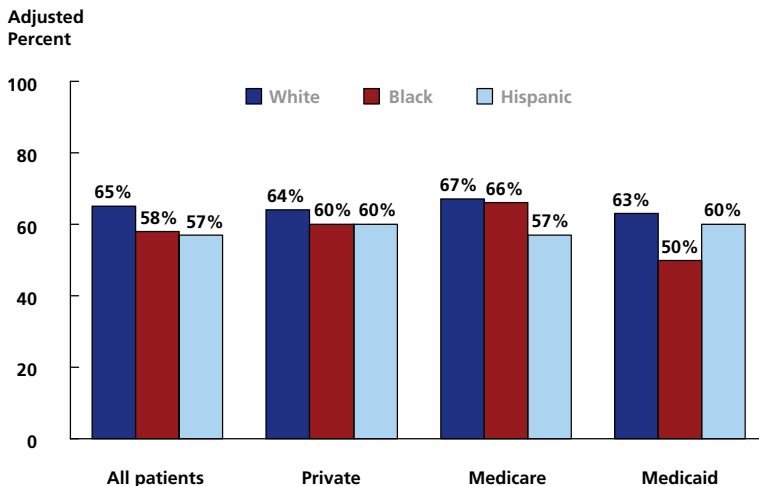
Source: Harlan et al. 2005. "Insurance Status and the Use of Guideline Therapy in the Treatment of Selected Cancers." J Clin Oncol 2005: 9079-9088.

Chart 3-3.

As new treatment technology is used, disparities in treatment may grow.

For example, disparities in the receipt of sentinel node lymph biopsy by insurance status have grown as the technology has become more popular.
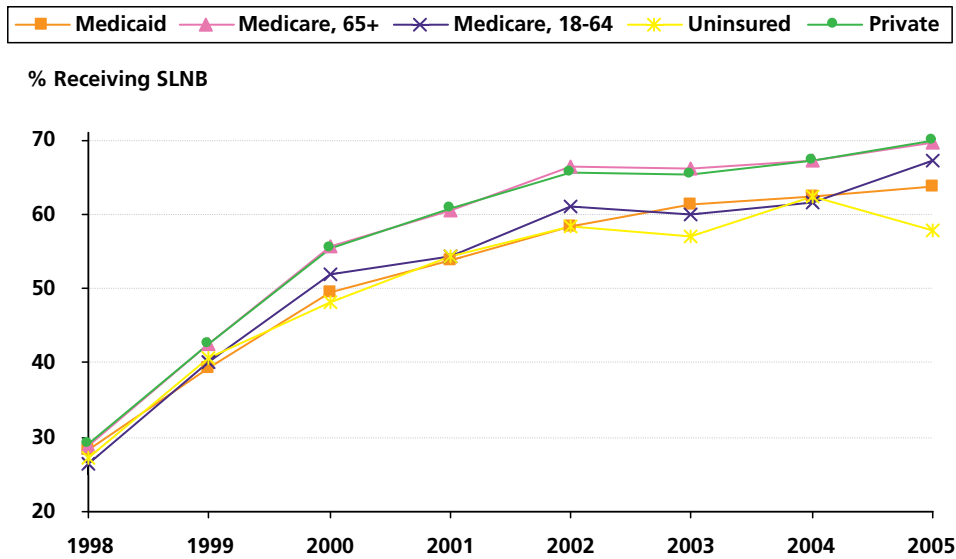
Legend: —■— Medicaid   —▲— Medicare, 65+   —✕— Medicare, 18-64   —✳— Uninsured   —●— Private

% Receiving SLNB

Source: Chen et al. 2008 "Disparities and Trends in Sentinel Lymph Node Biopsy Among Early-Stage Breast Cancer Patients." Journal of Clinical Oncology. 100(7): 462-474.

Chart 3-4.

Blacks are less likely to receive curative surgery for lung cancer, and consequently, are less likely to survive.

Percent
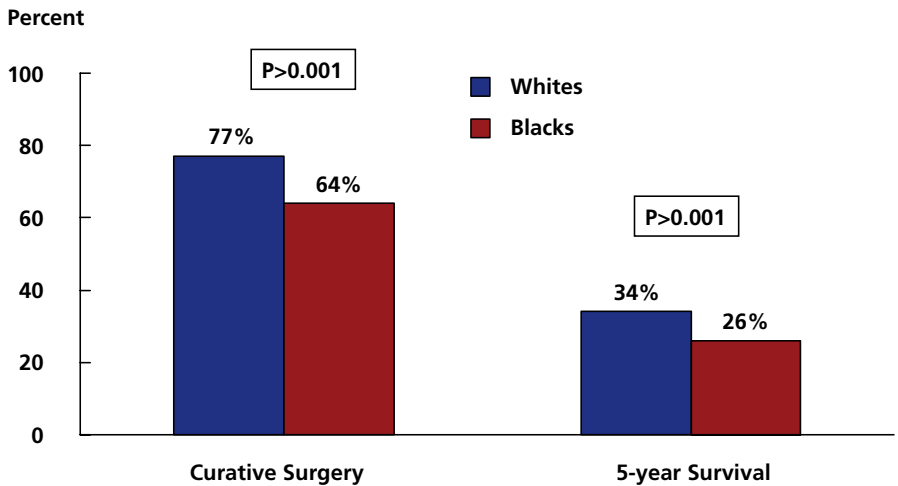
Bach et al. 1999. "Racial Differences in the Treatment of Early Stage Lung Cancer." N Engl J Medicine. 341: 1198-1205.

Chart 3-5.

Inequities in cancer treatment may be linked to cultural beliefs.

Percent

White
Black

All P ≤ 0.001

- 61% Tumors spread when exposed to air (Black)
- 29% Tumors spread when exposed to air (White)
- 19% Opposed to surgery (Black)
- 5% Opposed to surgery (White)
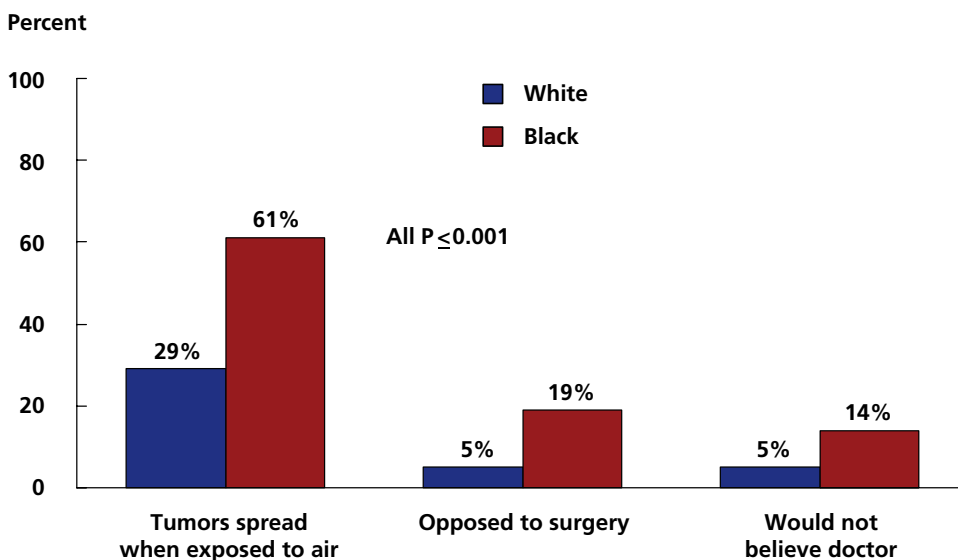- 14% Would not believe doctor (Black)
- 5% Would not believe doctor (White)

Tumors spread when exposed to air   **Opposed to surgery**   **Would not believe doctor**

Source: Margolis et al. 2003. "Racial Differences Pertaining to a Belief about Lung Cancer Surgery:
Results of a Multicenter Survey." Ann Intern Med. 139(7): 558-563.

Chart 3-6.

Racial/ethnic minorities and non-English speakers are less likely
to rate their cancer care as excellent or very good.

Percent believing they received excellent or very good care

- 82% White
- 74% Black
- 67% Hispanic
- 61% Asian
- 81% English
- 52% Non-English

White   **Black**   **Hispanic**   **Asian**   **English**   **Non-English**
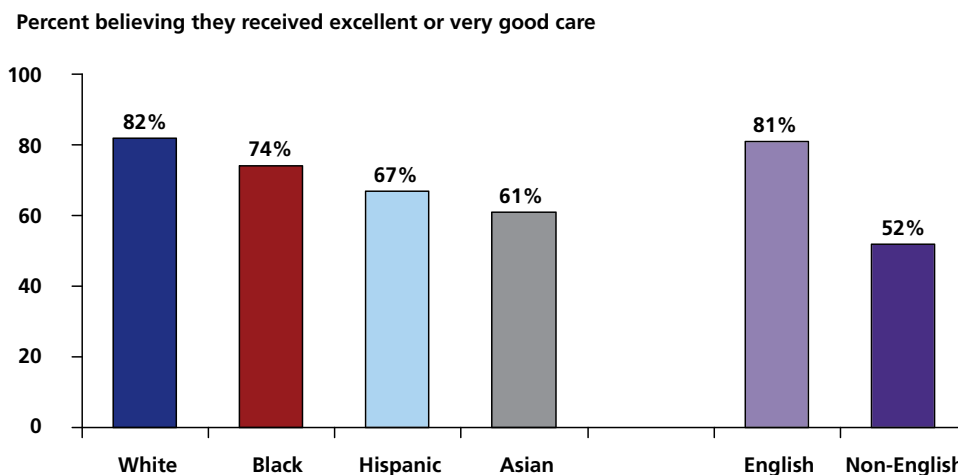
Source: Ayanian et al. 2005. "Patients' Perceptions of Quality of Care for Colorectal Cancer by Race,
Ethnicity and Language." J Clin Oncol. 23(27): 6576-6586.

Chart 3-7.

Blacks are less likely than whites to use hospice services prior to their deaths from cancer.

Percent

All P<0.001

White
Black

	All cancers	Lung	Colorectal	Breast	Prostate
White	44%	46%	45%	43%	48%
Black	36%	38%	37%	38%	36%
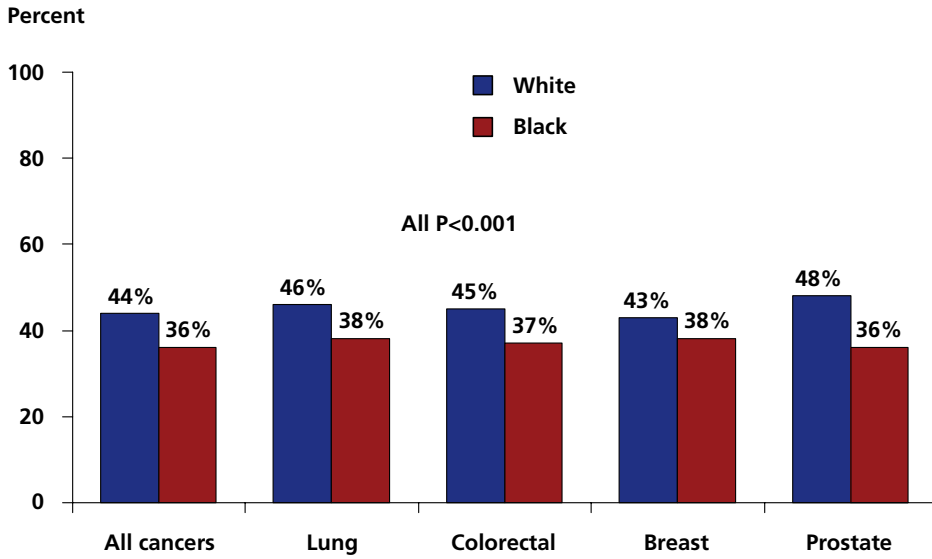
Source: Virnig et al. 2002. "Hospice Use Before Death: Variability Across Cancer Diagnoses." Medical Care. 40(1): 73-78.

DISPARITIES IN CANCER:
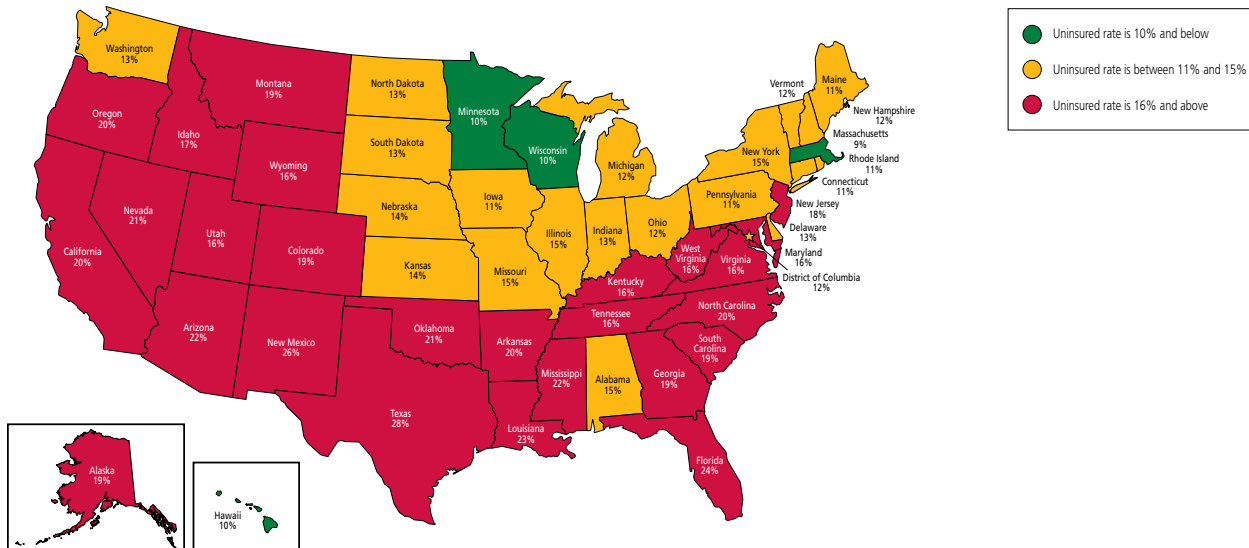STRATEGIES FOR CLOSING THE GAP

Chart 4-1.

Ensure that Affordable and Available Health Insurance is available for All.

The Uninsured

Proportion of State Population under Age 65 Who Were Uninsured, 2006-2007

Legend:
- Uninsured rate is 10% and below
- Uninsured rate is between 11% and 15%
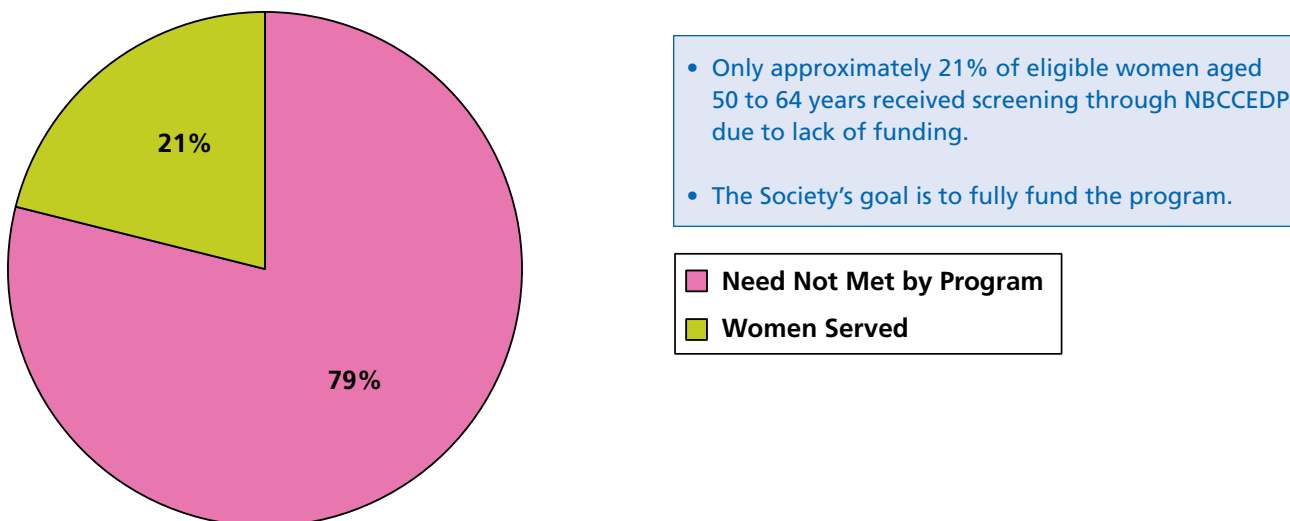- Uninsured rate is 16% and above

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

* According to a report from the Urban Institute updated March 2009, less than 3 percent of residents under 65 were uninsured when the 2008 Massachusetts Health Insurance Survey (HIS) was conducted.

Chart 4-2.

Fully Fund the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

- Only approximately 21% of eligible women aged 50 to 64 years received screening through NBCCEDP due to lack of funding.

- The Society's goal is to fully fund the program.
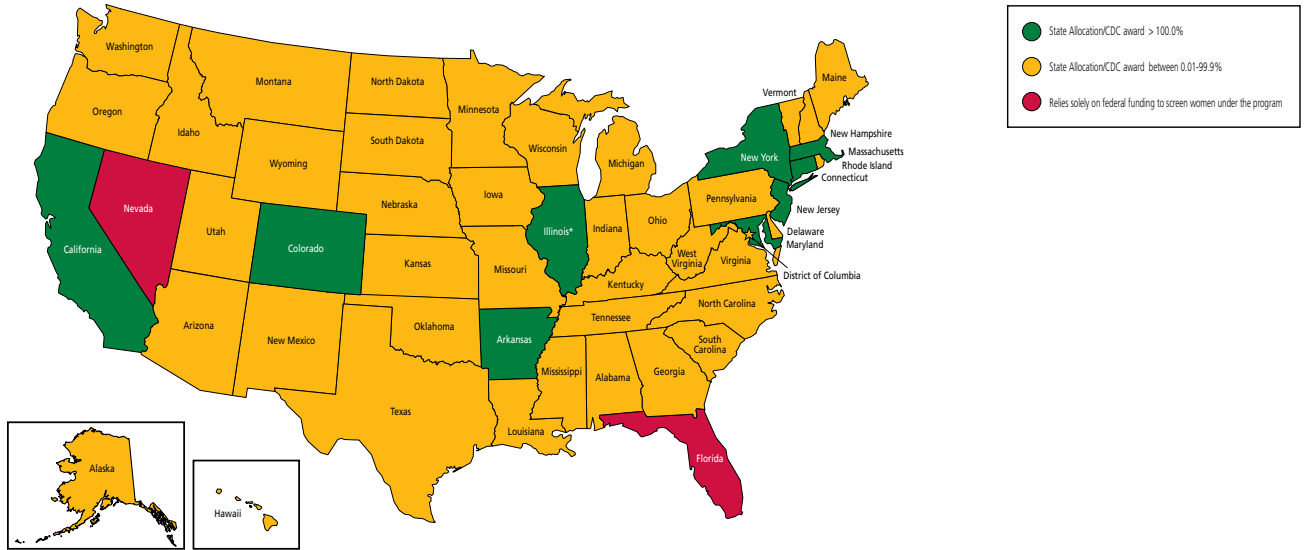
Need Not Met by Program
Women Served

Source: The National Breast and Cervical Cancer Early Detection Program Fact Sheet 2004/2005.
Department of Health and Human Services, Centers for Disease Control and Prevention. Atlanta, GA. 2005.

Chart 4-3.

State Appropriations for Breast and Cervical Cancer Screening Programs

State Allocation/CDC award > 100.0%

State Allocation/CDC award between 0.01-99.9%

Relies solely on federal funding to screen women under the program

Source: 2008 data from the Centers for Disease Control and Prevention and unpublished data collected from NGRD, Divisions, including input form NBCCEDP directors.

 * Illinois expanded their program to serve all uninsured women in Illinois in the age group served.

Chart 4-4.

Pass the Colorectal Cancer Early Detection and Treatment Act.

The New York City Colorectal Cancer Screening Program, which offers free screenings to the uninsured, both dramatically increased the screening rate and eliminated racial disparities in screening.
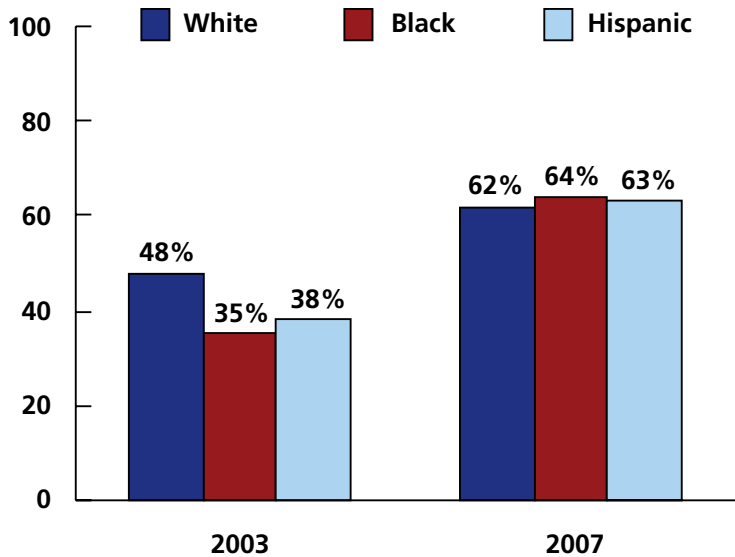
New York Times, June 6, 2008

Chart 4-5.

Fund the Patient Navigator Outreach and Chronic Disease Prevention Act.

Patient Navigators increase compliance with screenings and timely follow-up to abnormal results.
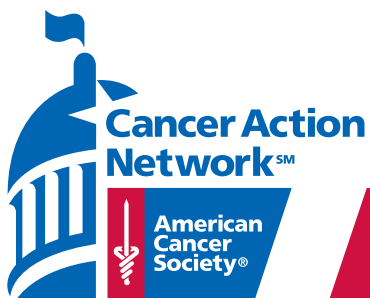
Percent

Follow-up to abnormal mammogram

Patient Navigator group — **15%**

No Patient Navigator group — **5%**

Colorectal Cancer Screening

Patient Navigator group — **78%**

No Patient Navigator group — **64%**

SOURCE: Jandorf et al. 2005. "Use of a patient navigator to increase colorectal cancer screening in an urban neighborhood health clinic." Journal of Urban Health. 82(2): 216-224.; Battaglia et al. 2007. "Improving follow-up to abnormal breast cancer screening in an urban population. A patient navigation intervention." Cancer. 109: 359-367.

Chart 4-6.

Increase Medicaid coverage of Tobacco Cessation Treatment

2006

Legend:
- No coverage
- Medication coverage only
- Medication and counseling coverage

Note: Coverage is counted only if offered to the entire Medicaid population.   Some states offer coverage, but only to pregnant women. Coverage of one of more medications is counted as medication coverage. Coverage of one or more types of counseling is counted as counseling coverage. Source: Halpin et al. 2008 MMWR.