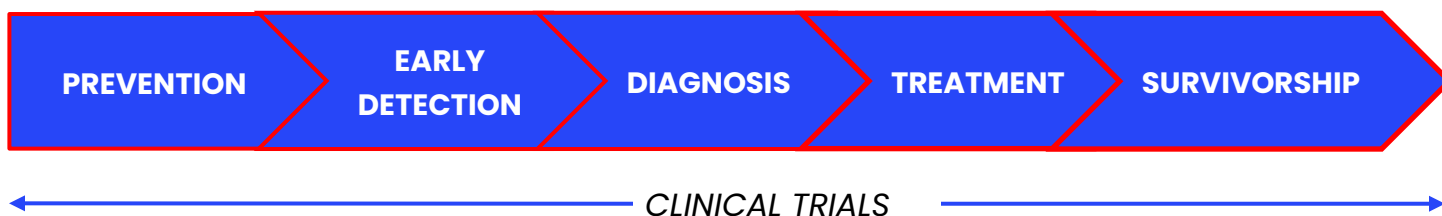


Factors Influencing Cancer Disparities

The American Cancer Society Cancer Action Network (ACS CAN) believes everyone should have a fair and just opportunity to prevent, detect, treat, and survive cancer. No one should be disadvantaged in their fight against cancer because of income, race, gender identity, sexual orientation, disability status, or where they live. From preventive screening and early detection, through diagnosis and treatment, and into survivorship, there are several factors that influence cancer disparities among different populations across the cancer continuum.

The Cancer Continuum



Some of these factors include but are not limited to:ⁱ



Lack of access to coverage – It is a well-established fact that having comprehensive health insurance is an important factor in a cancer patient’s access to care, and in their health outcomes – and therefore not having comprehensive health insurance or being underinsured is harmful to a patient with cancer. Individuals with a history of cancer that lack access to comprehensive health insurance or do not have adequate insurance coverage have high health care costs, poor access to care, poor cancer outcomes, and experience a great amount of financial hardship.ⁱⁱ Uninsured cancer survivors have more than double the health care costs compared to uninsured people who have not been diagnosed with cancer,ⁱⁱⁱ and people without health insurance are more likely to be diagnosed with cancer at a late stage, when the disease is harder to treat, more costly and more difficult to survive.^{iv}



Social determinants of health (SDOH) – The social determinants of health are a mix of the factors of economic stability, education, access to health care, where we live, and social support. People who do not have access to resources that protect, improve, and maintain a good quality of life can experience unfair and unjust cancer disparities. The American Cancer Society’s (ACS) research has found substantial disparities in social determinants of health. For example, ACS research shows that Black and American Indian and Alaska Native people continue to bear a disproportionately higher burden of cancer deaths, both overall and from major cancers. The disparities in overall cancer mortality by education level within each race are considerably larger than the Black-White disparities, underscoring the major role of poverty in racial disparity. In addition, mortality from all-cancer and leading causes of cancer death is substantially higher in non-metropolitan areas than in large metropolitan areas and in individuals with limited education. ACS research also shows how differences in social determinants of health—specifically housing, transportation, and food insecurity among patients with cancer—are associated with profound inequities in cancer incidence,

care delivery, and patient outcomes, including stark disparities in survival. More than one in five patients with cancer in the United States struggle to meet at least one of these basic needs, and estimates are much higher for patients from populations that have been historically marginalized including Black and Hispanic individuals, and those living in poverty.^v



Individual and structural racism – The discrimination individuals experience based on their race can be perpetuated and reinforced by policies, practices, cultural representation, and/or other norms embedded within the major systems such as health care. For example, many factors influencing the racial disparities in prostate cancer among Black men are rooted in structural racism which has led to decreased access to high-quality care.^{vi} Structural racism can also adversely lead to disparities in educational, job opportunities and economic mobility between Black and White individuals, even among those with similar parental household incomes. For instance, the Black-White disparities in income growth overtime or over a lifetime, which is largely due to structural racism, have been associated with Black-White disparities in many major causes of death, including all malignant cancers combined, and 14 cancer types.^{vii}

What are health disparities?

A health disparity is “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”ⁱ



Comorbid medical conditions – Comorbidity is the coexistence of disorders in addition to a primary disease. For instance, individuals with diabetes, regardless of age, are more likely to be diagnosed with cancer than those without diabetes, and mortality in patients with cancer is significantly increased if diabetes is present.^{viii} The prevalence of comorbidity tends to be higher among cancer patients who are people of color and individuals with limited income.^{ix}



Mistrust of the medical system – Studies have shown that Black people have higher mistrust of the medical system compared to White people.^{x,xi} This is likely due in part to a long history of racial bias and discrimination in the U.S. health care system. For instance, emerging evidence suggests that medical mistrust may influence screening disparities for colorectal cancer among African Americans.^{xii} Additionally, many people of color and Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ+) people have experienced health care bias and discrimination.^{xiii,xiv} Lack of trust in the medical system may prevent people from getting primary care and seeking follow-up care when needed.^{xv}



Unconscious bias in medical settings – “Unconscious bias” refers to when people are unaware they have an inclination or predisposition for or against something and that those attitudes are harmful and can affect their behavior without their awareness. Unconscious bias in medical settings can

lead to people receiving poor treatment, receiving inaccurate diagnoses, or experiencing delays in diagnosis. For instance, many LGBTQ+ people have negative experiences with health care providers. In one study, among medical students, 46% expressed explicit bias and over 80% expressed some implicit bias against LGBTQ+ people.^{xvi} When health care providers exhibit such unconscious or implicit bias towards certain individuals, barriers are erected to screening, cancer treatment and other health care services, and health care settings are created that feel unsafe for these individuals.



Unequal access to clinical trials – Clinical trials are key to advancing new standards of care that can improve survival and quality of life for people with cancer. Clinical trials are also a key part of research and enable the development of better drugs and treatments for cancer. However, cost is often a barrier to enrollment because trial participants are frequently responsible for non-medical costs such as transportation and lodging associated with trial participation. Trials also tend to be concentrated in urban areas and at large academic medical centers. As such, some groups are underrepresented in clinical trial populations, including certain racial and ethnic groups, older adults, rural residents, and those with limited incomes.



Financial burdens such as medical debt – As a leading cause of death and disease in the U.S., cancer takes a huge toll on the health of patients and survivors, and it also has a great impact on their finances. But the costs of cancer do not impact all patients equally. Evidence consistently shows that certain factors – like race/ethnicity, health insurance status, income and where a person lives – impact cancer diagnosis, treatment, survival and financial hardship experienced by people with cancer and their families. ACS CAN’s own survey data show that roughly half (51%) of cancer survivors surveyed carried cancer-related medical debt – and African American respondents were more likely to have debt than White respondents.^{xvii} Other research also documents the negative effect medical debt has on people with cancer including having housing concerns, strained relationships,^{xviii} and having to declare bankruptcy.^{xix} Delaying or forgoing care because of cost, which is more common among people with medical debt, is associated with increased mortality risk among cancer survivors.^{xx}

ACS CAN’s Position

ACS CAN advocates for evidence-based policies at the local, state, and federal levels that aim to reduce disparities, especially cancer disparities, and improve health outcomes for all individuals. From ensuring robust federal funding for cancer research to improving access to quality, affordable health care, we are asking lawmakers to reduce disparities in cancer care by advancing policies that break down existing barriers and help to end cancer as we know it, for everyone. ASC CAN advocates at the federal, state and local level to:

- ❖ ensure that everyone has access to affordable comprehensive health insurance coverage;
- ❖ expand Medicaid in the 10 remaining states that have not done so to close the coverage gap for lower income Americans who live in these states – a majority of whom are people of color – to reduce cancer disparities;

- ❖ ensure access to and coverage of evidence-based early detection services, including urging Congress and states to increase funding for the NCCEDP to ensure access to breast and cervical cancer screenings for those who continue to lack access to lifesaving screening;
- ❖ ensure health insurance networks adequately provide all enrollees reasonable and timely access to in-network facilities that provides cancer screening, follow-up cancer testing, high quality treatment, and appropriate health care providers;
- ❖ support policies to allow Medicare to cover multi-cancer early detection tests once they are FDA-approved and clinical benefit is shown;
- ❖ support policies to allow all men at high-risk for prostate cancer, including African American men and men who have a first-degree relative who has been diagnosed with prostate cancer, have access to screening that is barrier-free without cost sharing;
- ❖ support policies to increase diversity in clinical trials and make it easier for all people with cancer to participate in clinical trials by reducing financial and geographic barriers to enrollment;
- ❖ support policies to increase access to quality cancer care among communities that have been under-resourced by extending the reach of patient navigation services by ensuring that these services can be paid for over the long term; and
- ❖ pursue passing comprehensive evidence-based tobacco^{xxi} control policies that aim to eliminate tobacco-related disparities and health inequities.

ⁱ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030, accessed March 14, 2023, retrieved from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030>.

ⁱⁱ The Costs of Cancer Among Uninsured People. American Cancer Society Cancer Action Network. (2022, October 19). Accessed June 8, 2023, retrieved from <https://www.fightcancer.org/policy-resources/costs-cancer-among-uninsured-people-0>.

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- ^{xxi} ACS CAN recognizes the important role of ceremonial tobacco for many indigenous communities. This letter is intended to address commercial tobacco, not the provision, possession, or use of tobacco products as part of an indigenous practice or other recognized religious or spiritual ceremony or practice. All references to tobacco and tobacco products in this fact sheet refer to commercial tobacco.