Cancer Disparities

An American Cancer Society Cancer Action Network Chartbook

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Cancer Disparities: An American Cancer Society Cancer Action Network Chartbook

Acknowledgements

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List of Figures by Section

Introduction

Cancer impacts everyone, but it doesn't impact everyone equally. For the American Cancer Society (ACS) and its advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN), health equity means everyone has a fair and just opportunity to prevent, detect, treat, and survive cancer – regardless of income, race, sexual orientation, gender identity, disability status, or where they live. ACS CAN advocates for evidence-based policies that reduce the cancer burden for everyone and is making cancer a top priority for public officials and candidates at the federal, state and local levels.

In 2018, ACS CAN released its inaugural Cancer Disparities: A Chartbook which illustrated the scope of cancer disparities across the cancer continuum in the United States, along with the evidence-based policy recommendations at the local, state and federal levels that seek to reduce these disparities. As ACS CAN continues in its commitment to advance health equity, this updated ACS CAN chartbook will examine cancer disparities across different populations, show how certain communities are more heavily burdened by cancer, and highlight the policies that can address these inequalities as we continue in our advocacy to end cancer as we know it, for everyone. This ACS CAN chartbook provides cancer-specific data related to disparities in cancer prevention, screening, and early detection; disparities in incidence mortality and survival; as well as disparities in access to coverage experienced by historically marginalized communities. Additionally, some of the maps included in this chartbook are interactive and can be further explored via the provided links.

Lastly, the chartbook uses the terms structural racism, social determinants of health and comprehensive health insurance, which are important to define. According to the Aspen Institute, structural racism refers to systems that reinforce and perpetuate racism through policies, practices, cultural representation, or other norms which can be embedded within major systems such as health care.[1] Per the World Health Organization's definition, 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.[2] ACS research shows how differences in social determinants of health are associated with profound inequities in cancer incidence, care delivery, and patient outcomes, including stark disparities in survival. Relatedly, 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. ACS CAN defines comprehensive health insurance as health insurance that is adequate, affordable, available and administratively simple.

Research Notes

It is important to acknowledge how data collection has been impacted by government actions. For example, certain widely used government data sets have been permanently removed or removed and later restored with redacted data.[3] The scope of data removal and longer-term data collection changes remain unclear and leave researchers and impacted communities uncertain of the potential impact of these changes. Robust and ongoing investment in research is essential to driving innovation and ensuring continued progress against cancer as scientific discovery evolves. Consistent, ongoing and comprehensive data collection and dissemination ensure that relevant and timely information informs the best interventions to prevent, detect and treat chronic diseases including cancer. When certain groups are underrepresented in survey data, it is difficult to identify existing widespread disparities. This can result in misleading data that fail to show important differences in comorbidity burden, cancer risk factors, screening rates and survival outcomes across different subgroups. Although some cancer risk factor data are presented across certain subgroups as available, it is important that every subgroup's data be collected as it's critical to inform preventive interventions to reduce the total cancer burden. Due to underrepresentation in some of the datasets used, a few of the populations included in this chartbook are not disaggregated. Lastly, note that when the chartbook references "common" cancers this includes breast (female), colon and rectum, lung and bronchus, prostate, uterine cancer or uterine corpus; "selected" cancers also include these cancer types as well as cervical, liver, stomach and other cancers. The chartbook also uses the terms "metropolitan" and "urban" as well as "nonmetropolitan" and "rural" interchangeably when describing disparities in these communities to not exclude the technical research terms used.

Disparities in Black Communities

Black people have a high cancer burden and face significant obstacles to cancer prevention, detection, treatment and survival. Cancer is the second-leading cause of death in Black men and women after heart disease, accounting for approximately 16% and 18% of all reported deaths in 2022, respectively. In fact, for most cancers in the U.S, Black people have among the highest death rate and lowest survival of any racial or ethnic group. The source of these disparities is exacerbated by the negative consequences of social determinants of health, including access to quality health care, healthy food, housing and education, reflective of ongoing structural racism.[4]

Disparities in Cancer Incidence, Mortality and Survival in Black Communities

Figure 1: Cancer Incidence (2018 – 2022) and Mortality (2019 – 2023) Rates for Selected Cancers, Black vs. White, United States

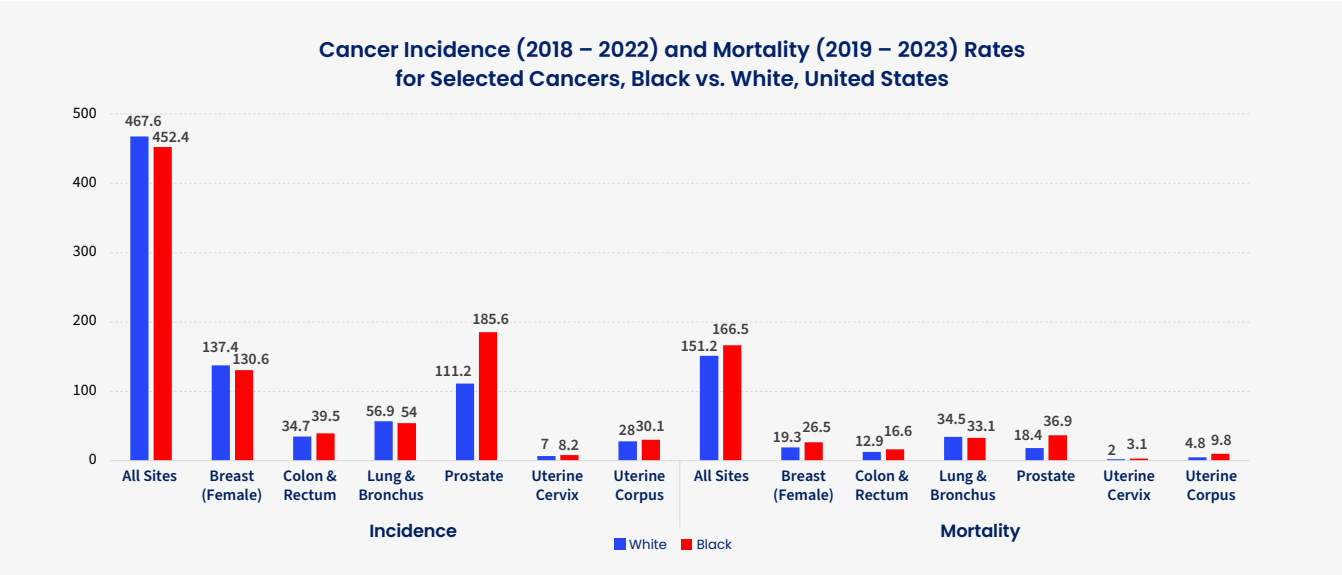
Compared to White people, mortality rates are 10% higher in Black people, despite lower incidence overall (Figure 1). Larger inequalities for mortality than incidence reflect two-fold higher death rates for uterine corpus, and stomach cancers and for myeloma, and 40%–50% higher rates for colorectal (CRC), breast, cervical, and liver cancers.[2]

Black men in the U.S. and Caribbean have the highest documented prostate cancer incidence rates in the world and are more likely to be diagnosed at an advanced stage compared to non-Hispanic White men. The incidence of prostate cancer is almost 70% higher in Black men than in White men. Prostate cancer mortality in Black men is approximately two to three times that of men in other racial and ethnic groups.[5]

Breast cancer mortality in Black women is about 40% higher than White women despite lower incidence (Figure 1), a disparity that has remained consistent since the mid-2000s and is a reversal of lower mortality than White women in 1975.[3] Breast cancer has long been the most commonly diagnosed cancer in Black women and was once again the leading cause of cancer death in 2022.[2]

Despite only 8% higher incidence rates, uterine corpus mortality rates among Black women are two-fold those of White women (Figure 1) and women of every other racial-ethnic group.[2]

About half of the racial disparity in CRC death rates is attributed to a combination of less screening and lower stage-specific survival among Black individuals.[6]



Notes: Rates are per 100,000 and age adjusted to the 2000 U.S. standard population; Uterine corpus incidence rates are adjusted for delays in reporting and mortality for all sites (entire U.S.) is adjusted using factors published by the National Center for Health Statistics. Black and White race categories are exclusive of Hispanic origin.
Source: Incidence - North American Association of Central Cancer Registries, 2025.; Mortality – National Center for Health Statistics, 2025.

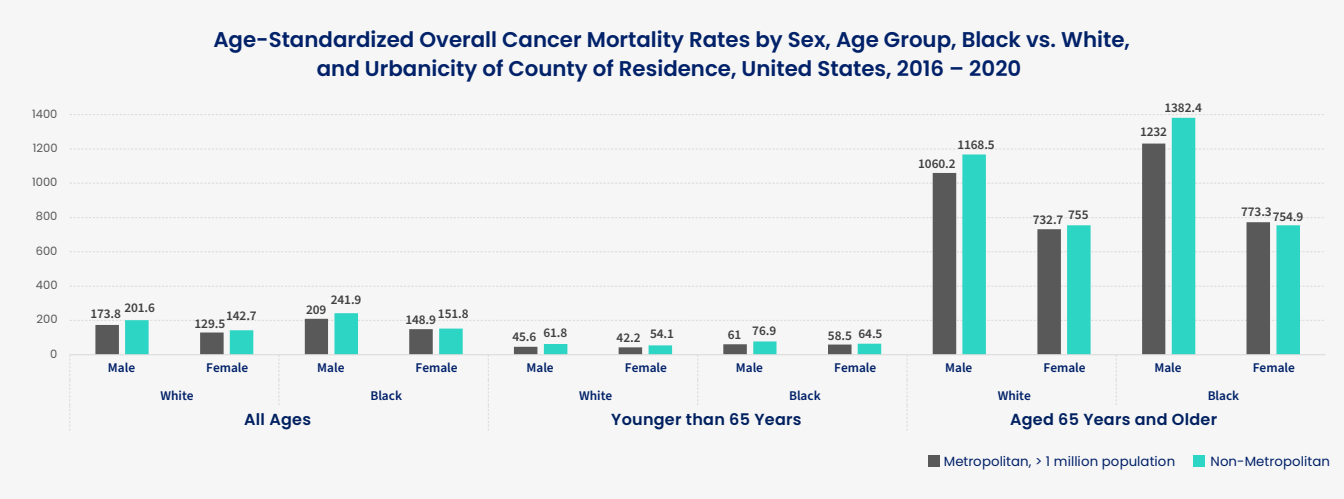
Maps 1 - 2: Rates of Cancer Incidence and Mortality for Black People by State

These interactive maps can be viewed at the following link here. One map shows the rates of cancer incidence and the other rates of mortality for Black people across the U.S. for common cancer types, including breast, cervix, colon and rectum, lung and bronchus, prostate and uterus and can be filtered to further show demographics by state and based on sex.

Mortality and incidence rates are retrieved from State Cancer Profile, a collaboration between the National Cancer Institute and Centers for Disease Control and Prevention, and are updated based on the most recent releases available on their website: https://statecancerprofiles.cancer.gov/.

Figure 2: Age-Standardized Overall Cancer Mortality Rates by Sex, Age Group, Black vs. White, and Urbanicity of County of Residence, United States, 2016 – 2020

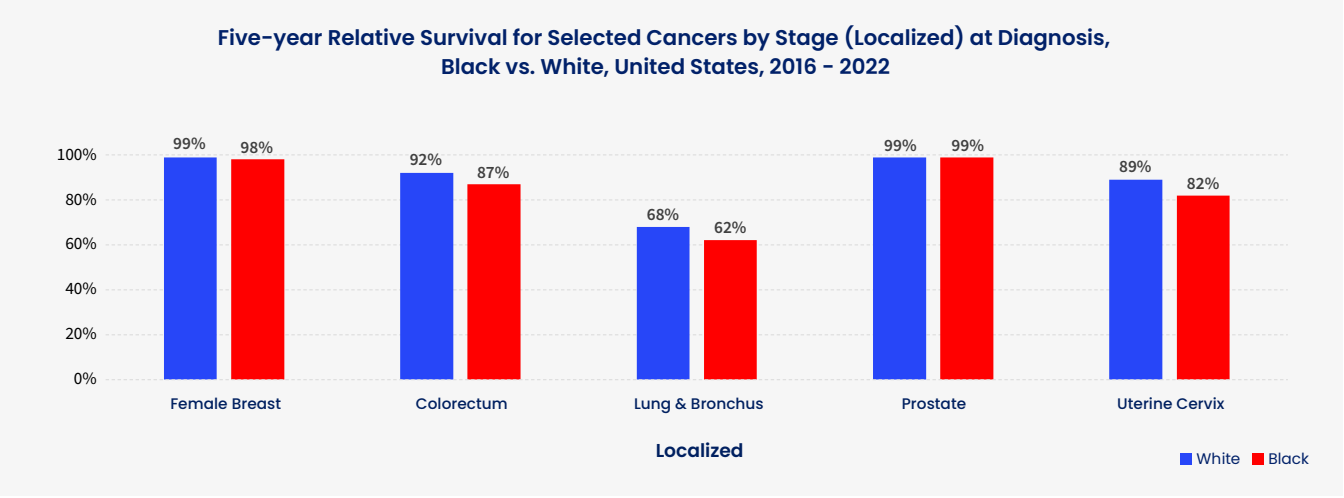
Disparities in overall cancer mortality between Black and White people younger than 65 years were greater in large metropolitan areas (>1 million population) than in nonmetropolitan areas. Compared to their White counterparts, for example, the overall cancer mortality rate in Black females younger than 65 years was 39% higher in large metropolitan areas compared with 19% in nonmetropolitan areas. This may reflect wider racial disparities in access to or quality of care in large metropolitan areas.

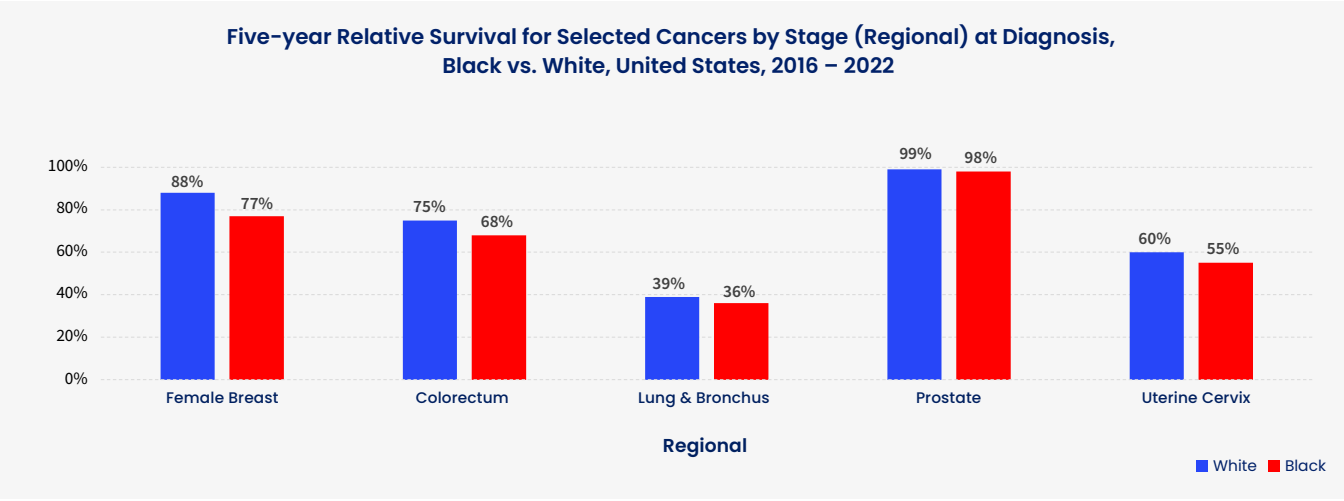


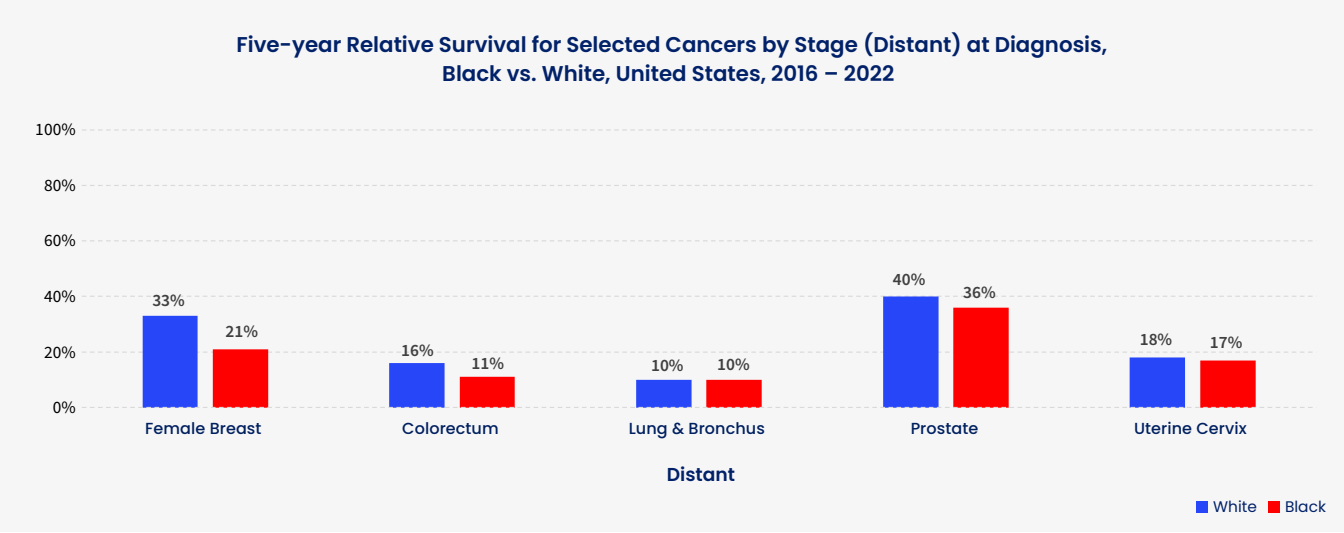
Notes: Rates are per 100,000 population and age adjusted to the 2000 U.S. standard population.
Source: National Center for Health Statistics.

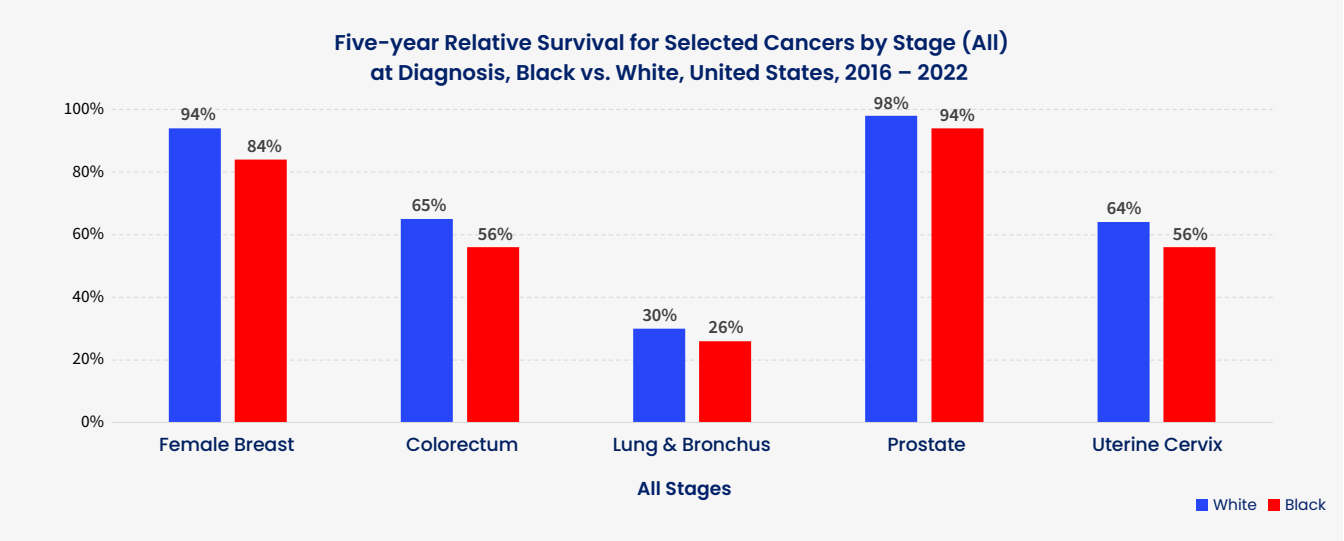
Figures 3 - 6: Five-year Relative Survival for Selected Cancers by Stage at Diagnosis, Black vs. White, United States, 2016 – 2022

Black people have lower survival for almost every type and stage of cancer compared to White people, with the largest differences for colorectal cancer (56% versus 65%). These disparities are largely due to later stage at diagnosis, more aggressive disease, and less access to high-quality treatment.[2]









Notes: Five-year relative survival for cancer in individuals younger than 99 years diagnosed in 2016–2022, excluding in situ carcinomas, age standardized to the International Cancer Survival Standards. Black and White race categories are exclusive of Hispanic ethnicity. Colorectum excludes appendiceal cancer.
Source: Surveillance, Epidemiology, and End Results (SEER) Program 21 registries, National Cancer Institute, 2024.

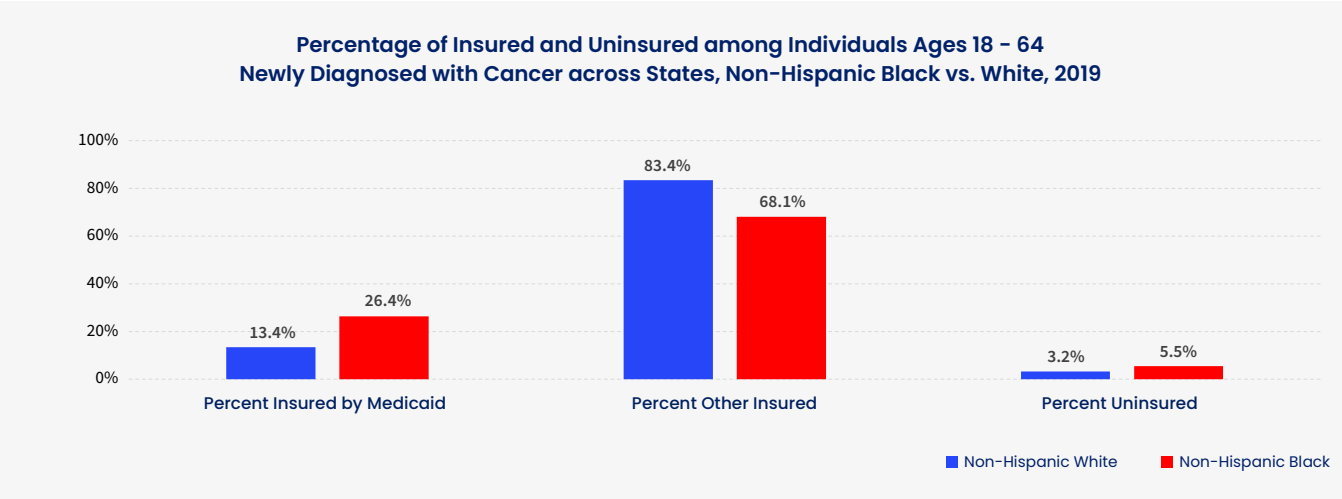
Disparities in Access to Coverage in Black Communities

Maps 3 - 4: Distribution of Uninsured and Medicaid Insured Black People Ages 0-64, 2023

These interactive maps can be viewed at the following link here. One map shows the rates of Black people who are uninsured and the other those who are insured by Medicaid from the ages of zero to 64 years. People facing cancer and survivors who are uninsured – or don't have health insurance – have high health care costs, poor access to care, poor cancer outcomes and experience a great amount of financial hardship. The health coverage provided by Medicaid helps to improve outcomes and reduce the burden of cancer by offering timely access to cancer prevention, screening and early detection services, as well as affordable treatment services and care.

Figure 7: Percentage of Insured and Uninsured among Individuals Ages 18 - 64 Newly Diagnosed with Cancer across States, Non-Hispanic Black vs. White, 2019

The percentage of Medicaid coverage was higher among non-Hispanic Black (26.4%) individuals compared with non-Hispanic White (13.4%) individuals ages 18 - 64, but non-Hispanic Black individuals also had higher uninsured rates (5.5%) compared with non-Hispanic White individuals (3.2%) diagnosed with cancer. However, non-Hispanic Black individuals were less likely to have other forms of insurance, such as private insurance or Medicare than their White counterparts.



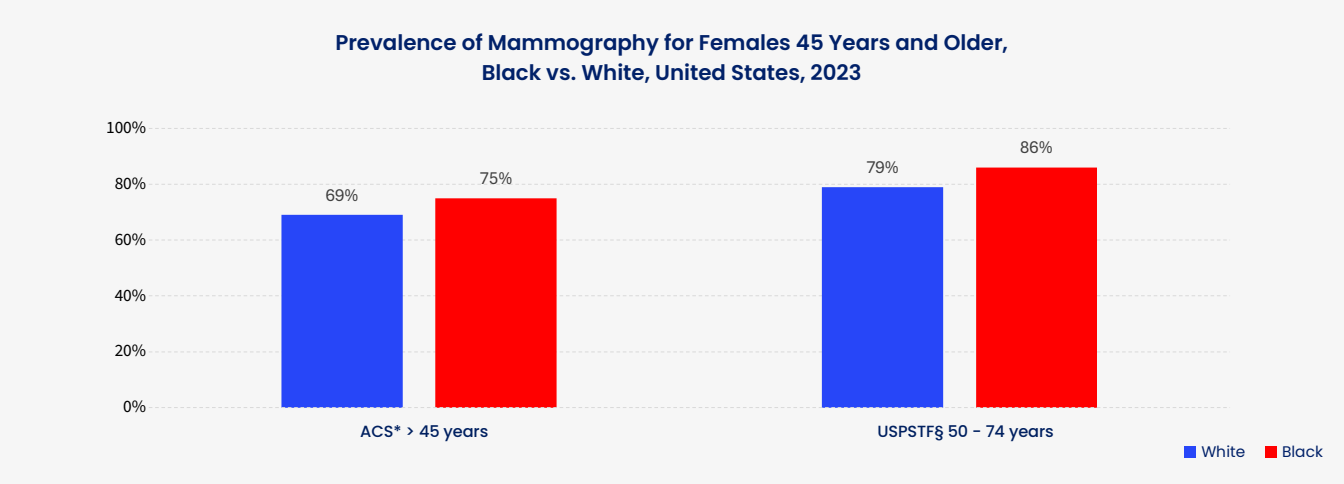
Notes: Percentages were calculated excluding cancer cases with unknown insurance status.
Source: Hu X, Yang NN, Fan Q, Yabroff KR, Han X. Health insurance coverage among incident cancer cases from population-based cancer registries in 49 US states, 2010-2019. Health Aff Sch. 2024 Jan 11;2(1):qxad083. doi: 10.1093/haschl/qxad083. PMID: 38756397; PMCID: PMC10986217.

Disparities in Cancer Prevention, Screening, and Early Detection in Black Communities

Figure 8: Prevalence of Mammography for Females 45 Years and Older, Black vs. White, United States, 2023

In 2023, prevalence of up-to-date screening according to ACS guidelines was lower for White (69%) females than for Black females (75%). Breast cancer screening was also lower in White (79%) than Black (86%) females per the 2016 United States Preventive Services Task Force (USPSTF) recommendation in 2023. The USPSTF recommendations were updated in 2024 and therefore not all recent USPSTF recommendation changes are yet measurable. For this reason, we report mammography prevalence per the 2016 USPSTF recommendations in this report.

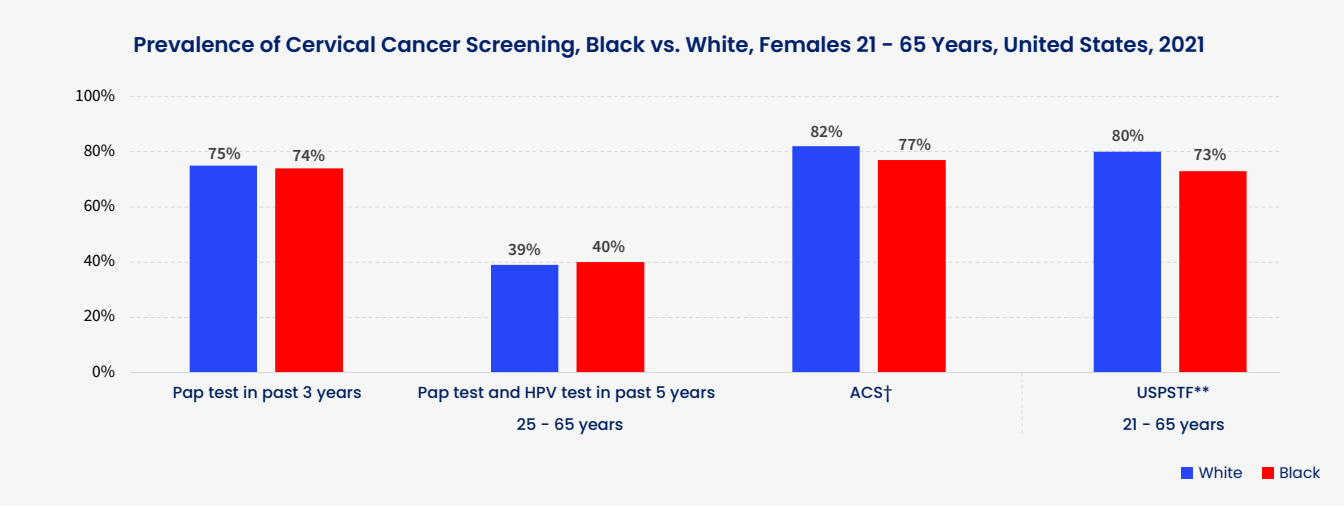
Although Black women have higher self-reported mammography prevalence than White women (Figure 8), they are more likely to overreport screening.[7] Black women are also less likely to have imaging at a facility with the most current technology, such as digital breast tomosynthesis,[8] and are more likely to experience delays in follow-up after an abnormal screening.[9]



Notes: All estimates except age and insurance are age adjusted to the year 2000 US population standard. *Mammogram within the past year (ages 45-54 years) or past 2 years (ages ≥55 years). Estimates are age adjusted using 3 age groups: 45-49, 50-64, and ≥65 years. §USPSTF 2016 recommendation: Mammogram within the past 2 years. Estimates are age adjusted using 2 age groups: 50-64, and 65-74 years.
Source: Cancer Prevention and Early Detection Facts and Figures, 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2023.

Figure 9: Prevalence of Cervical Cancer Screening, Black vs. White, Females 21-65 Years, United States, 2021

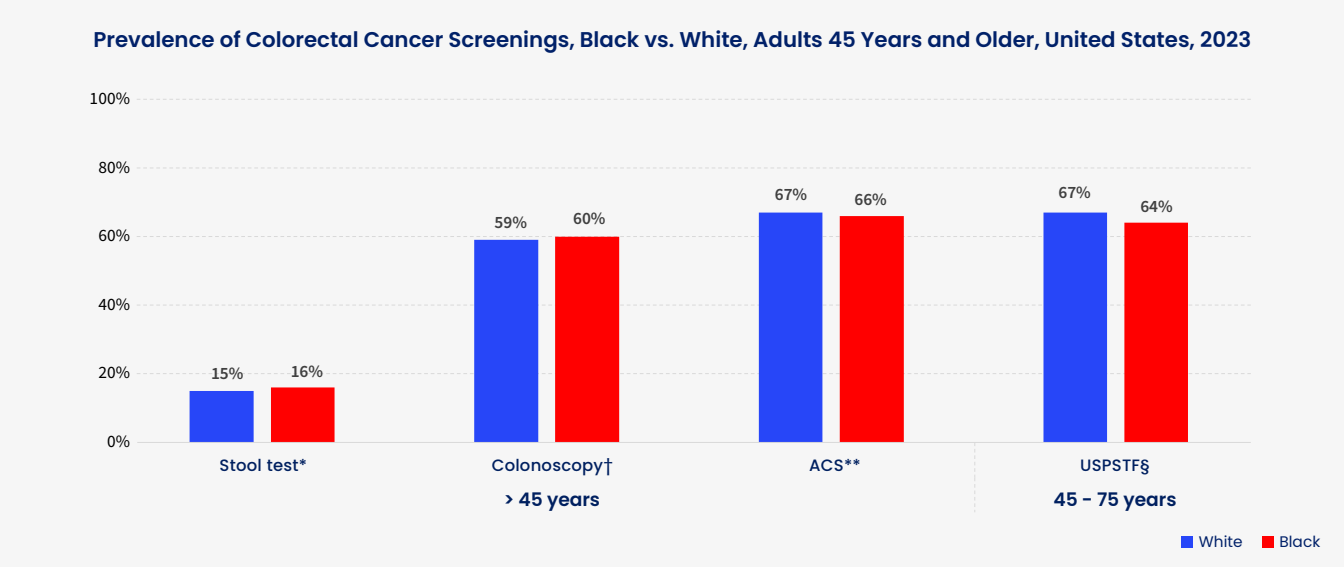
In 2021, the prevalence of up-to-date cervical cancer screening according to ACS guidelines among females 25-65 years was 78% and was similar among White (82%) and Black (77%) females.



Notes: Estimates are among females who have not had a hysterectomy. All estimates are age adjusted to the year 2000 US population standard. Up-to-date cervical cancer screening data are not available in the National Health Interview Survey 2023. †Pap test in the past 3 years or Pap test and HPV test or HPV test alone within the past 5 years among females 25-65 years. Pap test, combined Pap and HPV tests, ACS estimates, and USPSTF education estimates are age adjusted using 4 age groups: 25-29, 30-39, 40-49, and 50-65 years. **Pap test in the past 3 years among females 21-65 years or Pap test and HPV test or HPV test alone within the past 5 years among females 30-65 years. USPSTF estimates are age adjusted using 4 age groups: 21-29, 30-39, 40-49, and 50-65 years.
Source: Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026;* and National Health Interview Survey, 2021.

Figure 10: Prevalence of Colorectal Cancer Screening, Black vs. White, Adults 45 Years and Older, United States, 2023

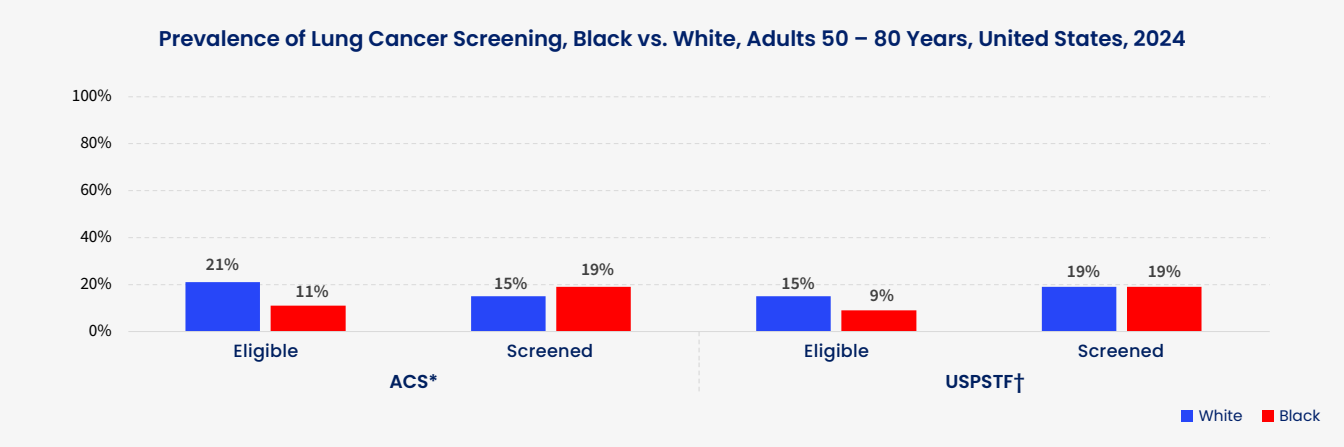
While historically colorectal cancer screening was lower among Black people, disparities have narrowed over time. In 2023, up-to-date screening prevalence was similar among White (67%) and Black (66%) individuals and higher than other racial-ethnic groups.[10]



Notes: *Stool tests, including fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past one year or multi-target stool DNA (sDNA) test, within the past three years. †Within the past ten years. **FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past one, five, ten, five and three years, respectively, per ACS guidelines. Stool testing, colonoscopy, and ACS estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. §FOBT/FIT, sigmoidoscopy, colonoscopy, CT colonography, or sDNA test in the past one, five, ten, five and three years, respectively, or sigmoidoscopy in the past ten years with FOBT/FIT in the past one year. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026;* and National Health Interview Survey, 2023.

Figure 11: Prevalence of Lung Cancer Screening, Black vs. White, Adults 50 – 80 Years, United States, 2024

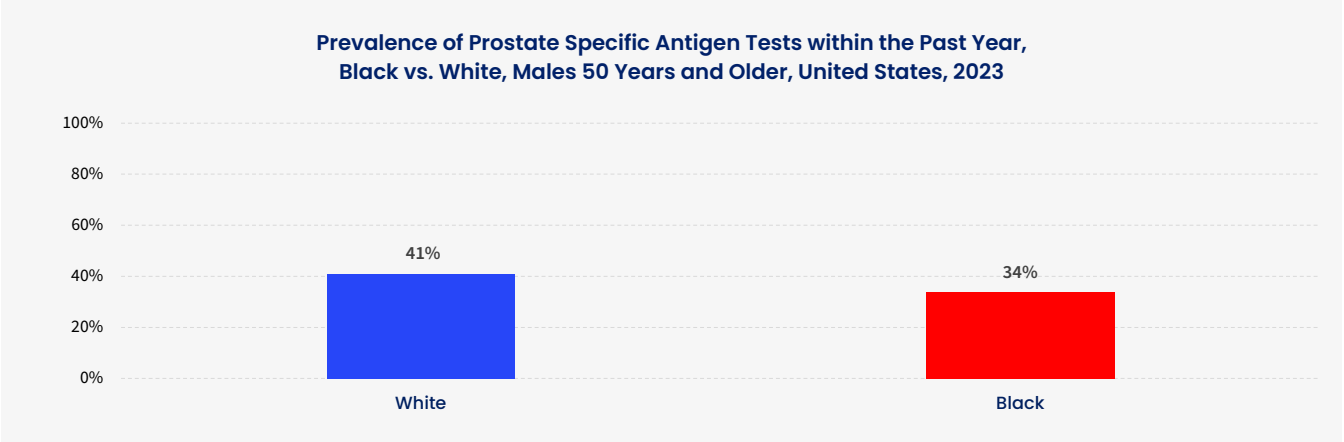
Despite clear guidelines, the rates of lung cancer screening remain low, and lung cancer is the leading cause of cancer death for both males and females. Approximately 18.4 million adults were eligible for lung cancer screening in 2024 according to ACS guidelines, and of these individuals, 15% were up to date with recommended screening overall. Black individuals were slightly above this average compared to White people.[11] ACS' guidelines were updated in 2023 and the USPSTF updated its recommendations in 2021 to capture more groups who tend to have low pack-year histories but high risk of lung cancer, including Black people. This was important because although Black individuals are smoking less than White adults, there is evidence that Black adults who smoke are still at higher risk for lung cancers despite their lower pack-year history.[12] Thus, lowering the pack-year history will increase the number of high-risk adults who are eligible for lung cancer screening.



Notes: Estimates are age-adjusted to the year 2000 US population standard using 3 age groups: 50-59, 60-69, and 70-80 years. *The American Cancer Society recommends annual screening for lung cancer with a low-dose CT (LDCT) scan for people ages 50 to 80 years who smoke or used to smoke and have at least a 20 packyear history of smoking. †The USPSTF recommends annual screening for lung cancer with LDCT in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2024.

Figure 12: Prevalence of Prostate Specific Antigen Tests within the Past Year, Black vs. White, Males 50 Years and Older, United States, 2023

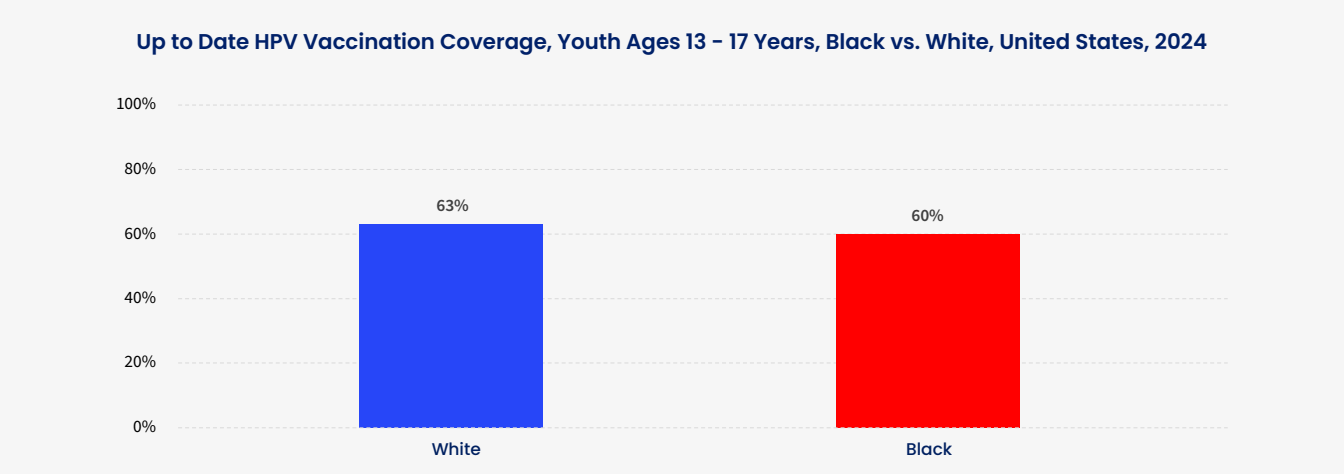
Prostate cancer survival rates increase when it is detected early through testing like the prostate-specific antigen (PSA) test. However, prostate cancer screening recommendations have changed over time based on evidence of benefits and harms and current guidelines are in the process of being updated. Currently, guidelines stress the need for shared decision making between patient and clinician (i.e., discussion of potential benefits, risks, patient values and preferences) in screening decisions.[13,14] In 2023, the prevalence of prostate cancer screening was higher in White (41%) than Black (34%) men.



Notes: Estimates are age adjusted to the year 2000 U.S. population standard using two age groups: 50-64 and ≥65 years. Prostate cancer screening is defined as PSA tests among males who have not been diagnosed with prostate cancer. ACS (males 50+ years) screening guidelines recommend shared decision making between patient and provider to guide screening decisions for PSA testing. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2023.

Figure 13: Up to Date HPV Vaccination Coverage, Youth Ages 13 - 17 Years, Black vs. White, United States, 2024

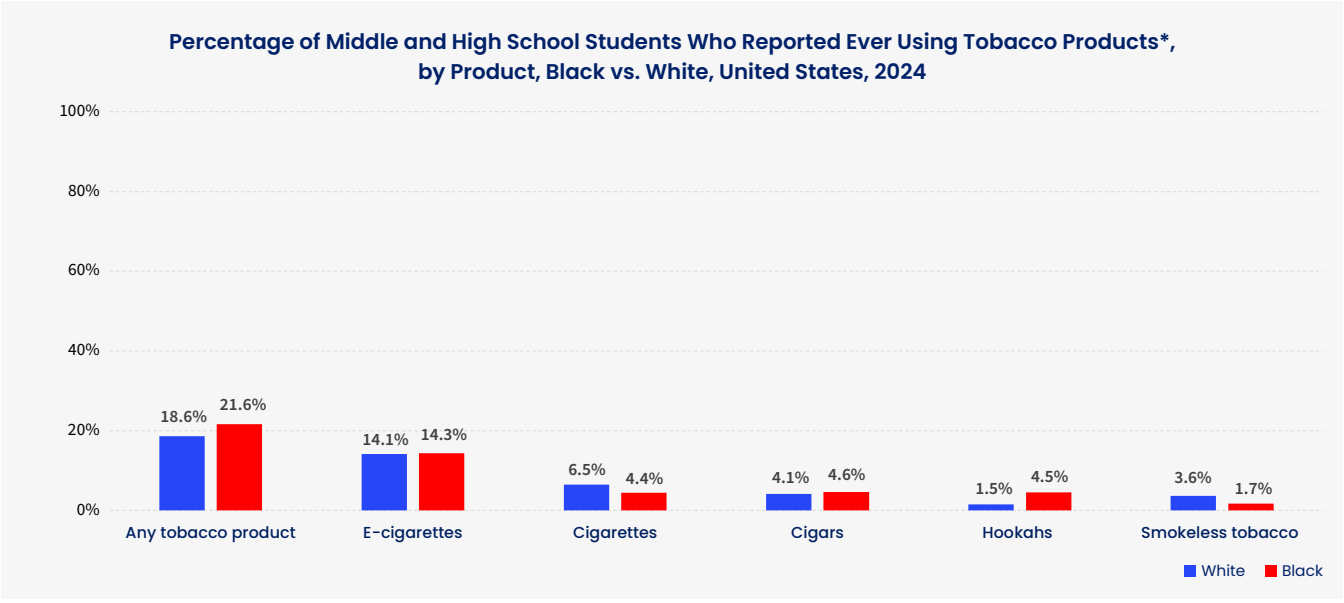
Human papillomavirus (HPV) vaccination is associated with population-level reductions in HPV infection, cervical cancer, and other HPV-associated cancers.[15,16,17,18] ACS' HPV vaccination guidelines were updated in 2020 to recommend routine vaccination for girls and boys starting at age nine. In 2024, the percentage of Black youth ages 13 to 17 that were up to date on the HPV vaccine was slightly less than their White peers.



Notes: Up to date human papillomavirus vaccination in ages 13-17 years is defined as two doses separated by five months (minus four days) for immunocompetent adolescents initiating the human papillomavirus vaccine series before their 15th birthday, and three doses for all others.
Source: Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Immunization Survey-Teen, 2024.

Figure 14: Percentage of Middle and High School Students Who Reported Ever Using Tobacco Products, by Product, Black vs. White, United States, 2024

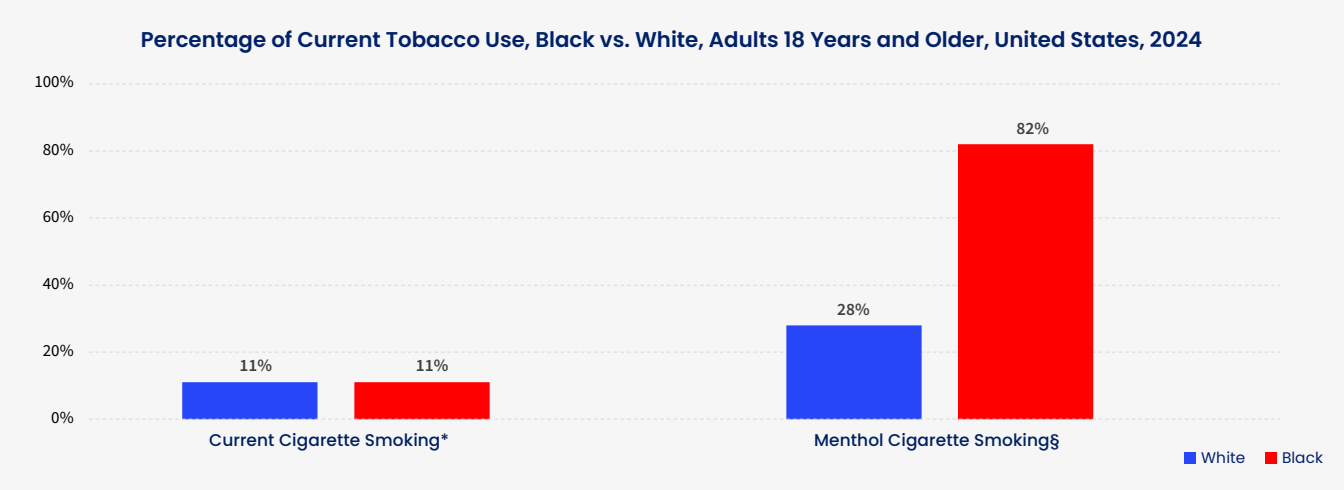
This chart shows that Black students reported ever using tobacco products more than their White counterparts, including e-cigarettes, cigars, and hookah.



Notes: *Ever use is defined as ever having used the product, even once or twice. Because of missing data on the ever use questions, denominators for each tobacco product might differ. For each question, response options were "yes" or "no." Overall estimates were reported based on 22,069 U.S. middle and high school students. Cigars were defined as cigars, cigarillos, or little cigars. Smokeless tobacco (composite) was defined as chewing tobacco, snuff, dip, or snus. Any combustible tobacco product use was defined as use of one or more of the following tobacco products: cigarettes, cigars, hookahs, pipe tobacco, or bidis. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; 2026; Jamal A, Park-Lee E, Birdsey J, et al. Tobacco Product Use Among Middle and High School Students — National Youth Tobacco Survey, United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:917–924. DOI:http://dx.doi.org/10.15585/mmwr.mm7341a2. National Youth Tobacco Survey, 2024.

Figure 15: Percentage of Current Tobacco Use, Black vs. White, Adults 18 Years and Older, United States, 2024

In 2024, about 36% of those currently smoking reported usually smoking menthol-flavored cigarettes, but this proportion was 82% in Black persons compared to 28% in White persons. While smoking prevalence has declined across most race/ethnicity groups, substantial disparities remain, with historically higher prevalence in Black males.

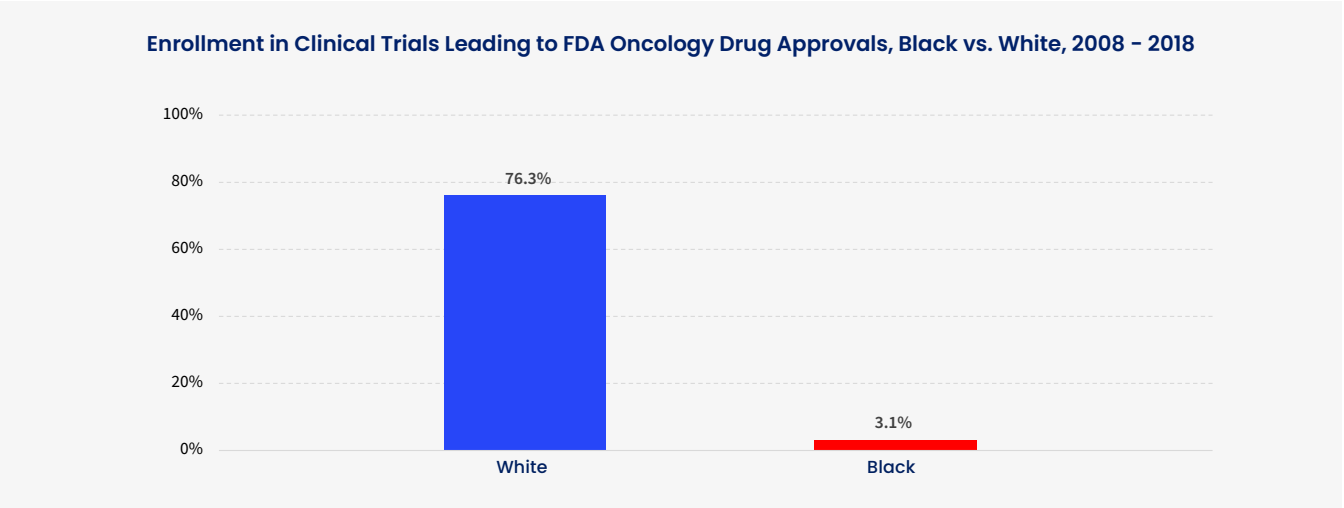


Notes: *Ever smoked 100 cigarettes in lifetime and currently smoke every day or some days. § Of those who currently smoke, those who usually smoked menthol cigarettes.
Source: National Health Interview Survey, 2024.

Disparities in Clinical Trial Participation in Black Communities

Figure 16: Enrollment in Clinical Trials Leading to FDA Oncology Drug Approvals, Black vs. White, 2008 – 2018

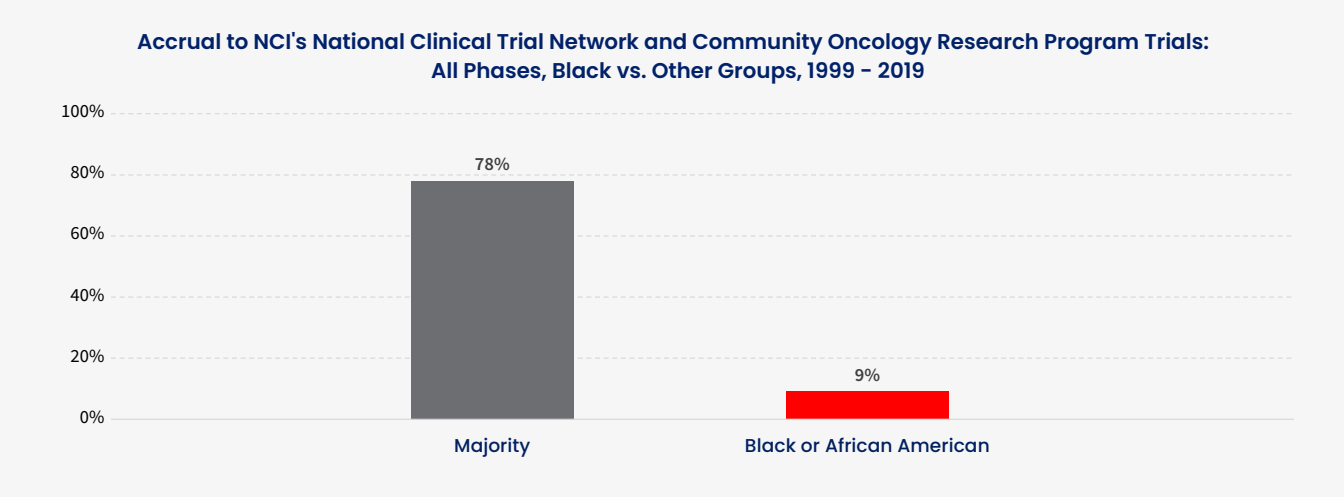
Compared to their cancer burden, some racial and ethnic populations in the U.S. are vastly underrepresented in cancer clinical trials that support new drug approvals. The majority of trials supporting these approvals occur outside of the U.S., which drives the lack of representation. Underrepresentation of minority populations will prevent generalizability of the findings to the target populations, and preclude characterization of potential differences related to safety or efficacy in these populations. The chart below shows the percentage of patients enrolled in Federal Drug Administration (FDA) drug approval trials from 2008-2018 which reported on patients of the assessed races.



Source: Loree JM, Anand S, Dasari A, et al. Disparity of Race Reporting and Representation in Clinical Trials Leading to Cancer Drug Approvals From 2008 to 2018. JAMA Oncol. 2019;5(10):e191870. doi:10.1001/jamaoncol.2019.1870.

Figure 17: Accrual to NCI's National Clinical Trial Network and Community Oncology Research Program Trials: All Phases, Black vs. Other Groups, 1999–2019

Participation from racial and ethnic minority patients in National Cancer Institute (NCI)-sponsored trials increased over 20 years from 1999-2019, with Black representation during 2014-2019 meeting or exceeding the proportion of Black patients in the overall cancer population. Offering clinical trials in a broad array of not only academic, but also community settings demonstrates that equitable participation in trials is possible when typically underrepresented populations are given opportunities to take part in trials. The chart below shows the percentage of patients enrolled in NCI's National Clinical Trial Network (NCTN) and National Community Oncology Research Program (NCORP) clinical trials from 1999-2019.



Notes: Minority and majority categorization according to 2020 Census definitions of race and ethnicity.
Source: McCaskill Stevens, W. (2020) Participation by minority racial, ethnic groups in NCI-funded trials nearly doubles in 20 years. Cancer Letter 46 https://cancerletter.com/the-cancer-letter/20200626_1/.

Disparities in Hispanic/ Latino Communities

Hispanic people make up the second largest and youngest racial and ethnic group in the U.S., with a population size of approximately 64 million – accounting for 19% of the total population. However, the distribution of Hispanic ethnic groups varies substantially by state, and in 2021, approximately one-third of Hispanic people in the U.S. were foreign-born (i.e., born outside the U.S. and its territories).

Race and ethnicity are defined as distinct concepts by federal standards, allowing individuals of Hispanic origin to identify as any race, including combinations of European, American Indian, and African ancestry. However, cancer occurrence data is limited to Hispanic ethnicity in aggregate, masking potential differences by race, origin, and nativity. For example, overall cancer mortality in US-born Hispanic men is 15% higher than their foreign-born counterparts.[19]

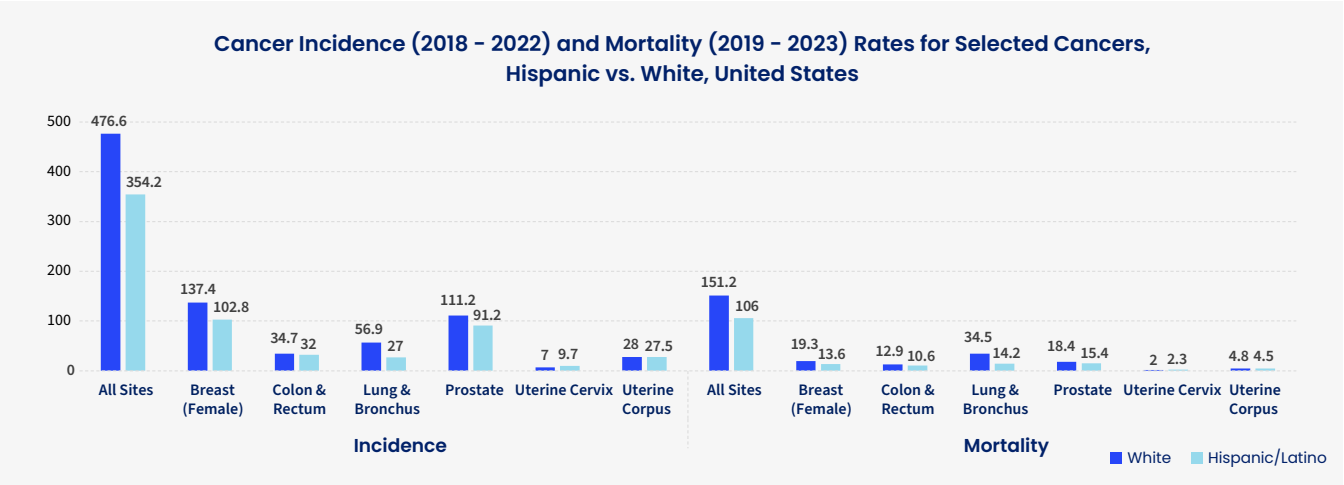
Cancer distribution among the U.S. Hispanic population varies from the general population due to younger age structure and differences in prevalence of risk factors.[20] Structural racism, a higher likelihood of poverty, a higher percentage uninsured, and language barriers are all obstacles to health care access that contribute to differences in cancer occurrence and outcomes among Hispanic people. Cancer is the second leading cause of death among Hispanic people, accounting for 17% of deaths.[21]

Disparities in Cancer Incidence, Mortality and Survival in Hispanic/Latino Communities

Figure 18: Cancer Incidence (2018 – 2022) and Mortality (2019 – 2023) Rates for Selected Cancers, Hispanic vs. White People, United States

Compared to (non-Hispanic) White people, Hispanic people have lower incidence and mortality for most common cancers (female breast, colorectum, lung, and prostate), but 14-39% higher rates of cervical cancer (Figure 18), which is associated with infectious agents and is largely preventable.[19]

Lung cancer incidence and mortality in Hispanic people are nearly half that in White people, consistent with historically lower smoking prevalence, although smoking patterns differ by origin group.



Notes: Rates are per 100,000 and age adjusted to the 2000 U.S. standard population; uterine corpus incidence rates are adjusted for delays in reporting. White race is exclusive of Hispanic origin.
Source: Incidence - North American Association of Central Cancer Registries, 2025.; Mortality – National Center for Health Statistics, 2025.

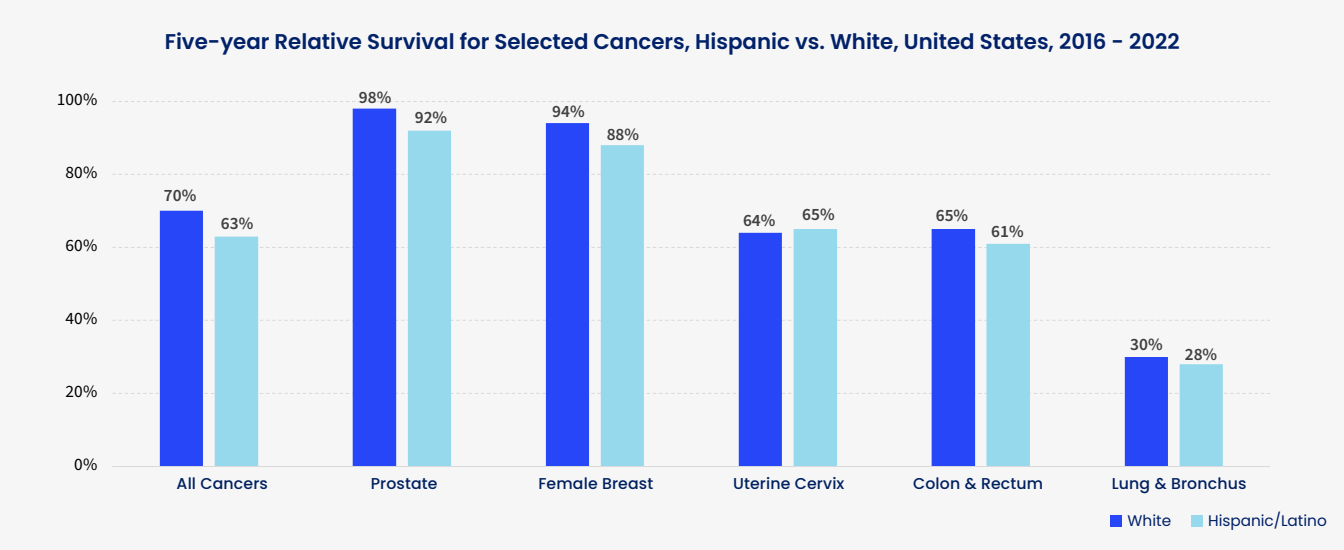
Maps 5 - 6: Rates of Cancer Incidence and Mortality for Hispanic People by State

These interactive maps can be viewed at the following link here. One map shows the rates of cancer incidence and the other rates of mortality for Hispanic people across the U.S. for selected cancer types, including breast, cervix, colon and rectum, lung and bronchus, prostate and uterus and can be filtered to further show demographics by state and based on sex.

Mortality and incidence rates are retrieved from State Cancer Profile, a collaboration between the National Cancer Institute and Centers for Disease Control and Prevention, and are updated based on the most recent releases available on their website: https://statecancerprofiles.cancer.gov/.

Figure 19: Five-year Relative Survival for Selected Cancers, Hispanic vs. White, United States, 2016 - 2022

Five-year survival in Hispanic people is only slightly lower than in White people for cancer overall (63% versus 70%); however, survival data for Hispanic people are known to be overestimated because of less successful patient follow-up and are also influenced by the younger age of the Hispanic population.[22]



Notes: Five-year relative survival for cancer in individuals younger than 99 years diagnosed in 2016–2022, excluding in situ carcinomas, age standardized to the International Cancer Survival Standards. White race is exclusive of Hispanic origin. Survival rates should be interpreted with caution.
Source: Surveillance, Epidemiology, and End Results (SEER) Program 21 registries, National Cancer Institute, 2024.

Disparities in Access to Coverage in Hispanic/Latino Communities

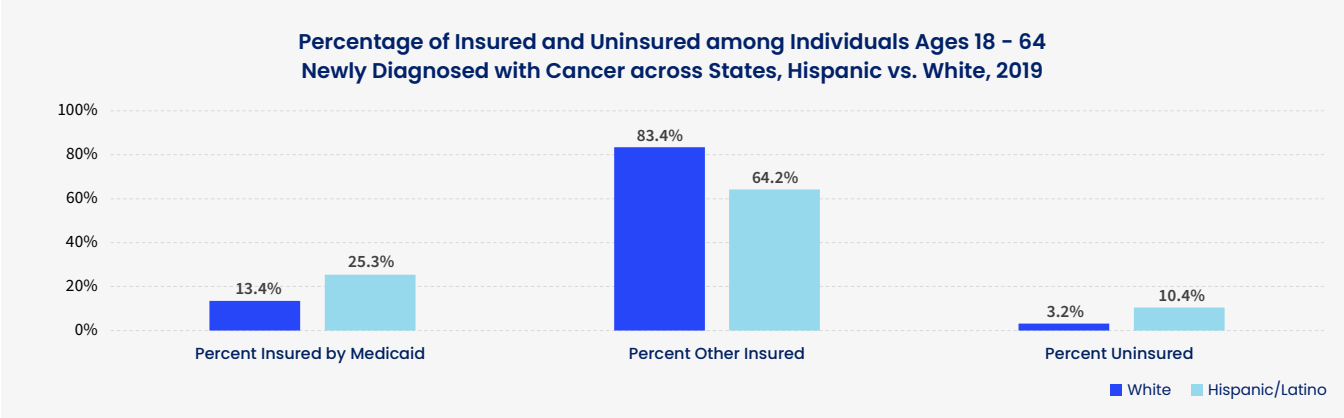
Maps 7 - 8: Distribution of Uninsured and Medicaid Insured Hispanic People Ages 0-64, 2023

These interactive maps can be viewed at the following link here. One map shows the rates of Hispanic people who are uninsured and the other map shows those who are insured by Medicaid from the ages of zero to 64 years. People facing cancer and survivors who are uninsured – or don't have health insurance – have high health care costs, poor access to care, poor cancer outcomes and experience a great amount of financial hardship. The health coverage provided by Medicaid helps to improve outcomes and reduce the burden of cancer by offering timely access to cancer prevention, screening and early detection services, as well as affordable treatment services and care.

Figure 20: Percentage of Insured and Uninsured among Individuals Ages 18 - 64 Newly Diagnosed with Cancer across States, Hispanic vs. White, 2019

The percentage of Medicaid coverage was higher among Hispanic (25.3%) compared with non-Hispanic White (13.4%), however Hispanic individuals ages 18 – 64 (10.4%) also had higher uninsured rates compared with non-Hispanic White (3.2%) individuals diagnosed with cancer. Moreover, Hispanic individuals were less likely to have other forms of insurance, such as private insurance or Medicare than their White counterparts.

More than half of Hispanic individuals with a history of cancer, ages 18-64, do not have private insurance and instead are insured by Medicaid, other public insurance, some other type of coverage or are uninsured.[23]

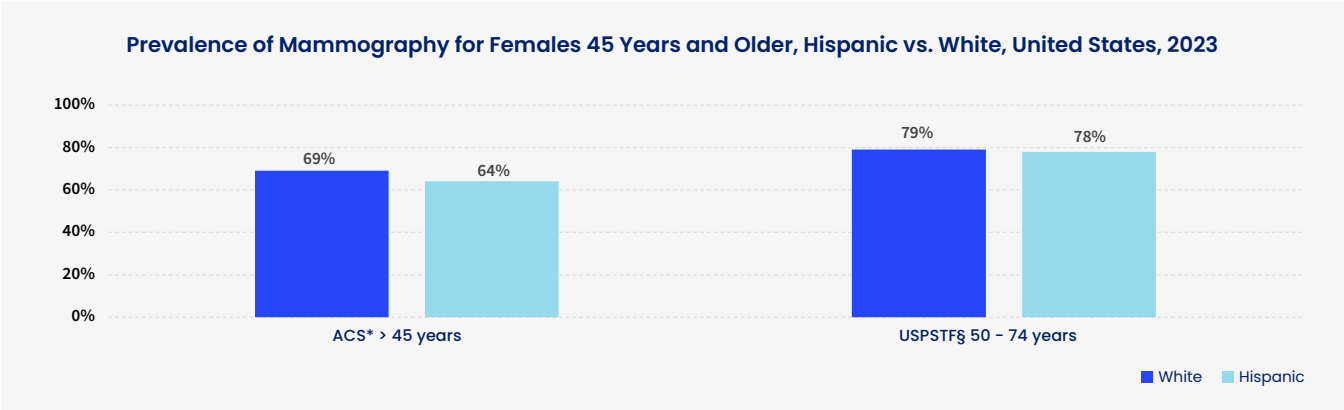


Notes: Percentages were calculated excluding cancer cases with unknown insurance status.
Source: Cancer Incidence in North America (CiNA) 2010–2019 compiled by the North American Association of Central Cancer Registries.

Disparities in Cancer Prevention, Screening, and Early Detection in Hispanic/Latino Communities

Figure 21: Prevalence of Mammography for Females 45 Years and Older, Hispanic vs. White, United States, 2023

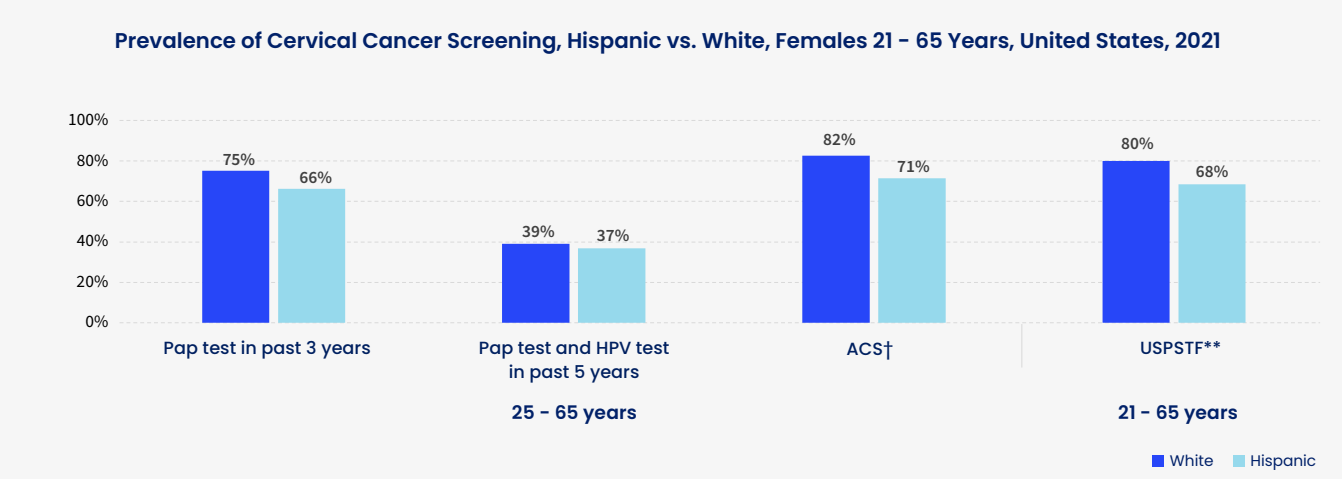
In 2023, prevalence of up-to-date screening according to the ACS guideline was lower among Hispanic females (64%) than White females (69%). This was also the case for USPSTF guidelines. The USPSTF recommendations were updated in 2024 and therefore not all recent USPSTF recommendation changes are yet measurable. For this reason, we report mammography prevalence per the 2016 USPSTF recommendations in this report. Historically, mammography prevalence has been lower in Hispanic females compared to White females. Recent immigrants in the U.S. fewer than ten years were another group with one of the lowest prevalence of up-to-date screening (54%) in 2023.[24]



Notes: All estimates except age and insurance are age adjusted to the year 2000 US population standard. *Mammogram within the past year (ages 45-54 years) or past 2 years (ages ≥55 years). Estimates are age adjusted using 3 age groups: 45-49, 50-64, and ≥65 years. §USPSTF 2016 recommendation: Mammogram within the past 2 years. Estimates are age adjusted using 2 age groups: 50-64, and 65-74 years. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2023.

Figure 22: Prevalence of Cervical Cancer Screening, Hispanic vs. White, Females 21-65 Years, United States, 2021

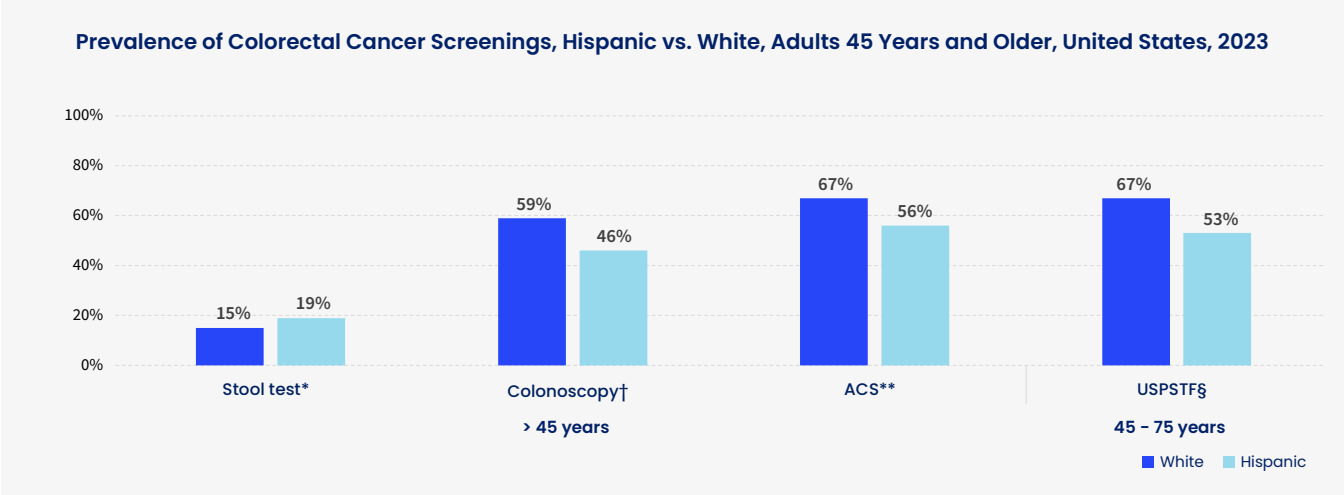
In 2021, the prevalence of up-to-date cervical cancer screening according to the ACS guideline among females 25-65 years was 78% overall and was higher among White (82%) than Hispanic females (71%). Historically, cervical cancer screening has been lower in Hispanic than White females. The utilization of cervical cancer screening in 2021 was also low (58%) among recent immigrants who had been in the U.S. fewer than ten years.



Notes: Estimates are age adjusted to the year 2000 US population standard. Up-to-date cervical cancer screening data are not available in the National Health Interview Survey 2023. †Pap test in the past 3 years or Pap test and HPV test or HPV test alone within the past 5 years among females 25-65 years. Pap test, combined Pap and HPV tests, ACS estimates, and USPSTF education estimates are age adjusted using 4 age groups: 25-29, 30-39, 40-49, and 50-65 years. **Pap test in the past 3 years among females 21-65 years or Pap test and HPV test or HPV test alone within the past 5 years among females 30-65 years. USPSTF estimates are age adjusted using 4 age groups: 21-29, 30-39, 40-49, and 50-65 years.
Source: Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2021.

Figure 23: Prevalence of Colorectal Cancer Screening, Hispanic vs. White, Adults 45 Years and Older, United States, 2023

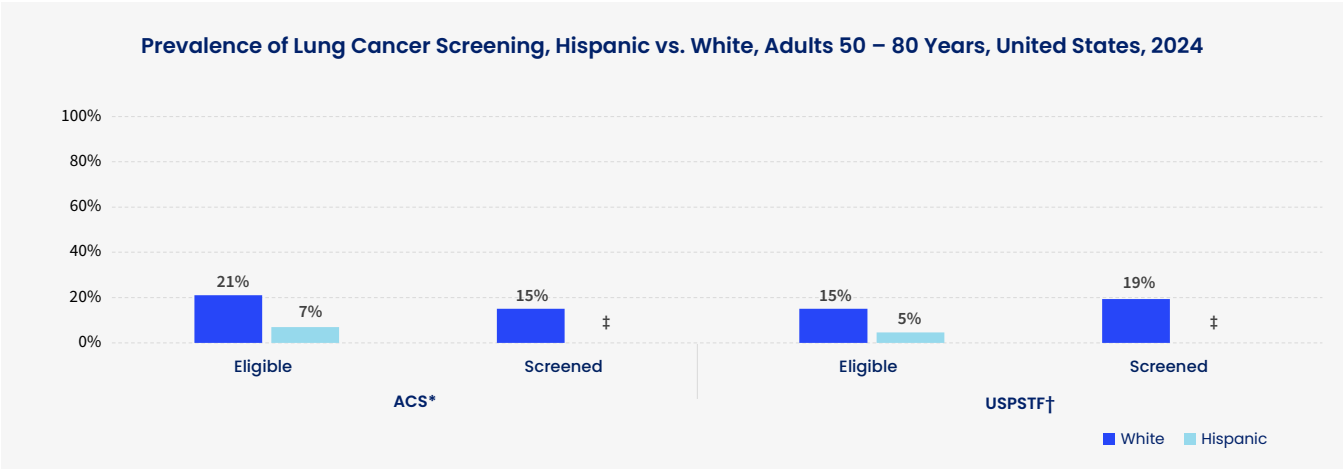
Historically and in 2023, up-to-date screening was higher among White (67%) and lower among Hispanic (56%) persons. Colorectal cancer screening prevalence was also low for immigrants in the U.S. fewer than ten years (43%).



Notes: *Stool tests, including fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past one year or multi-target stool DNA (sDNA) test, within the past three years. †Within the past ten years. **FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past one, five, ten, five and three years, respectively. Stool testing, colonoscopy, and ACS estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years. §FOBT/FIT, sigmoidoscopy, colonoscopy, CT colonography, or sDNA test in the past one, five, ten, five and three years, respectively, or sigmoidoscopy in the past ten years with FOBT/FIT in the past one year. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2023.

Figure 24: Prevalence of Lung Cancer Screening, Hispanic vs. White, Adults 50 – 80 Years, United States, 2024

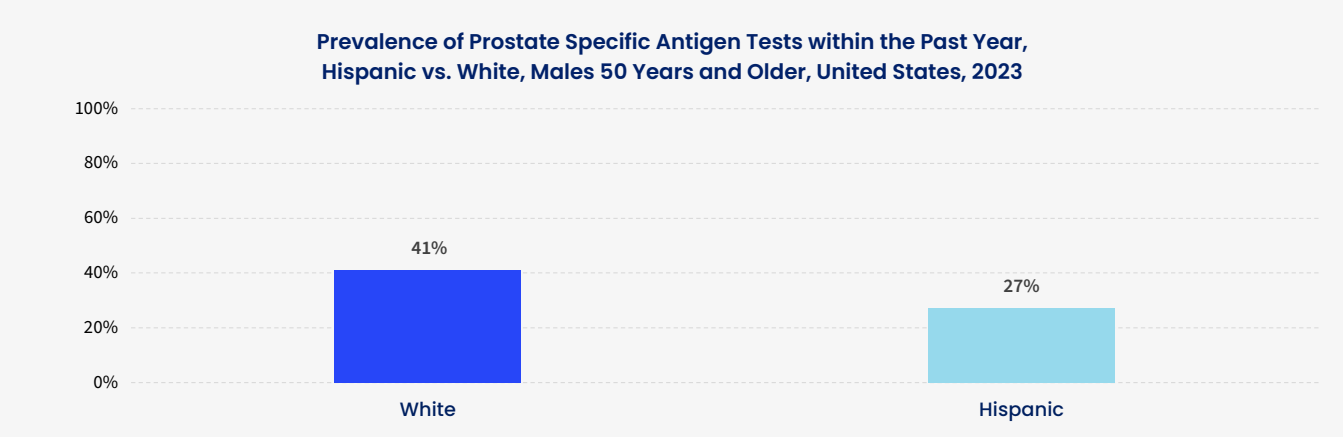
In 2024, only 15% of the more than 18 million adults eligible for lung cancer screenings were up to date with recommended screening in accordance with the ACS guideline. Lung cancer screening rates for both Hispanic and White people were similar. ACS' guidelines were updated in 2023 and the USPSTF updated its recommendations in 2021 in order to capture more groups of people who tend to have low pack-year histories but high risk of lung cancer, including Hispanic/Latino people. This was important because Latinx/Hispanics who smoke accumulate less pack-years history than Whites who smoke.[15] Thus, lowering the pack-year history will increase the number of high-risk adults who are eligible for lung cancer screening.



Notes: Estimates are age-adjusted to the year 2000 US population standard using 3 age groups: 50-59, 60-69, and 70-80 years. *The American Cancer Society recommends annual screening for lung cancer with a low-dose CT (LDCT) scan for people ages 50 to 80 years who smoke or used to smoke and have at least a 20 packyear history of smoking. †The USPSTF recommends annual screening for lung cancer with LDCT in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. ‡Estimates are statistically unstable and not shown. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2024.

Figure 25: Prevalence of Prostate Specific Antigen Tests within the Past Year, Hispanic vs. White, Males 50 Years and Older, United States, 2023

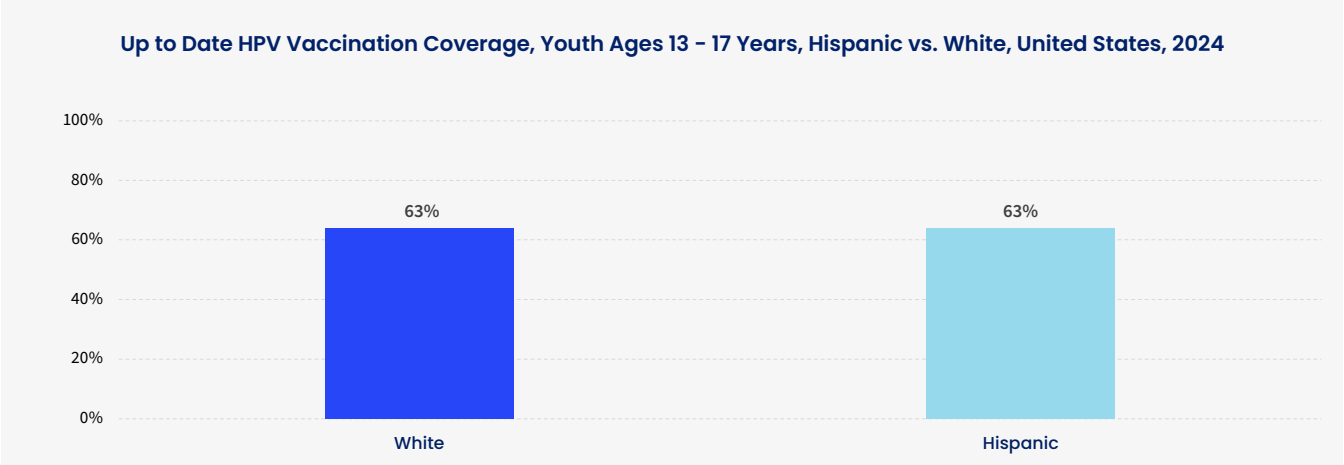
In 2023, the prevalence of prostate cancer screening in the past year was higher in White (41%) than Hispanic (27%) persons. Prostate cancer survival rates increase when it is detected early through testing like the prostate-specific antigen (PSA) test. However, prostate cancer screening recommendations have changed over time based on evidence of benefits and harms and current guidelines are in the process of being updated. Currently, guidelines stress the need for shared decision making between patient and clinician (i.e., discussion of potential benefits, risks, patient values and preferences) in screening decisions.[16,17]



Notes: Estimates are age adjusted to the year 2000 US population standard using two age groups: 50-64 and ≥65 years. Prostate cancer screening is defined among males who have not been diagnosed with prostate cancer. ACS (males 50+ years) screening guidelines recommend shared decision making between patient and provider to guide screening decisions for PSA testing.
Source: National Health Interview Survey, 2023.

Figure 26: Up to Date HPV Vaccination Coverage, Youth Ages 13 - 17 Years, Hispanic vs. White, United States, 2024

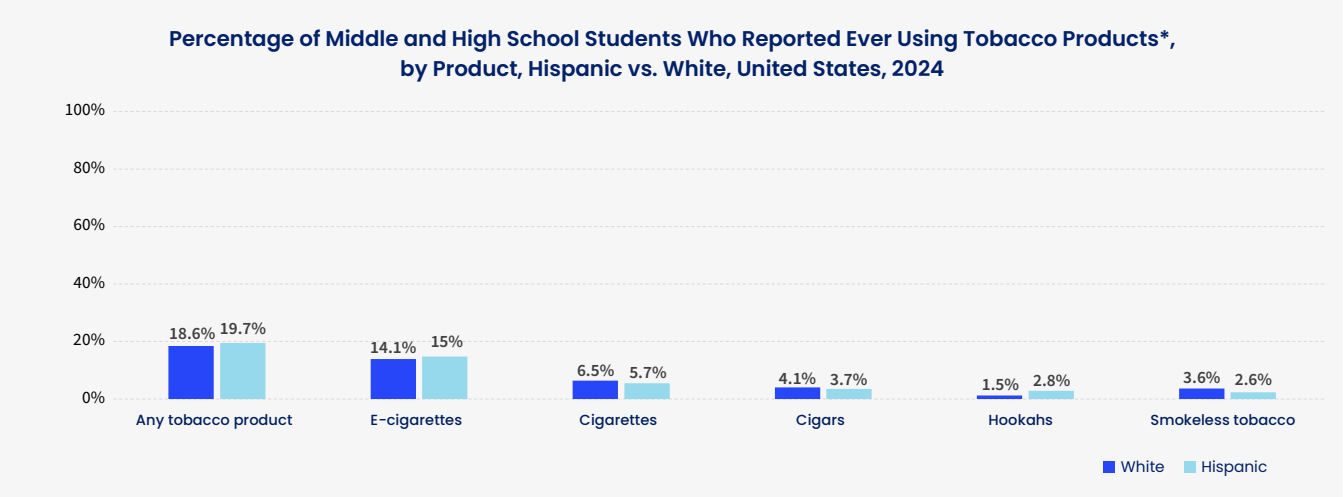
HPV vaccination is associated with population-level reductions in HPV infection, cervical cancer, and other HPV-associated cancers. [13,14,15,16] ACS' HPV vaccination guidelines were updated in 2020 to recommend routine vaccination for girls and boys starting at age nine. In 2024, the percentage of Hispanic youth ages 13 to 17 that were up to date on the HPV vaccine was the same as their White peers. Although HPV rates are similar between both groups, HPV vaccination rates vary year-to-year, especially when stratifying smaller sample sizes by race and ethnicity. Across most racial and ethnic groups, HPV vaccination showed an increasing trend until about 2021-2022 when rates then either stabilized or dropped amongst most groups.[25]



Notes: Up to date human papillomavirus vaccination in ages 13-17 years is defined as two doses separated by five months (minus four days) for immunocompetent adolescents initiating the human papillomavirus vaccine series before their 15th birthday, and three doses for all others.
Source: National Immunization Survey-Teen, 2024.

Figure 27: Percentage of Middle and High School Students Who Reported Ever Using Tobacco Products, by Product, Hispanic vs. White, United States, 2024

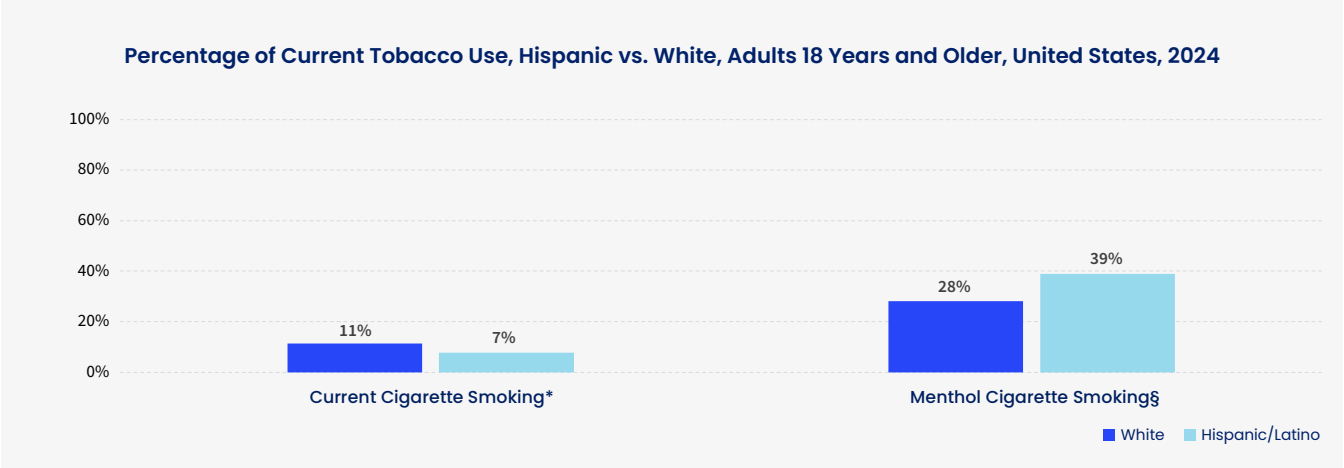
This chart shows that Hispanic students reported using tobacco products at rates comparable to their White counterparts.



Notes: *Ever use is defined as ever having used the product, even once or twice. Because of missing data on the ever use questions, denominators for each tobacco product might differ. For each question, response options were "yes" or "no." Overall estimates were reported based on 22,069 U.S. middle and high school students. Cigars were defined as cigars, cigarillos, or little cigars. Smokeless tobacco (composite) was defined as chewing tobacco, snuff, dip, or snus. Any combustible tobacco product use was defined as use of one or more of the following tobacco products: cigarettes, cigars, hookahs, pipe tobacco, or bidis.
Source: National Youth Tobacco Survey, 2024.

Figure 28: Percentage of Current Tobacco Use, Hispanic vs. White, Adults 18 Years and Older, United States, 2024

In 2024, about 36% of those currently smoking reported using menthol-flavored cigarettes, but this proportion was 39% in Hispanic persons compared to 28% in White persons.

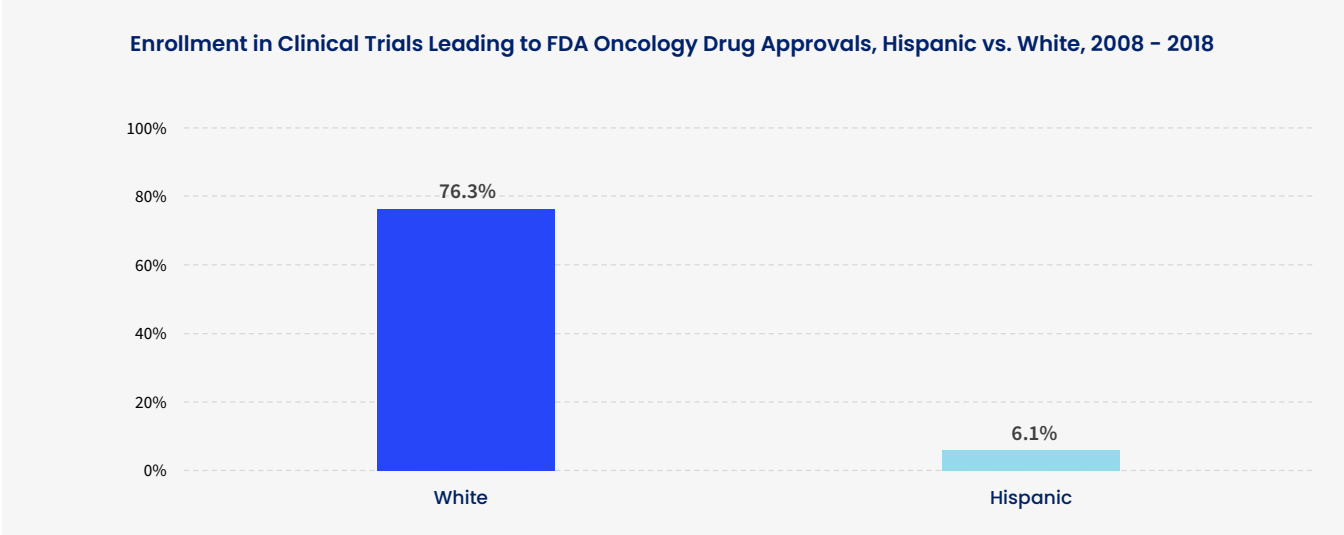


Notes: *Ever smoked 100 cigarettes in lifetime and currently smoke every day or some days. §Of those who currently smoke, those who usually smoked menthol cigarettes.
Source: National Health Interview Survey, 2024.

Disparities in Clinical Trial Participation in Hispanic/Latino Communities

Figure 29: Enrollment in Clinical Trials Leading to FDA Oncology Drug Approvals, Hispanic vs. White, 2008 – 2018

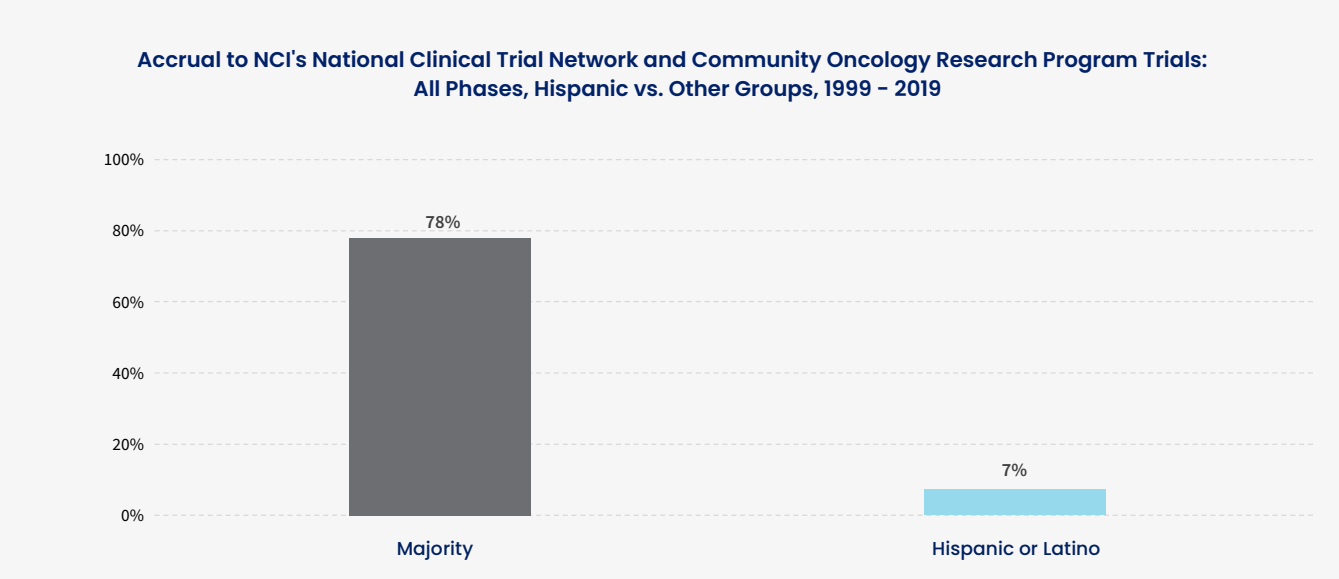
Compared to their cancer burden, some racial and ethnic populations in the U.S. are vastly underrepresented in cancer clinical trials that support new drug approvals. The majority of trials supporting these approvals occur outside of the U.S., which drives the lack of representation. Underrepresentation of minority populations will prevent generalizability of the findings to the target populations, and preclude characterizing potential differences related to safety or efficacy in these populations. The chart below shows the percentage of patients enrolled in Federal Drug Administration (FDA) drug approval trials from 2008-2018 which reported on patients of the assessed races.



Source: Loree JM, Anand S, Dasari A, et al. Disparity of Race Reporting and Representation in Clinical Trials Leading to Cancer Drug Approvals From 2008 to 2018. JAMA Oncol. 2019;5(10):e191870. doi:10.1001/jamaoncol.2019.1870.

Figure 30: Accrual to NCI's National Clinical Trial Network and Community Oncology Research Program Trials: All Phases, Hispanic vs. Other Groups, 1999-2019

Although participation from racial and ethnic minority patients in National Cancer Institute (NCI)-sponsored trials increased over 20 years from 1999-2019, these groups remain underrepresented in clinical trials compared to members of non-minority populations.[26] Studies have shown that the representation of minority populations in U.S. clinical trials do not match the proportional cancer burden in those populations.[27,38] In oncology, structural issues outside a patient's control are the overwhelming cause of low and unequal trial participation, even though most patients, when asked, would participate in a trial.[28,29] Specific trial design and infrastructure elements such as inclusion/exclusion criteria, where trials are offered, whether providers screen and refer patients, and participant burdens (e.g., costs, time, and travel needs) lead to low or inequitable trial enrollment. The chart below shows the percentage of patients enrolled in NCI's National Clinical Trial Network (NCTN) and National Community Oncology Research Program (NCORP) clinical trials from 1999-2019.



Notes: Minority and majority categorization according to 2020 Census definitions of race and ethnicity.
Source: McCaskill Stevens, W. (2020) Participation by minority racial, ethnic groups in NCI-funded trials nearly doubles in 20 years. Cancer Letter 46 https://cancerletter.com/the-cancer-letter/20200626_1/.

Disparities in Asian, Asian American, Native Hawaiian and Pacific Islander (AANHPI) Communities

In 2021, approximately 24 million Asian American and 1.7 million Native Hawaiian and Pacific Islander (NHPI) individuals (single or mixed race) lived in the U.S., representing about 8% of the total U.S. population. Aside from multiracial people, Asian Americans are the fastest-growing population in the U.S. Between 2016 and 2060, the population size of Asian Americans in the U.S. is projected to double, mostly due to international migration.[30]

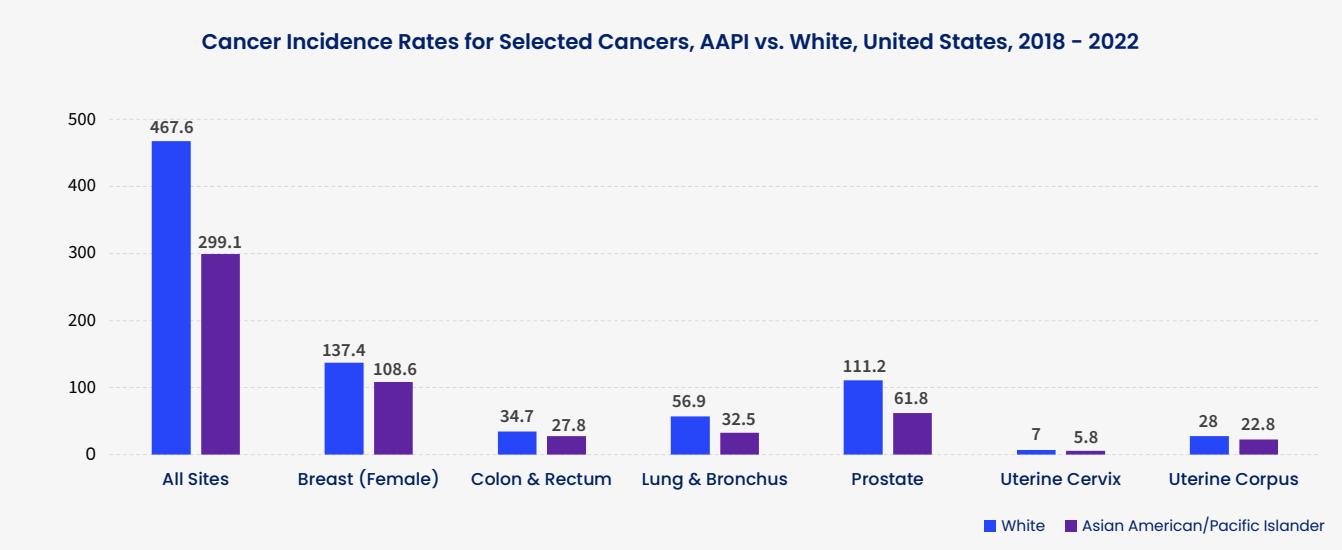
Cancer is the leading cause of death in Chinese, Filipino, Korean and Vietnamese individuals, ranks second in Asian Indian, Native Hawaiian and Japanese individuals, and third in Samoan individuals. The stage at cancer diagnosis varies widely among Asian American and NHPI ethnic groups and cancer screening is generally lower among Asian American individuals compared to the White population.

Health statistics are often presented in aggregate for the Asian American and NHPI populations, masking vast differences and disparities in their respective cancer burden. The cancer profile differs among Asian American ethnic groups because of variations in immigration patterns, behavior, culture, exposures in countries of origin and social determinants of health.[31]

Disparities in Cancer Incidence, Mortality and Survival in AANHPI Communities

Figure 31: Cancer Incidence Rates for Selected Cancers, AAPI vs. White, United States, 2018 – 2022

Even though AANHPI people as a population have lowest cancer and mortality rates for most common cancers, aggregated data masks disparities within this heterogeneous population.

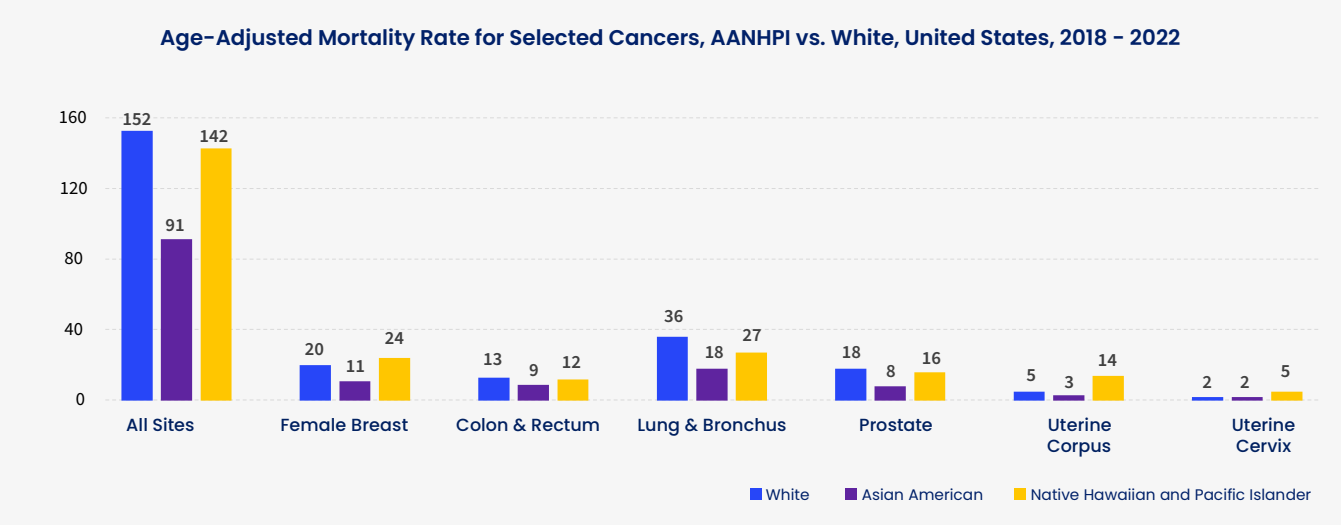


Notes: Rates are per 100,000 and age adjusted to the 2000 U.S. standard population; Uterine corpus incidence rates are adjusted for delays in reporting. All race groups are exclusive of Hispanic origin. **Source:** North American Association of Central Cancer Registries, 2024.

Figure 32: Age Adjusted Mortality Rate Among Asian American, Native Hawaiian and Other Pacific Islander People vs. White People for Selected Cancers, United States, 2018 – 2022

Asian American people have a 40% lower overall cancer death rate than White people but are twice as likely to die from stomach cancer and 30% more likely to die from liver cancer.

Disparities in the NHPI population are more striking. Despite having a 7% lower overall cancer mortality compared to White people, the NHPI death rate is about 20% higher for breast cancer and about two to three-fold higher for liver, cervical and uterine corpus cancers.



Notes: Rates are per 100,000, age adjusted to the 2000 U.S. standard population, rounded to the nearest whole number and exclude individuals of Hispanic ethnicity.**Source:** National Center for Health Statistics, 2025.

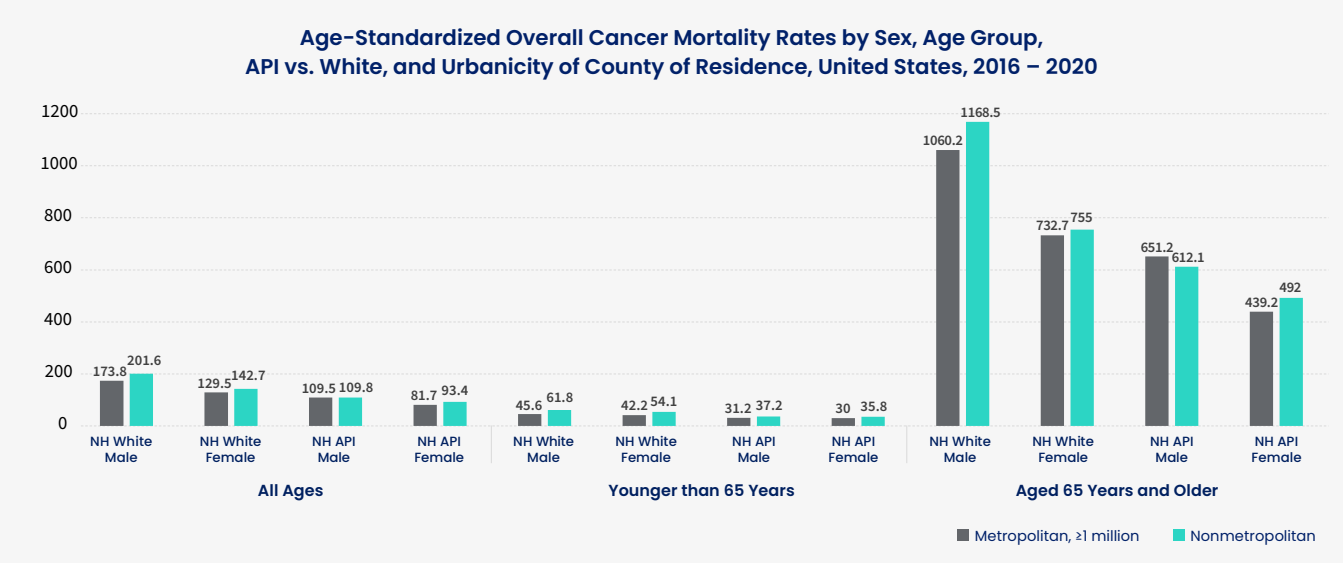
Maps 9 - 10: Rates of Cancer Incidence and Mortality for Asian Pacific Islander People by State

These interactive maps can be viewed at the following link here. One map shows the rates of cancer incidence and the other shows rates of mortality for Asian Pacific Islander people across the U.S. for selected cancer types, including breast, cervix, colon and rectum, lung and bronchus, prostate and uterus and can also be filtered to further show demographics by state and based on sex.

Mortality and incidence rates are retrieved from State Cancer Profile, a collaboration between the National Cancer Institute and Centers for Disease Control and Prevention, and are updated based on the most recent releases available on their website: https://statecancerprofiles.cancer.gov/.

Figure 33: Age-Standardized Overall Cancer Mortality Rates by Sex, Age Group, API vs. White, Urbanicity of County of Residence, United States, 2016 – 2020

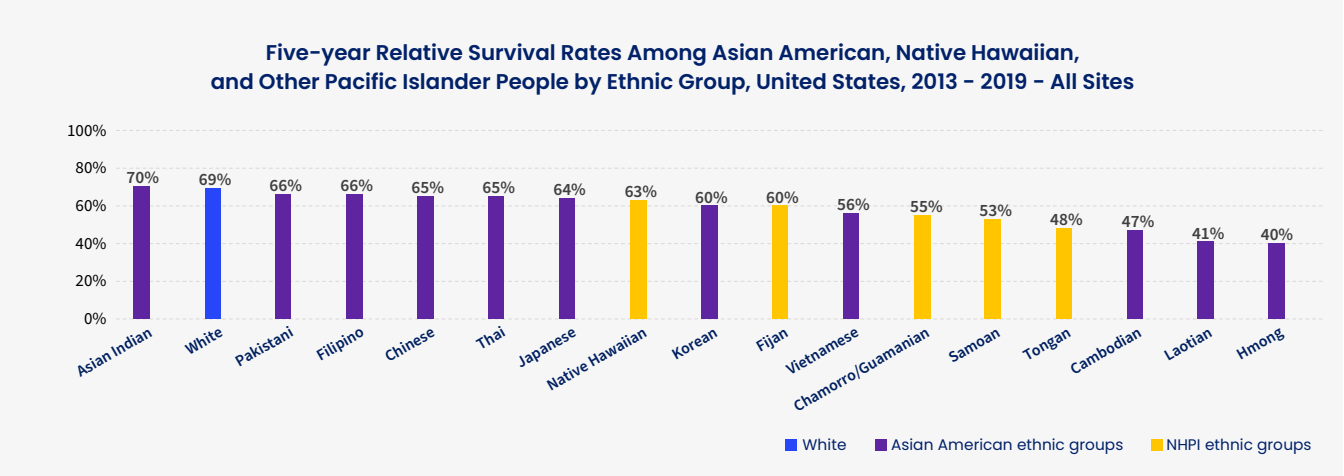
Overall cancer mortality rates were higher in nonmetropolitan areas than in large metropolitan areas among both males and females across all evaluated racial/ethnic groups, including AANHPI individuals.



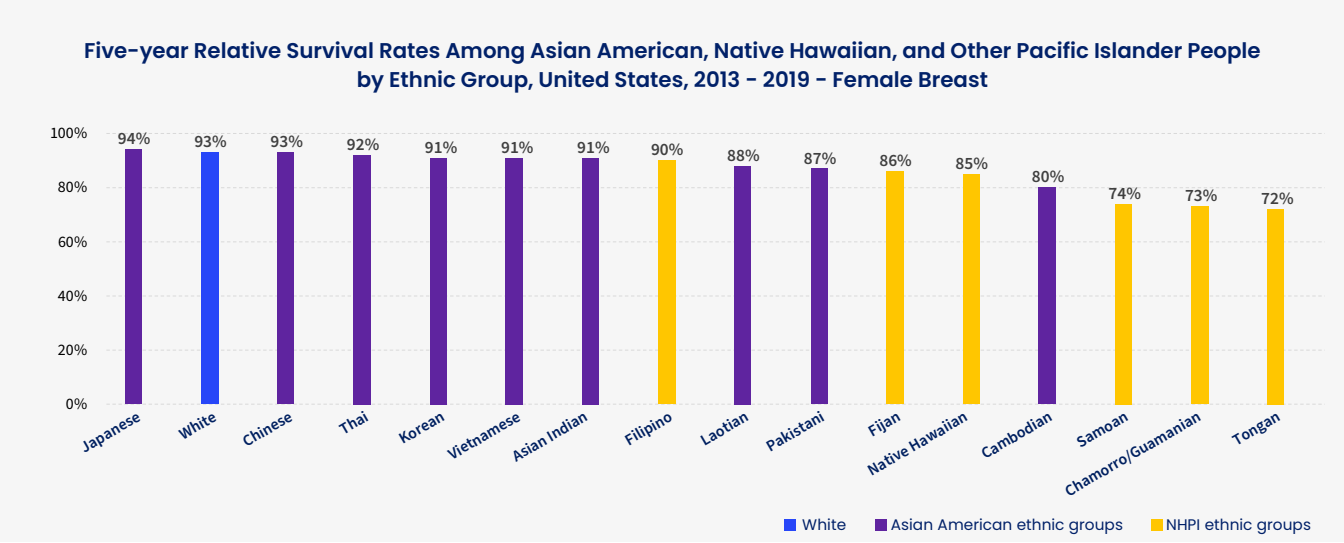
Notes: Rates are per 100,000 population and age adjusted to the 2000 U.S. standard population.
Source: National Center for Health Statistics 2025.

Figures 34 - 38: Five-year Relative Survival Rates Among Asian American, Native Hawaiian and Other Pacific Islander People by Ethnic Group and Cancer Type, United States, 2013 - 2019

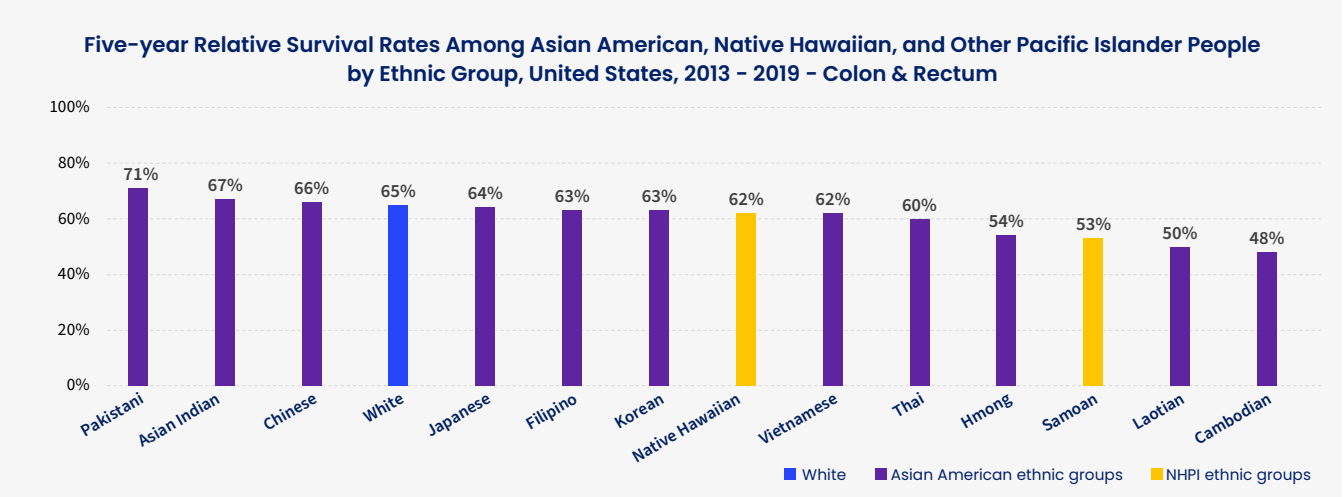
Apart from Asian Indian people, Asian American and NHPI ethnic groups have lower overall five-year relative cancer survival compared to White people (69%), with rates as low as 40% to 48% among Hmong, Laotian, Cambodian and Tongan people.



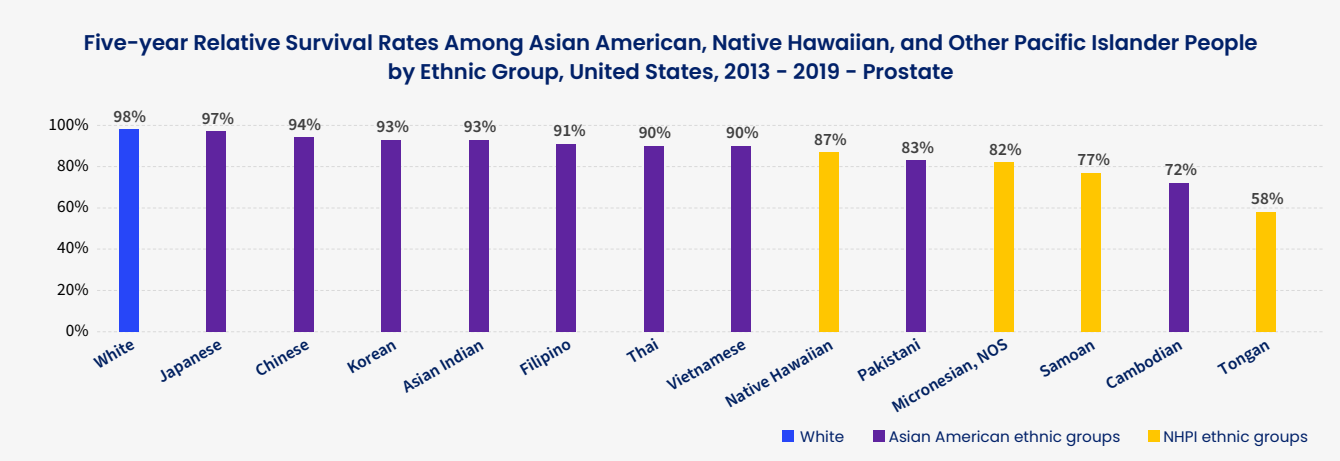
For breast cancer, five-year relative survival ranges from 72%-74% in Tongan, Chamorro/Guamanian and Samoan women to 94% in Japanese women (93% in White women).



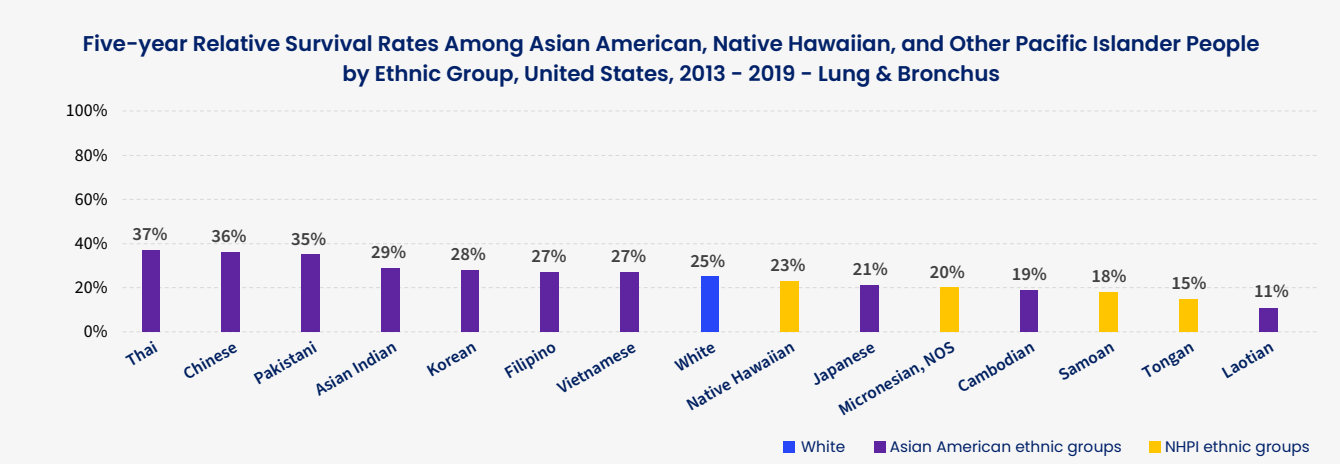
Colorectal cancer survival ranges from 48% in Cambodian people to 71% in Pakistani people (65% in White people).



Asian American and NHPI ethnic groups have a lower five-year relative cancer survival for prostate cancer compared to White people.



Five-year relative survival for lung cancer is higher in many Asian American ethnic groups than in White people (25%), including 35% to 37% in Pakistani, Chinese and Thai people.



Notes: All estimates exclude individuals of Hispanic ethnicity. Excludes ethnic groups with fewer than 50 cases.
Source: Surveillance, Epidemiology, and End Results Program, 2023.

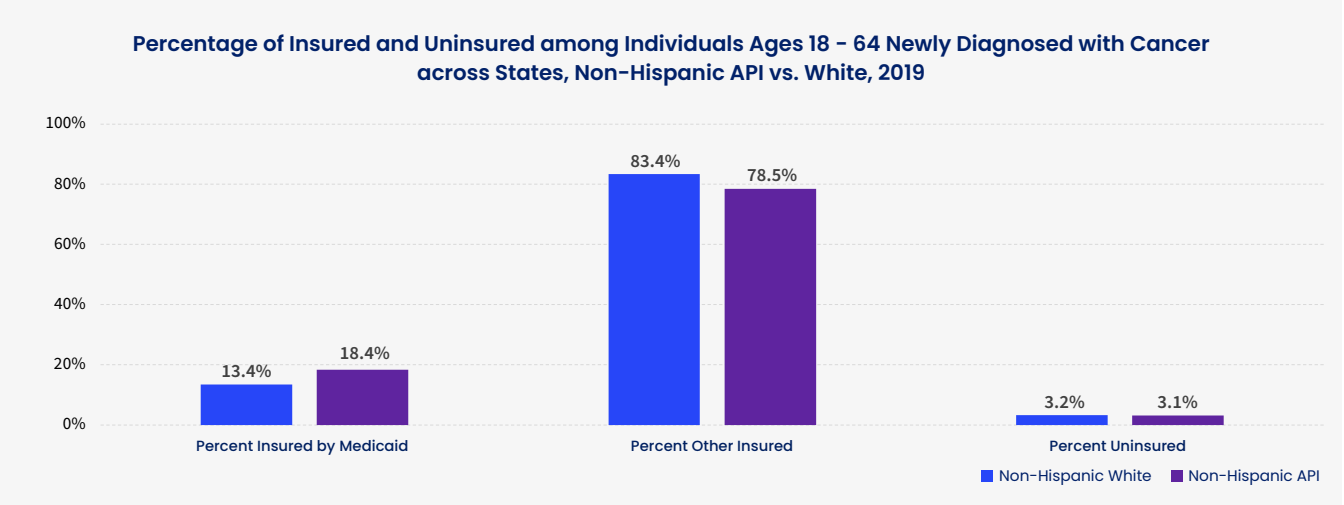
Disparities in Access to Coverage in AANHPI Communities

Maps 11 - 12: Distribution of Uninsured and Medicaid Insured Asian, Native Hawaiian and Pacific Islander People Ages 0-64, 2023

These interactive maps can be viewed at the following link here. One map shows the rates of AANHPI people who are uninsured and those who are insured by Medicaid from the ages of zero to 64 years. People facing cancer and survivors who are uninsured – or don't have health insurance – have high health care costs, poor access to care, poor cancer outcomes and experience a great amount of financial hardship. The health coverage provided by Medicaid helps to improve outcomes and reduce the burden of cancer by offering timely access to cancer prevention, screening and early detection services, as well as affordable treatment services and care.

Figure 39: Percentage of Insured and Uninsured among Individuals Ages 18 - 64 Newly Diagnosed with Cancer across States, Non-Hispanic API vs. White, 2019

The percentage of Medicaid coverage was higher among non-Hispanic API (18.4%) people compared with non-Hispanic White people (13.4%) aged 18 – 64 years. However, non-Hispanic API people were less likely to have other forms of insurance, such as private insurance or Medicare than their White counterparts.

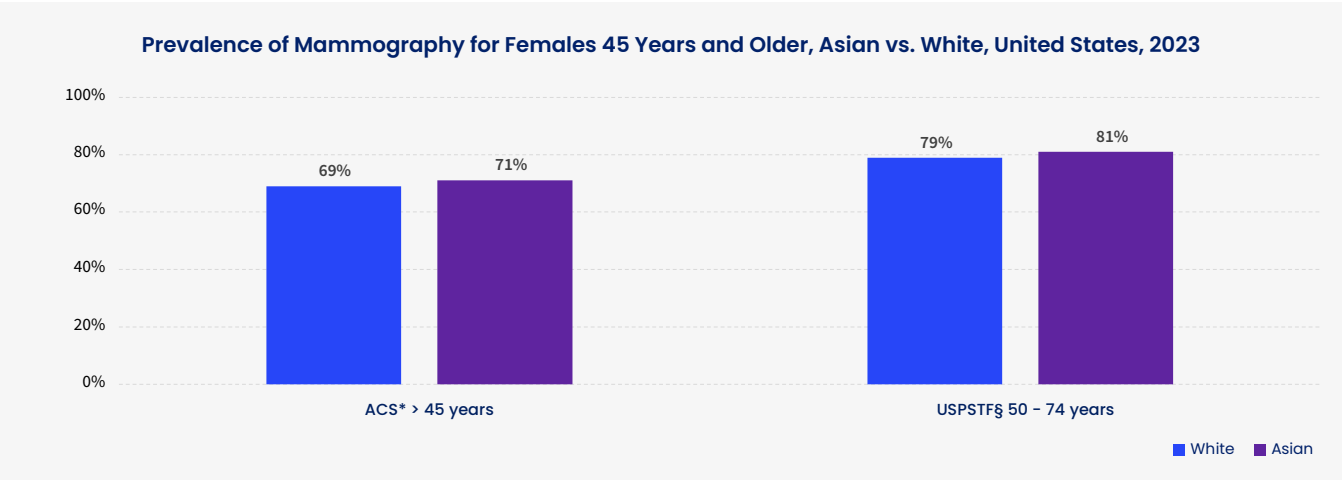


Notes: Percentages were calculated excluding cancer cases with unknown insurance status.
Source: Cancer Incidence in North America (CiNA) 2010 – 2019 compiled by the North American Association of Central Cancer Registries.

Disparities in Cancer Prevention, Screening and Early Detection in AANHPI Communities

Figure 40: Prevalence of Mammography for Females 45 Years and Older, Asian vs. White, United States, 2023

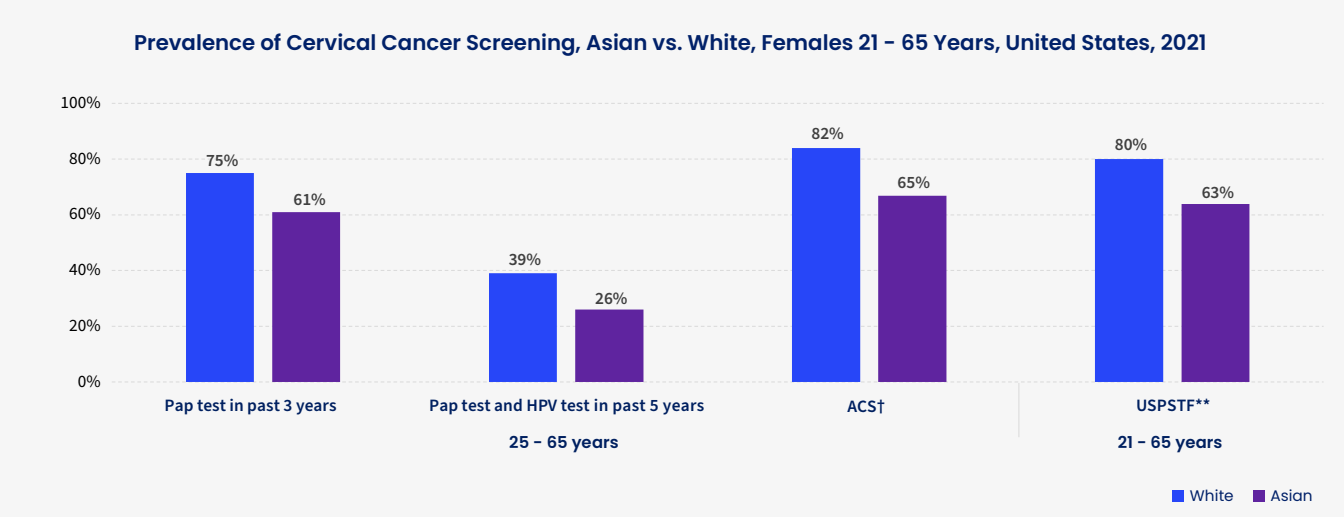
In 2023, prevalence of up-to-date screening according to the ACS guidelines was slightly lower among White (69%) than Asian (71%) females. This was also the case for USPSTF guidelines. The USPSTF recommendations were updated in 2024 and therefore not all recent USPSTF recommendation changes are yet measurable. For this reason, we report mammography prevalence per the 2016 USPSTF recommendations in this report.



Notes: *ACS Recommendation: Mammogram within the past year (ages 45-54 years) or past two years (ages ≥55 years). Estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. §USPSTF 2016 Recommendation: Mammogram within the past two years. Estimates are age adjusted using two age groups: 50-64, and 65-74 years.
Source: National Health Interview Survey, 2023.

Figure 41: Prevalence of Cervical Cancer Screening, Asian vs. White, Females 21-65 Years, United States, 2021

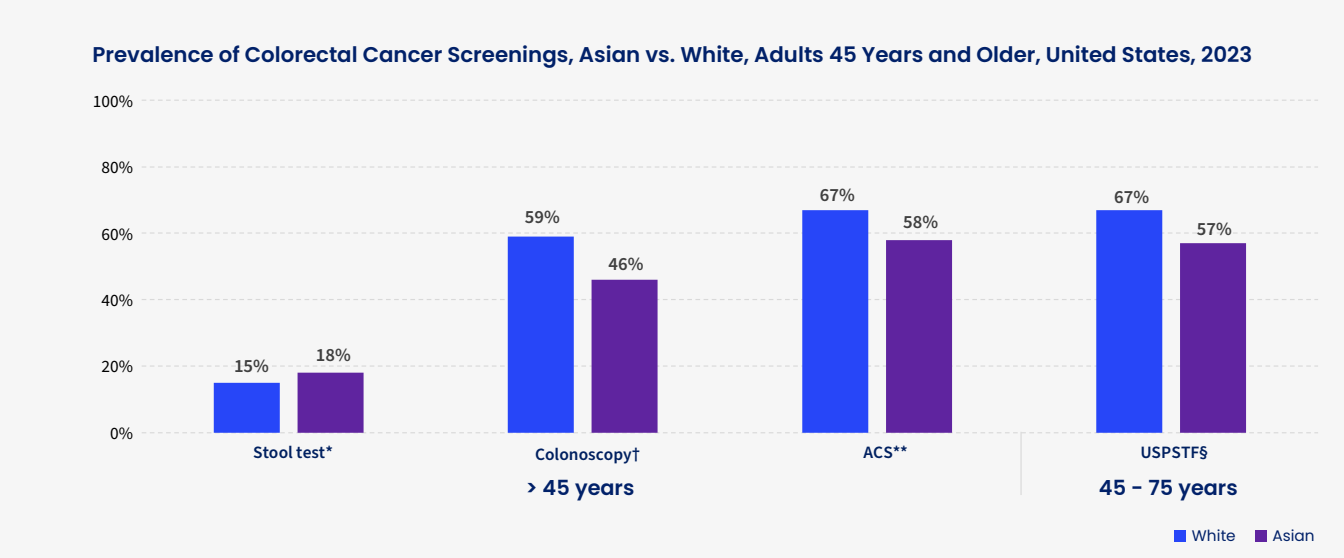
In 2021, the prevalence of up-to-date cervical cancer screening according to the ACS guideline among females 25-65 years was 78% overall and was similar among White (82%), but lower among Asian (65%) females. Historically, cervical cancer screening has been lower in Asian than White females.



Notes: All estimates except age and insurance are age adjusted to the year 2000 US population standard. *Mammogram within the past year (ages 45-54 years) or past 2 years (ages ≥55 years). Estimates are age adjusted using 3 age groups: 45-49, 50-64, and ≥65 years. §USPSTF 2016 recommendation: Mammogram within the past 2 years. Estimates are age adjusted using 2 age groups: 50-64, and 65-74 years.
Source: Cancer Prevention and Early Detection Facts and Figures, 2026. Atlanta: American Cancer Society; *2026;* and National Health Interview Survey, 2023

Figure 42: Prevalence of Colorectal Cancer Screening, Asian vs. White, Adults 45 Years and Older, United States, 2023

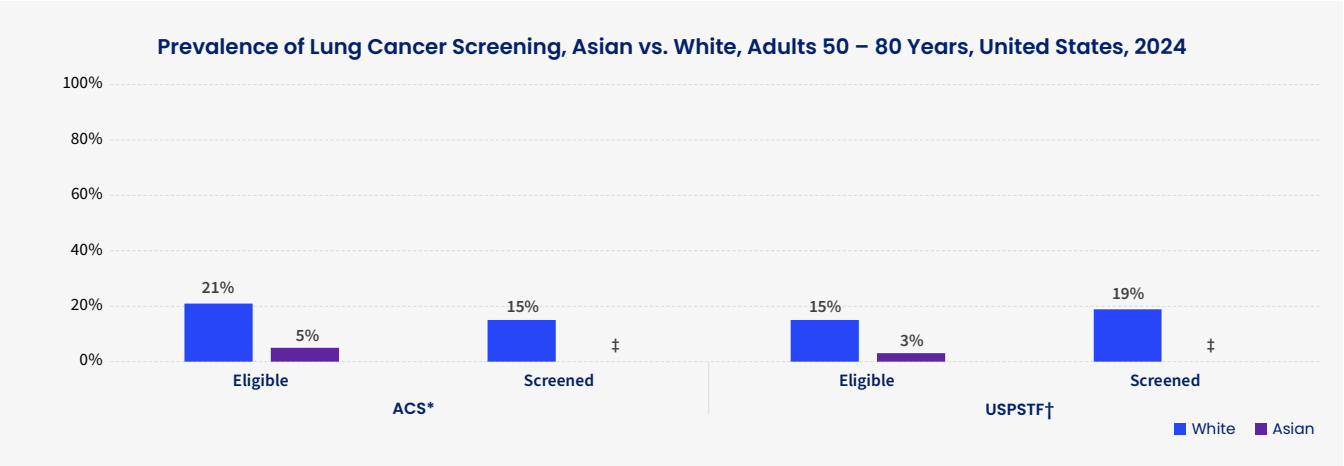
Historically and in 2023, up-to-date screening was highest among White (67%) people by race/ethnicity and lower among Asian (58%) people.



Notes: *Stool tests, including fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past one year or multi-target stool DNA (sDNA) test, within the past three years. †Within the past ten years. **ACS Recommendation: FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past one, five, ten, five and three years, respectively. Stool testing, colonoscopy, and ACS estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. §USPSTF Recommendation: FOBT/FIT, sigmoidoscopy, colonoscopy, CT colonography, or sDNA test in the past one, five, ten, five and three years, respectively, or sigmoidoscopy in the past ten years with FOBT/FIT in the past one year. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2023.

Figure 43: Prevalence of Lung Cancer Screening, Asian vs. White, Adults 50 – 80 Years, United States, 2024

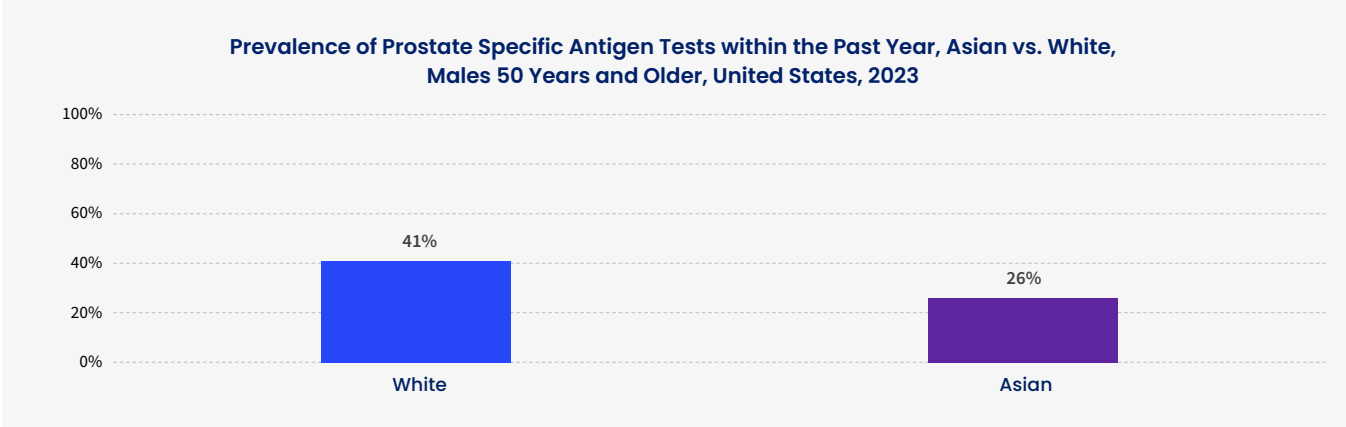
In 2021, the USPSTF updated their lung cancer screening recommendation by lowering the recommended age to begin screening to age 50 years (from age 55 years) and the pack-year threshold to 20 years (from 30 years). ACS' guidelines were updated in 2023. These guideline changes were in order to capture more groups of people who tend to have low pack-year histories but high risk of lung cancer, including Asian people. Thus, lowering the pack-year history will increase the number of high-risk adults who are eligible for lung cancer screening. Lung cancer screening among Asian people was not available per ACS guidelines nor USPSTF.



Notes: Estimates are age-adjusted to the year 2000 US population standard using 3 age groups: 50-59, 60-69, and 70-80 years. *The American Cancer Society recommends annual screening for lung cancer with a low-dose CT (LDCT) scan for people ages 50 to 80 years who smoke or used to smoke and have at least a 20 packyear history of smoking. †The USPSTF recommends annual screening for lung cancer with LDCT in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. ‡Estimates are statistically unstable and not shown. **Source:** National Health Interview Survey, 2024.

Figure 44: Prevalence of Prostate Specific Antigen Tests within the Past Year, Asian vs. White, Males 50 Years and Older, United States, 2023

In 2023, the prevalence of prostate cancer screening was higher in White (41%) than Asian (26%) people. Prostate cancer survival rates increase when it is detected early through testing like the prostate-specific antigen (PSA) test. However, prostate cancer screening recommendations have changed over time based on evidence of benefits and harms, and current guidelines are in the process of being updated. Currently, guidelines stress the need for shared decision making between patient and clinician (i.e., discussion of potential benefits, risks, patient values and preferences) in screening decisions.[16,17]



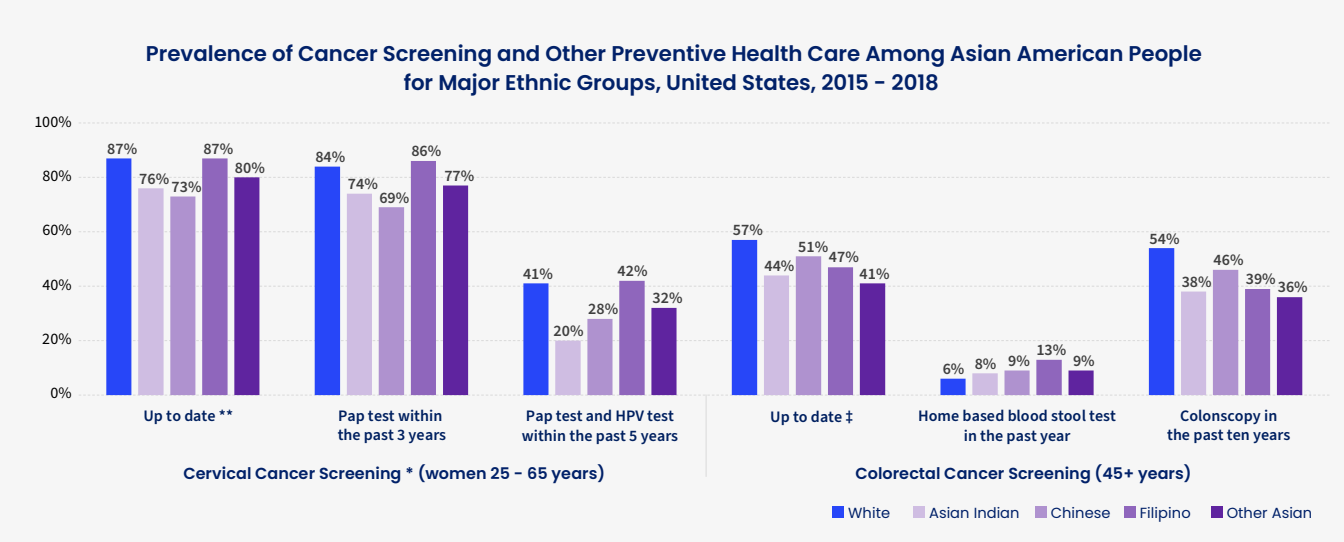
Notes: Prostate cancer screening is defined among males who have not been diagnosed with prostate cancer. Estimates are age adjusted to the year 2000 US population standard using two age groups: 50-64 and ≥65 years. ACS (males 50+ years) screening guidelines recommend shared decision making between patient and provider to guide screening decisions for PSA testing.
Source: National Health Interview Survey, 2023.

Figure 45: Prevalence of Cancer Screening and Other Preventive Health Care Among Asian American People for Major Ethnic Groups, United States, 2015-2018

Cancer screening is generally lower among the most populous ethnic groups among the Asian American population compared to the White population. For example, based on the National Health Interview Survey, prevalence of cervical cancer screening with the Pap test was 69% among Chinese women and 74% among Asian Indian women versus 84% among White women.

Up-to-date colorectal cancer screening in people aged 45 years and older ranged from 44% in Asian Indian people to 51% in Chinese people, compared to 57% in White individuals; however, uptake of stool testing was higher in Asian ethnic groups, ranging from 8% in Asian Indian people to 13% in Filipino people compared to 6% in White people.

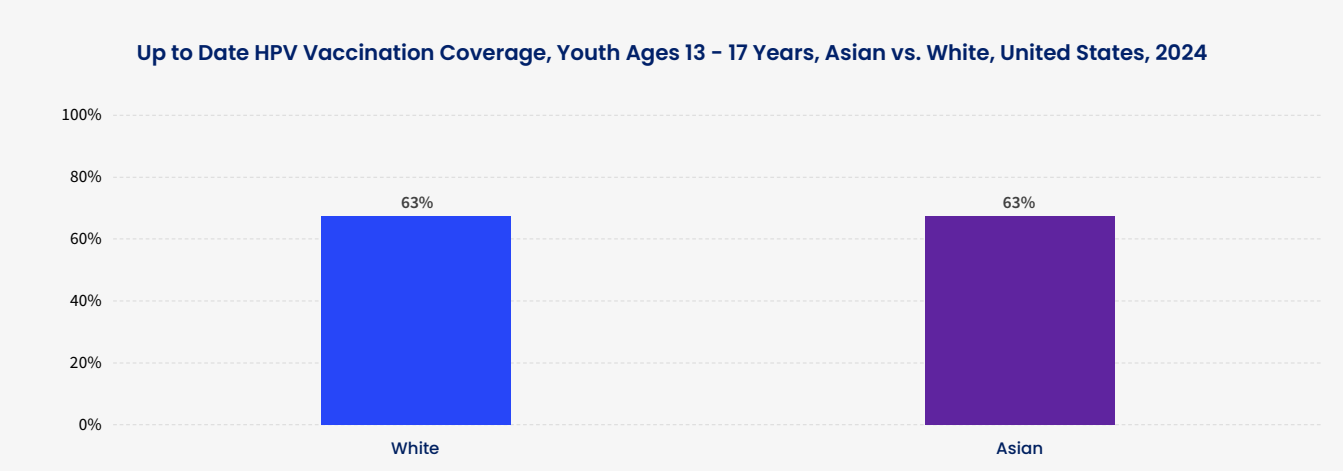
Unfortunately, publicly available national survey data did not contain information on cancer screening and other preventative health care for the NHPI ethnic groups.



Notes: *Among women with intact uterus. **Pap test in the past three years OR Pap test and HPV test within the past five years among women ages 25-65 years. ‡For ages ≥45 years: Fecal occult blood test (FOBT)/fecal immunochemical test (FIT), sigmoidoscopy, colonoscopy, OR computed tomography (CT) colonography, in the past one, five, ten, and five years, respectively.
Source: National Health Interview Survey, 2015-2018.

Figure 46: Up to Date HPV Vaccination Coverage, Youth Ages 13 - 17 Years, Asian vs. White, United States, 2024

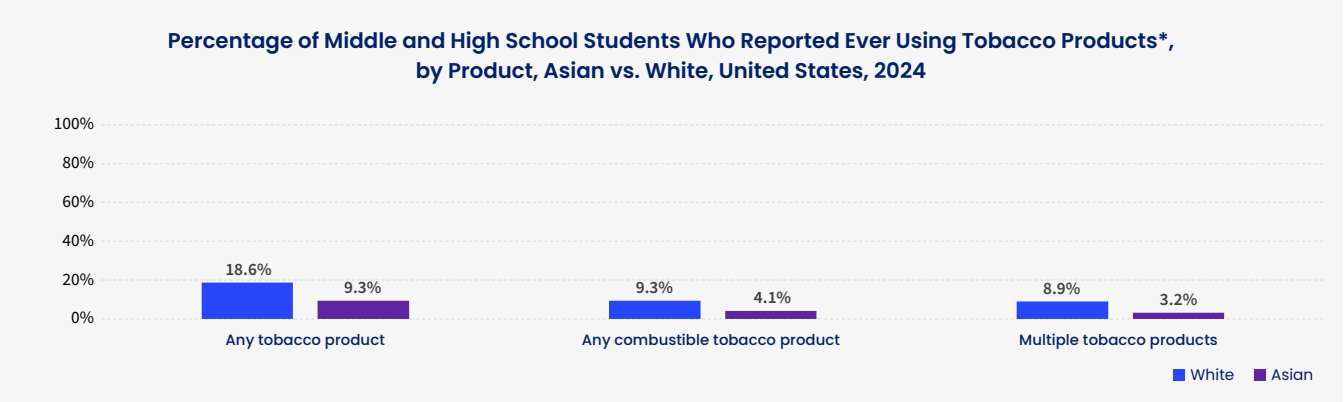
HPV vaccination is associated with population-level reductions in HPV infection, cervical cancer, and other HPV-associated cancers.[13,14,15,16] ACS' HPV vaccination guidelines were updated in 2020 to recommend routine vaccination for girls and boys starting at age nine. In 2024, the percentage of Asian youth ages 13 to 17 that were up to date on the HPV vaccine was the same as their White peers. Although HPV rates are similar between both groups, HPV vaccination rates vary year-to-year, especially when stratifying smaller sample sizes by race and ethnicity. Across most racial and ethnic groups, HPV vaccination showed an increasing trend until about 2021-2022 when rates then either stabilized or dropped amongst most groups.[34]



Notes: Up to date human papillomavirus vaccination in ages 13-17 years is defined as two doses separated by five months (minus four days) for immunocompetent adolescents initiating the human papillomavirus vaccine series before their 15th birthday, and three doses for all others.
Source: National Immunization Survey-Teen, 2024.

Figure 47: Percentage of Middle and High School Students Who Reported Ever Using Tobacco Products, by Product, Asian vs. White, United States, 2024

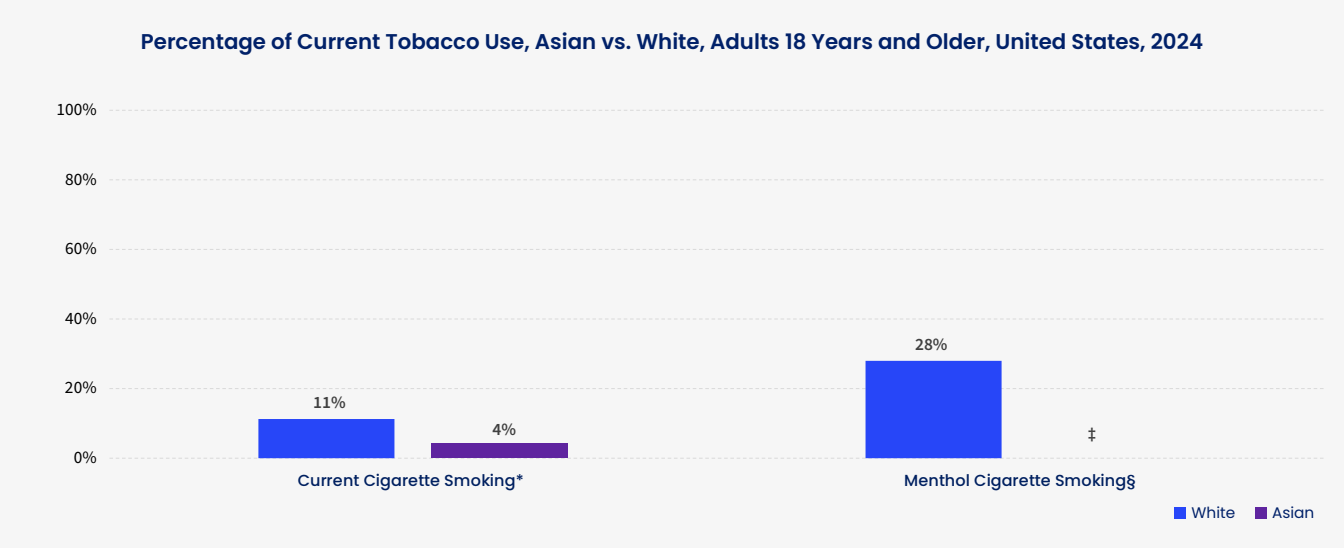
Asian students reported using certain tobacco products at lower rates than their White counterparts. Other estimates among Non-Hispanic Asian and Non-Hispanic Native Hawaiian or other Pacific Islander students were statistically unreliable and are not presented in this figure.



Notes: *Ever use is defined as ever having used the product, even once or twice. Because of missing data on the ever use questions, denominators for each tobacco product might differ. For each question, response options were "yes" or "no." Overall estimates were reported based on 22,069 U.S. middle and high school students. Any combustible tobacco product use was defined as use of one or more of the following tobacco products: cigarettes, cigars, hookahs, pipe tobacco, or bidis. Multiple tobacco product use was defined as use of two or more of the following tobacco products: e-cigarettes, cigars, cigarettes, smokeless tobacco (composite), hookahs, nicotine pouches, heated tobacco products, pipe tobacco, bidis, or other oral nicotine products. **Source:** National Youth Tobacco Survey, 2024; and Jamal A, Park-Lee E, Birdsey J, et al. Tobacco Product Use Among Middle and High School Students — National Youth Tobacco Survey, United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:917–924. DOI: http://dx.doi.org/10.15585/mmwr.mm7341a2 .

Figure 48: Percentage of Current Tobacco Use, Asian vs. White, Adults 18 Years and Older, United States, 2024

In 2024, about 36% of those currently smoking reported using menthol-flavored cigarettes.

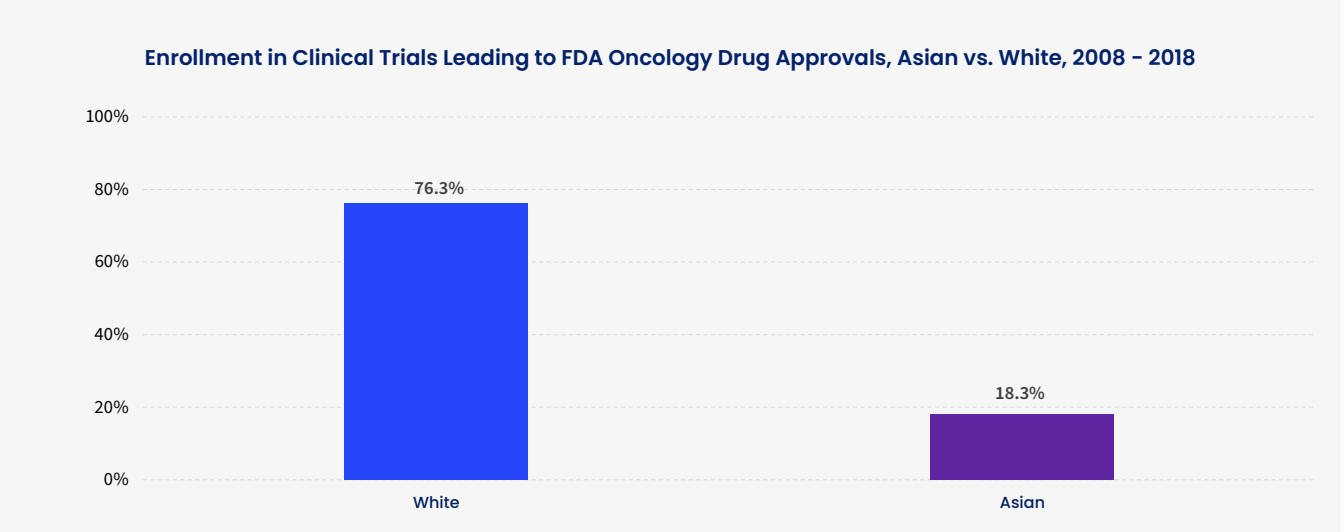


Notes: *Ever smoked 100 cigarettes in lifetime and currently smoke every day or some days. §Of those who currently smoke, those who usually smoked menthol cigarettes. ‡Estimates are statistically unstable and not shown.
Source: National Health Interview Survey, 2024.

Disparities in Clinical Trial Participation in AANHPI Communities

Figure 49: Enrollment in Clinical Trials Leading to FDA Oncology Drug Approvals, Asian vs. White, 2008 – 2018

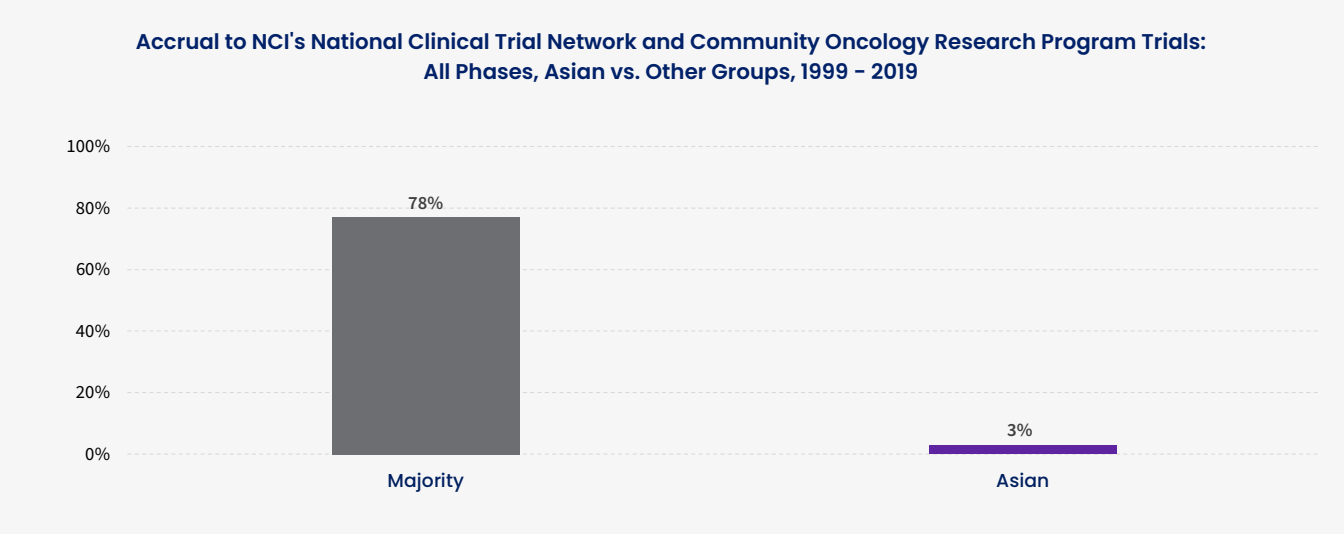
Compared to their cancer burden, Asians are overrepresented in cancer clinical trials that support new drug approvals in the U.S. The majority of trials supporting these approvals occur outside of the U.S., many in Asia, which drives the over-representation relative to the U.S. Asian population with cancer. The lived environment and exposures of Asians living in Asian countries is likely different than Asians living in the U.S., thus it is unclear if the findings from the high representation in these trials is transferrable to Asian Americans. The chart below shows the percentage of patients enrolled in FDA drug approval trials from 2008-2018 which reported on patients of the assessed races.



Source: Loree JM, Anand S, Dasari A, et al. Disparity of Race Reporting and Representation in Clinical Trials Leading to Cancer Drug Approvals From 2008 to 2018. JAMA Oncol. 2019;5(10):e191870. doi:10.1001/jamaoncol.2019.1870.

Figure 50: Accrual to NCI's National Clinical Trial Network and Community Oncology Research Program Trials: All Phases, Asian vs. Other Groups, 1999 - 2019

Although participation from racial and ethnic minority patients in National Cancer Institute (NCI)-sponsored trials increased over 20 years from 1999-2019, these groups remain underrepresented in clinical trials compared to members of non-minority populations.[35] Studies have shown that the representation of minority populations in U.S. clinical trials do not match the proportional cancer burden in those populations.[36,38] In oncology, structural issues outside a patient's control are the overwhelming cause of low and unequal trial participation, even though most patients, when asked, would participate in a trial.[37,38] Specific trial design and infrastructure elements such as inclusion/exclusion criteria, where trials are offered, whether providers screen and refer patients, and participant burdens (e.g., costs, time, and travel needs) lead to low or inequitable trial enrollment. The chart below shows the percentage of patients enrolled in NCI's National Clinical Trial Network (NCTN) and National Community Oncology Research Program (NCORP) clinical trials from 1999-2019.



Notes: Minority and majority categorization according to 2020 Census definitions of race and ethnicity.
Source: McCaskill Stevens, W. (2020) Participation by minority racial, ethnic groups in NCI-funded trials nearly doubles in 20 years. Cancer Letter 46 https://cancerletter.com/the-cancer-letter/20200626_1/.

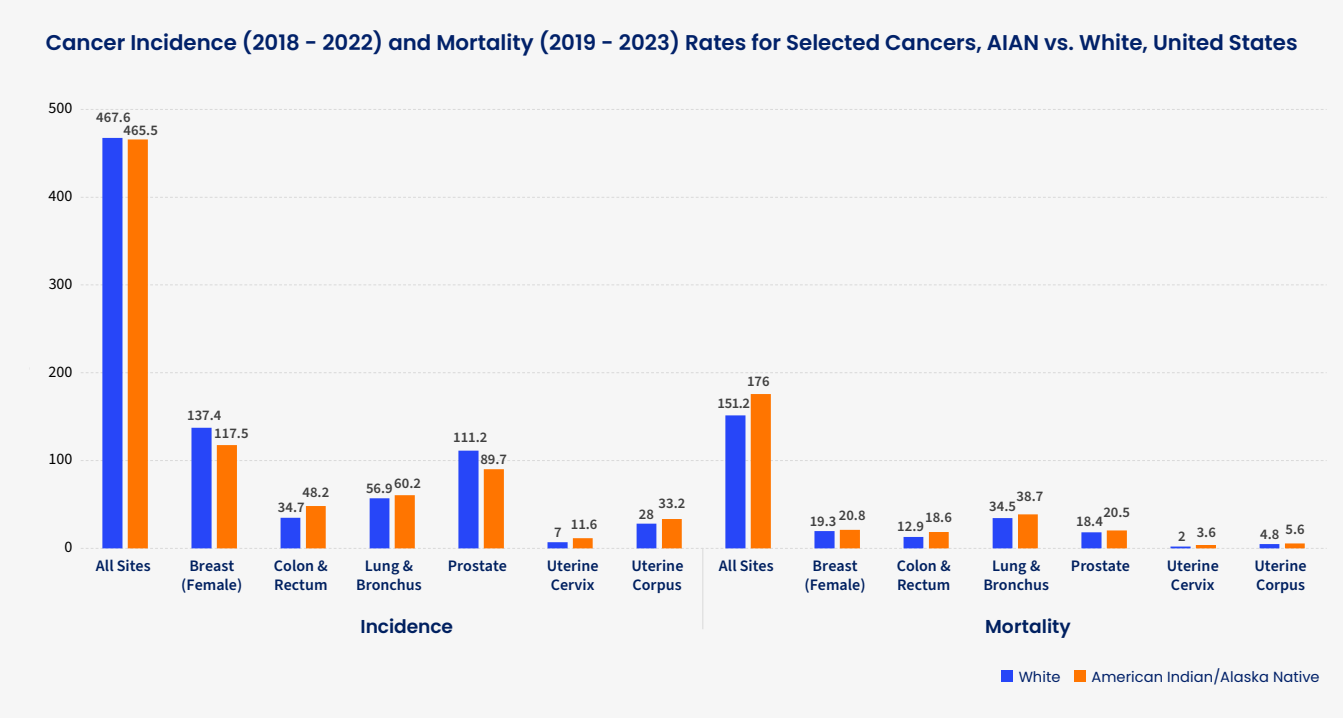
Disparities in American Indian and Alaska Native (AIAN) Communities

In 2020, an estimated 9.7 million people identified as American Indian and Alaska Native (AIAN), representing about 3% of the U.S. population.[32] AIAN men and women combined have the highest cancer incidence and mortality of any population group, partly because of the high rates in women.[3] Nationally, AIAN people have the highest incidence and mortality from cancers of the colorectum, and lung and bronchus than any population.[33] Cancer screening disparities for AIAN people largely reflect long-standing systemic racism that has resulted in limited access to quality care, including cancer screening. Many of these cancer disparities could be reduced by increasing access to high-quality cancer prevention, early detection, diagnosis and treatment care.

Disparities in Cancer Incidence, Mortality and Survival in AIAN Communities

Figure 51: Cancer Incidence (2018 - 2022) and Mortality (2019 - 2023) Rates for Selected Cancers, AIAN vs. White, United States

For AIAN individuals, the incidence of common cancers like cervical and colorectal cancer is 50% higher in comparison to their White counterparts. The excess colorectal cancer burden is partly driven by the extraordinary burden among Alaska Native individuals with the highest incidence rates in the world.[34] Despite the preventability of cervical cancer mortality, the death rate in Native American women is 70% higher than in White women.



Notes: Rates are per 100,000,age adjusted to the 2000 U.S. standard population, and adjusted for delays in case reporting. Uterine corpus incidence rates are adjusted for hysterectomy prevalence. All race groups are exclusive of Hispanic origin. To reduce racial misclassification, incidence is limited to Purchased/Referred Care Delivery Area counties, and mortality (entire U.S.) is adjusted using factors published by the National Center for Health Statistics.

Source: North American Association of Central Cancer Registries (incidence, 2018-2022), National Center for Health Statistics (mortality, 2019-2023) data and Arias E, Xu JQ, Curtin S, Bastian B, Tejada-Vera B. Mortality profile of the non-Hispanic American Indian or Alaska Native population, 2019. National Vital Statistics Reports; vol 70 no 12. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://dx.doi.org/10.15620/cdc:110370.

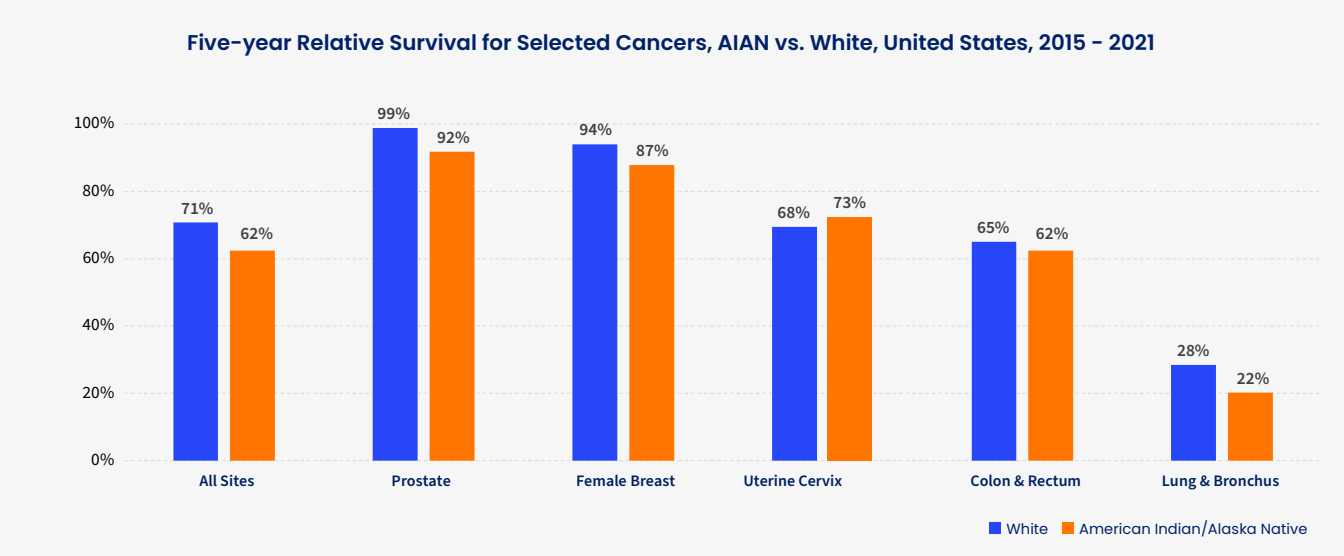
Map 13: Rates of Cancer Incidence for AIAN People by State

This interactive map can be viewed at the following link here. This map shows the rates of cancer incidence for American Indian and Alaskan Native people across the U.S. for selected cancer types, including breast, cervix, colon and rectum, lung and bronchus, prostate and uterus, and can also be filtered to further show demographics by state and based on sex. Mortality data are unavailable due to misclassification on death certificates. Adjustment for this misclassification is available only at the national level.

Incidence rates are retrieved from State Cancer Profile, a collaboration between the National Cancer Institute and Centers for Disease Control and Prevention, and are updated based on the most recent releases available on their website: https://statecancerprofiles.cancer.gov/.

Figure 52: Five-year Relative Survival for Selected Cancers, AIAN vs. White, United States, 2015 – 2021

Five-year survival in AIAN people is lower than in White people for cancer overall (62% versus 71%) and across several other cancer types, including prostate, breast, and lung and bronchus.



Notes: Estimates for the AIAN population were based on Purchased/Referred Care Delivery Area (PRCDA) counties.
Source: Surveillance, Epidemiology, and End Results Program, National Cancer Institute, 2025.

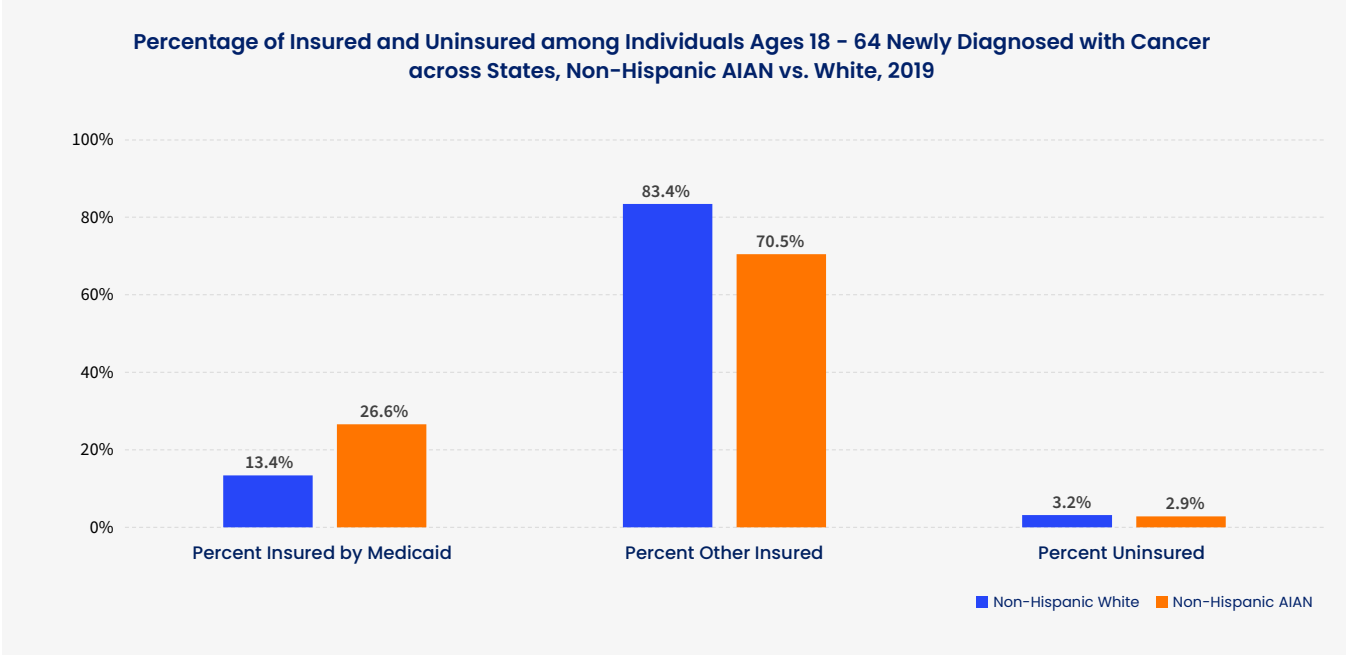
Disparities in Access to Coverage in AIAN Communities

Maps 14 – 15: Distribution of Uninsured and Medicaid Insured AIAN People Ages 0-64, 2023

These interactive maps can be viewed at the following link here. One map shows the rates of AIAN people who are uninsured and the other map shows those who are insured by Medicaid from the ages of zero to 64 years. People facing cancer and survivors who are uninsured – or don't have health insurance – have high health care costs, poor access to care, poor cancer outcomes and experience a great amount of financial hardship. The health coverage provided by Medicaid helps to improve outcomes and reduce the burden of cancer by offering timely access to cancer prevention, screening and early detection services, as well as affordable treatment services and care.

Figure 53: Percentage of Insured and Uninsured among Individuals Ages 18 - 64 Newly Diagnosed with Cancer across States, Non-Hispanic AIAN vs. White, 2019

Medicaid coverage was found to be higher among non-Hispanic AIAN groups (26.6%) in comparison to non-Hispanic White individuals (13.4%) ages 18 - 64. Conversely, uninsured rates were slightly higher for non-Hispanic White individuals (3.2%), compared to non-Hispanic AIAN individuals (2.9%). However, non-Hispanic AIAN individuals were less likely to have other forms of insurance, such as private insurance or Medicare than their White counterparts.

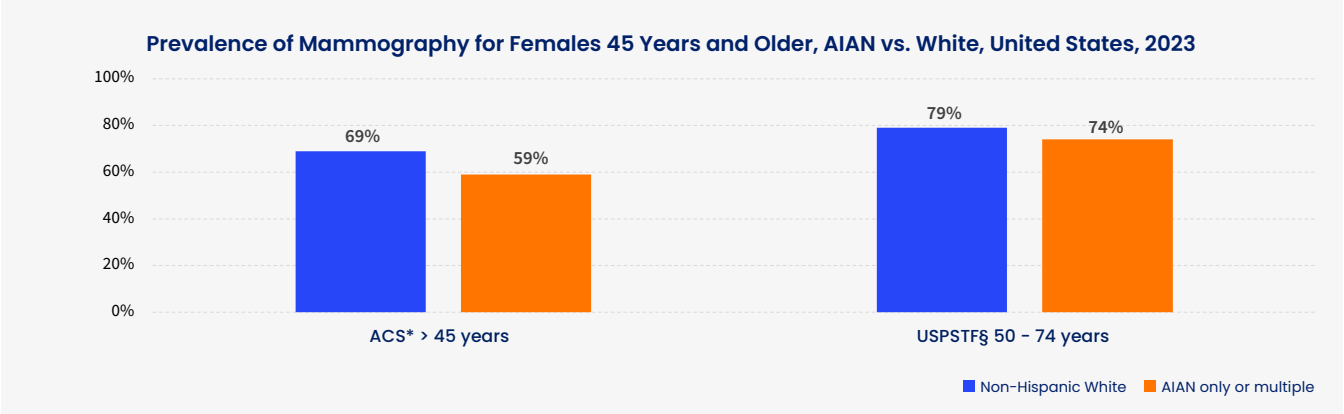


Notes: Percentages were calculated excluding cancer cases with unknown insurance status.
Source: Cancer Incidence in North America (CiNA) 2010–2019 compiled by the North American Association of Central Cancer Registries.

Disparities in Cancer Prevention, Screening, and Early Detection in AIAN Communities

Figure 54: Prevalence of Mammography for Females 45 Years and Older, AIAN vs. White, United States, 2023

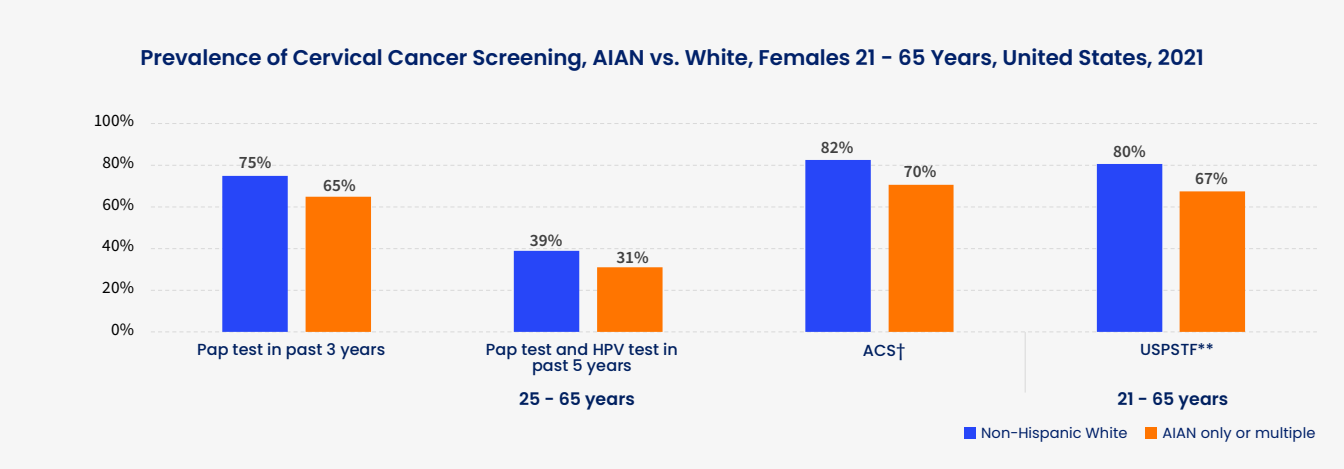
In 2023, the prevalence of up-to-date mammography screening across different guidelines were consistently lower among American Indian or Alaska Native females in comparison to White females. Specifically, the prevalence of up-to-date screenings for AIAN females was 59% and 74% for ACS, and USPSTF guidelines, respectively. The USPSTF guidelines were updated in 2024 and therefore not all recent USPSTF recommendation changes are yet measurable. For this reason, we report mammography prevalence per the 2016 USPSTF recommendations in this report.



Notes: *ACS Recommendation: Mammogram within the past year (ages 45-54 years) or past two years (ages ≥55 years). Estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. §USPSTF 2016 Recommendation: Mammogram within the past two years. Estimates are age adjusted using two age groups: 50-64, and 65-74 years. **Source:** National Health Interview Survey, 2023.

Figure 55: Prevalence of Cervical Cancer Screening, AIAN vs. White, Females 21-65 Years, United States, 2021

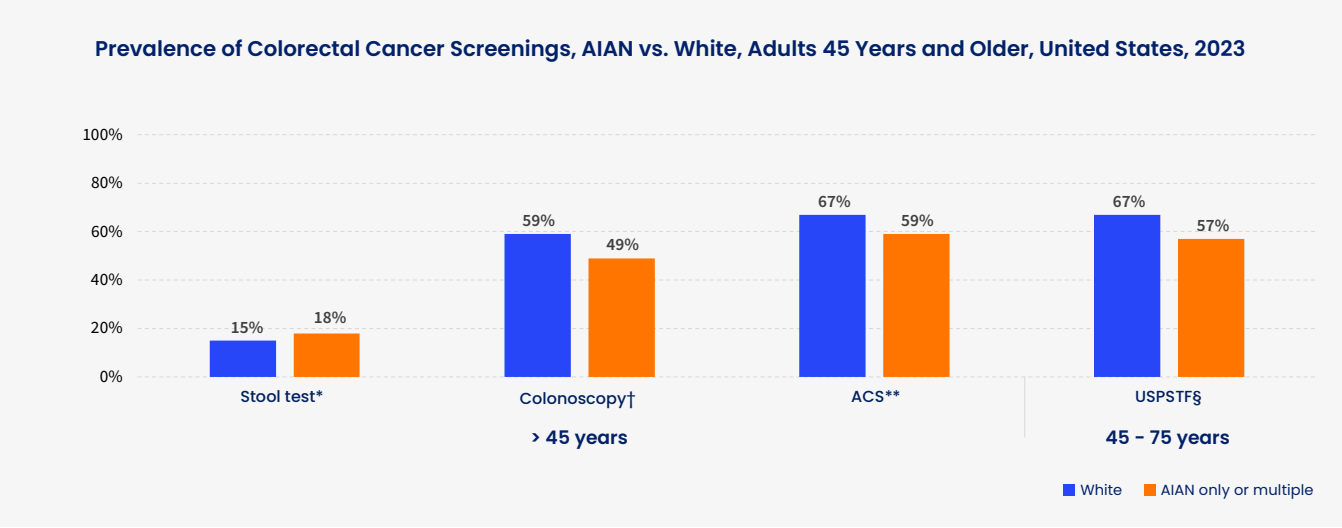
In 2021, the prevalence of up-to-date cervical cancer screening across different guidelines were consistently lower among American Indian or Alaska Native females in comparison to White females. Specifically, the prevalence of up-to-date screenings for White females was 82% and 80% for ACS and USPSTF guidelines, respectively. Corresponding prevalence of up-to-date screenings for AIAN females was 70% and 67%.



Notes: Estimates are among females who have not had a hysterectomy. All estimates are age adjusted to the year 2000 US population standard. Up-to-date cervical cancer screening data are not available in the National Health Interview Survey 2023. †Pap test in the past 3 years or Pap test and HPV test or HPV test alone within the past 5 years among females 25-65 years. Pap test, combined Pap and HPV tests, ACS estimates, and USPSTF education estimates are age adjusted using 4 age groups: 25-29, 30-39, 40-49, and 50-65 years. **Pap test in the past 3 years among females 21-65 years or Pap test and HPV test or HPV test alone within the past 5 years among females 30-65 years. USPSTF estimates are age adjusted using 4 age groups: 21-29, 30-39, 40-49, and 50-65 years. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026;* and National Health Interview Survey, 2021.

Figure 56: Prevalence of Colorectal Cancer Screening, AIAN vs. White, Adults 45 Years and Older, United States, 2023

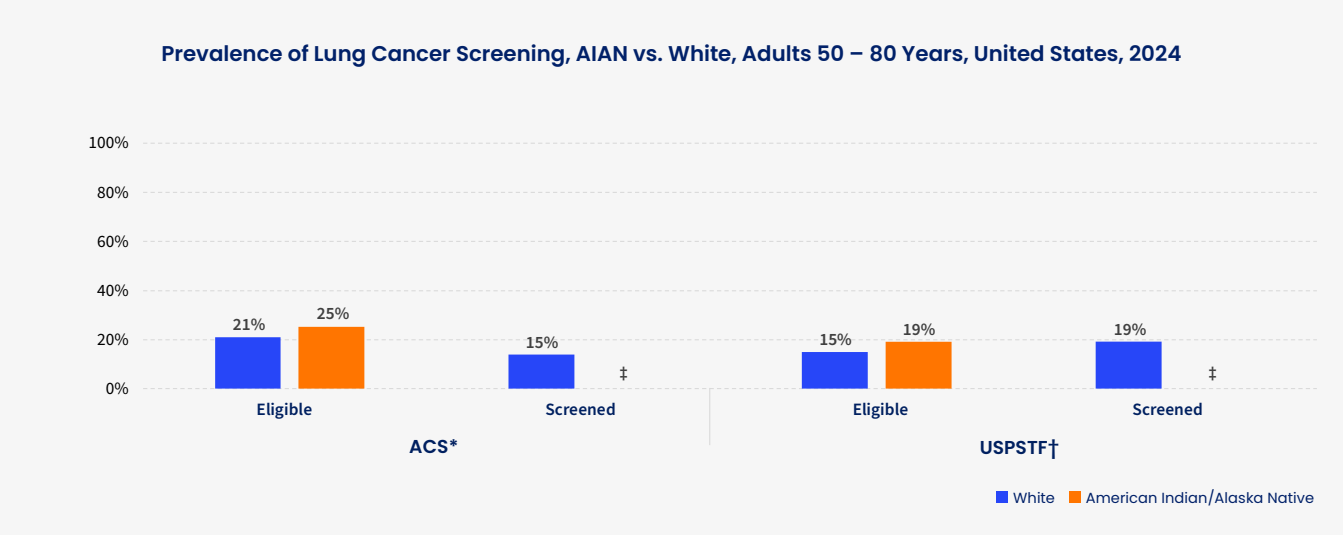
In 2023, the prevalence of up-to-date colorectal cancer screening across different guidelines varied for American Indian or Alaska Native individuals in comparison to White individuals. Specifically, the prevalence of up-to-date screening for AIAN people in terms of stool tests (18%) was higher than White individuals (15%). However, for other screening paradigms such as colonoscopies (49%) and across different guidelines like ACS (59%) and USPSTF (57%), AIAN individuals had consistently lower prevalence of up-to-date screening in comparison to White individuals who had a prevalence of 59%, 67%, and 67%, respectively.



Notes: *Stool tests, including fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past one year or multi-target stool DNA (sDNA) test, within the past three years. †Within the past ten years. **ACS Guideline: FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past one, five, ten, five and three years, respectively. Stool testing, colonoscopy, and ACS estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years. §USPSTF Guideline: FOBT/FIT, sigmoidoscopy, colonoscopy, CT colonography, or sDNA test in the past one, five, ten, five and three years, respectively, or sigmoidoscopy in the past ten years with FOBT/FIT in the past one year. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years.
Source: National Health Interview Survey, 2023.

Figure 57: Prevalence of Lung Cancer Screening, AIAN vs. White, Adults 50 – 80 Years, United States, 2024

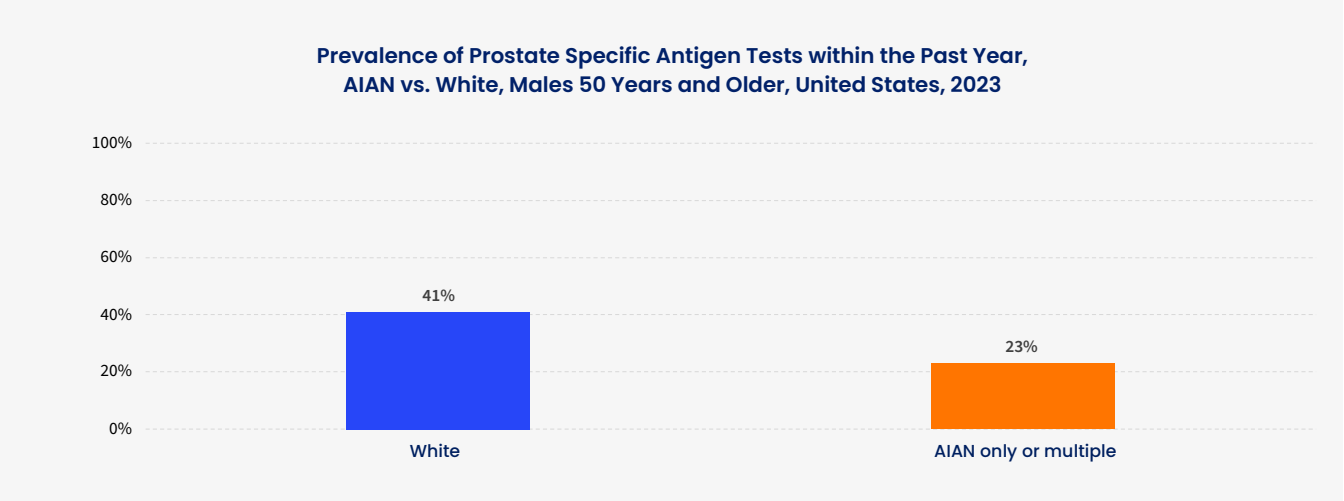
In 2024, the prevalence of lung cancer screening was lower among AIAN individuals compared to White individuals for different screening guidelines, despite a greater prevalence of AIAN individuals being eligible for screening. Specifically, 19% of AIAN individuals were eligible for screening under USPSTF guidelines in comparison to 15% of White individuals. Similarly, 25% of AIAN individual were eligible for screening under ACS guidelines in comparison to 21% of White individuals. ACS' guidelines were updated in 2023 and the USPSTF updated its recommendations in 2021. These guideline changes were in order to capture more groups of people who tend to have low pack-year histories but high risk of lung cancer. Thus, lowering the pack-year history will increase the number of high-risk adults who are eligible for lung cancer screening.



Notes: Estimates are age-adjusted to the year 2000 US population standard using 3 age groups: 50-59, 60-69, and 70-80 years. *The American Cancer Society recommends annual screening for lung cancer with a low-dose CT (LDCT) scan for people ages 50 to 80 years who smoke or used to smoke and have at least a 20 packyear history of smoking. †The USPSTF recommends annual screening for lung cancer with LDCT in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. ‡Estimates are statistically unstable and not shown. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026;* and National Health Interview Survey, 2024.

Figure 58: Prevalence of Prostate Specific Antigen Tests within the Past Year, AIAN vs. White, Males 50 Years and Older, United States, 2023

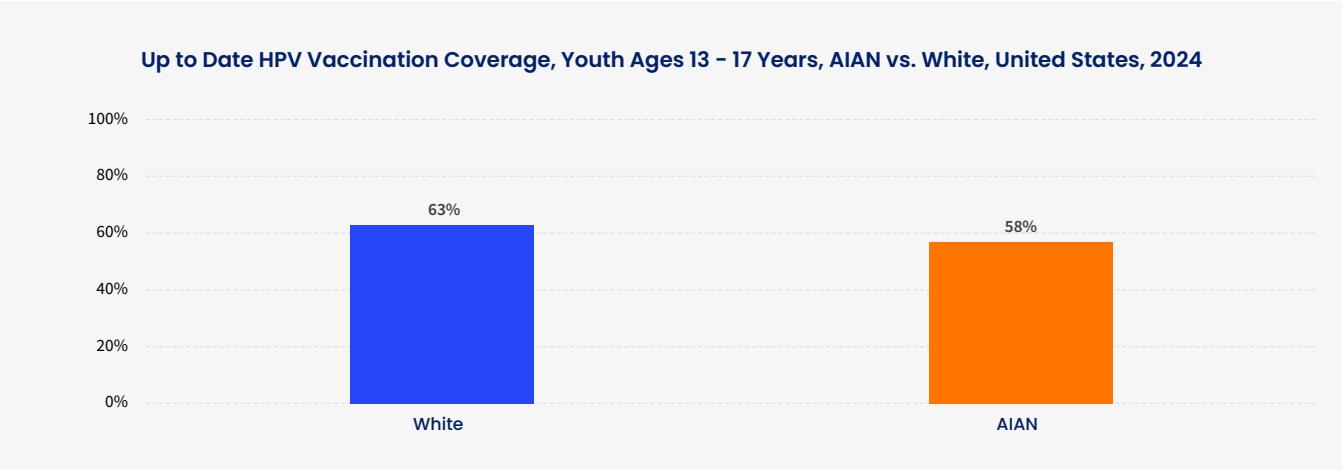
In 2023, the prevalence of prostate cancer screening among AIAN individuals (23%) was much lower than the prevalence of screening for White individuals (41%). Prostate cancer survival rates increase when it is detected early through testing like the prostate-specific antigen (PSA) test. However, prostate cancer screening recommendations have changed over time based on evidence of benefits and harms and current guidelines are in the process of being updated. Currently, guidelines stress the need for shared decision making between patient and clinician (i.e., discussion of potential benefits, risks, patient values and preferences) in screening decisions.[16,17]



Notes: Prostate cancer screening is defined among males who have not been diagnosed with prostate cancer. Estimates are age adjusted to the year 2000 US population standard using two age groups: 50-64 and ≥65 years. ACS (males 50+ years) screening guidelines recommend shared decision making between patient and provider to guide screening decisions for PSA testing. **Source:** Cancer Prevention and Early Detection Facts and Figures 2026. Atlanta: American Cancer Society; *2026*; and National Health Interview Survey, 2023.

Figure 59: Up to Date HPV Vaccination Coverage, Youth Ages 13 - 17 Years, AIAN vs. White, United States, 2024

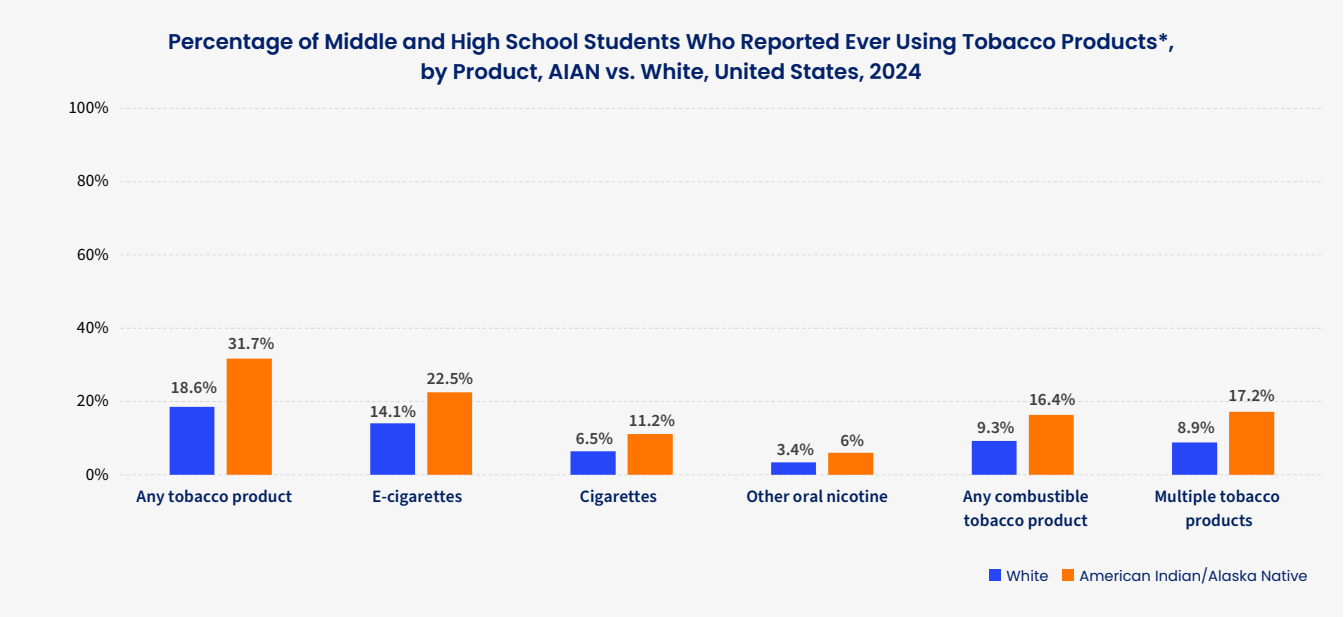
HPV vaccination is associated with population-level reductions in HPV infection, cervical cancer, and other HPV-associated cancers.[13,14,15,16] ACS' HPV vaccination guidelines were updated in 2020 to recommend routine vaccination for girls and boys starting at age nine. In 2024, the percentage of AIAN youth ages 13 to 17 that were up to date on the HPV vaccine was lower than their White peers.



Notes: Up to date human papillomavirus vaccination in ages 13-17 years is defined as two doses separated by five months (minus four days) for immunocompetent adolescents initiating the human papillomavirus vaccine series before their 15th birthday, and three doses for all others.
Source: National Immunization Survey-Teen, 2024.

Figure 60: Percentage of Middle and High School Students Who Reported Ever Using Tobacco Products, by Product, AIAN vs. White, United States, 2024

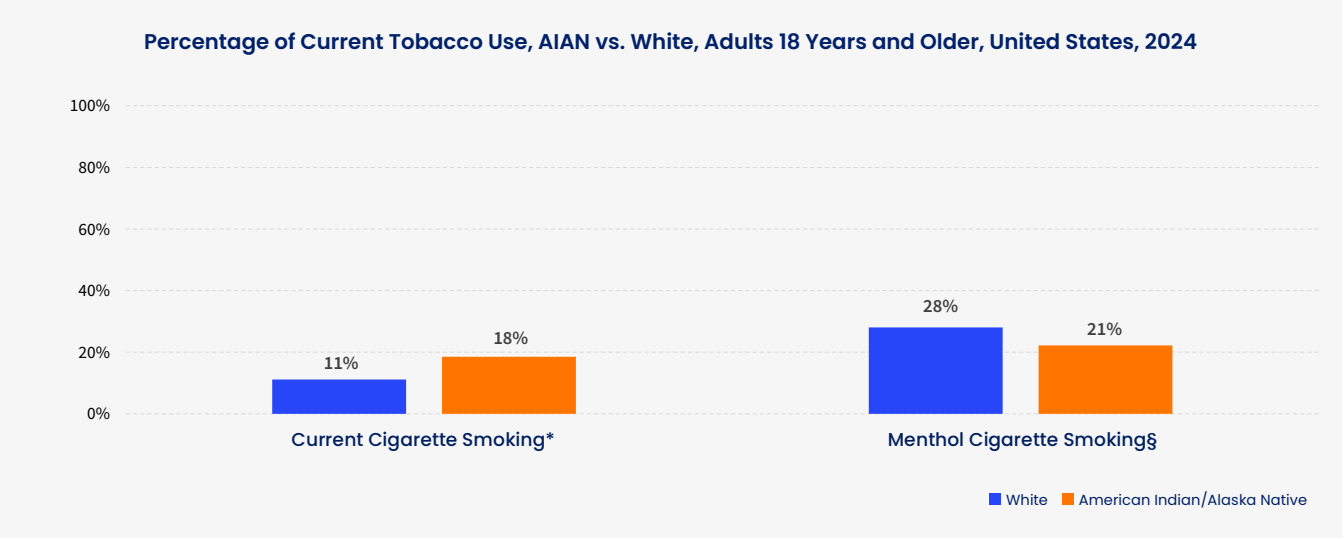
In 2024, the percentages of middle and high school students who reported ever using tobacco products were higher for AIAN students for every type of tobacco product.



Notes: *Ever use is defined as ever having used the product, even once or twice. Because of missing data on the ever use questions, denominators for each tobacco product might differ. For each question, response options were "yes" or "no." Overall estimates were reported based on 22,069 U.S. middle and high school students. Cigars were defined as cigars, cigarillos, or little cigars. Other oral nicotine products were defined as lozenges, discs, tablets, gums, dissolvable tobacco products, and other products. Any combustible tobacco product use was defined as use of one or more of the following tobacco products: cigarettes, cigars, hookahs, pipe tobacco, or bidis. Multiple tobacco product use was defined as use of two or more of the following tobacco products: e-cigarettes, cigars, cigarettes, smokeless tobacco (composite), hookahs, nicotine pouches, heated tobacco products, pipe tobacco, bidis, or other oral nicotine products. **Source:** National Youth Tobacco Survey, 2024; and Jamal A, Park-Lee E, Birdsey J, et al. Tobacco Product Use Among Middle and High School Students — National Youth Tobacco Survey, United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:917–924. DOI: http://dx.doi.org/10.15585/mmwr.mm7341a2.

Figure 61: Percentage of Current Tobacco Use, AIAN vs. White, Adults 18 Years and Older, United States, 2024

In 2024, about 36% of those currently smoking reported using menthol-flavored cigarettes, but this proportion was 21% in American Indian or Alaska Native persons compared to 28% in White persons.



Notes: *Ever smoked 100 cigarettes in lifetime and currently smoke every day or some days. §Of those who currently smoke, those who usually smoked menthol cigarettes. **Source:** National Health Interview Survey, 2024.

Disparities in Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ+) Communities

In 2021, an estimated 7% of U.S. adults reported identifying as lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ+) or other diverse sexual orientation or gender identity, with larger percentages among younger generations.[35] LGBTQ+ people face a unique and increased cancer burden, disproportionately affected by disparities in risk factors and obstacles to prevention, detection and treatment because of systemic factors that go beyond the connection to cancer.

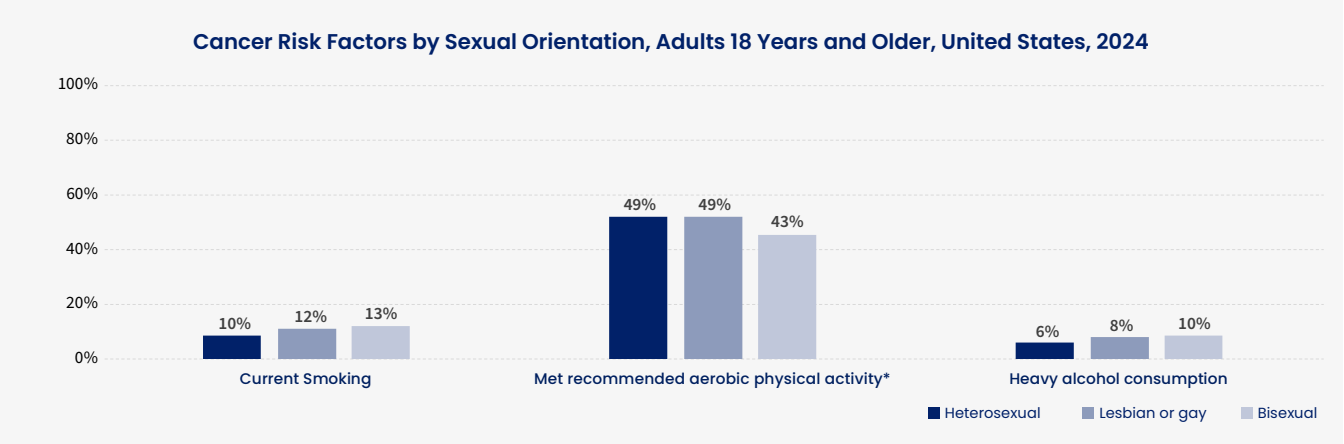
Many LGBTQ+ people experience health care bias and discrimination[36,37], including negative experiences with health care providers, and most medical intake forms do not encourage or allow disclosure of sexual orientation and/or gender identity.[38] LGBTQ+ people are also more likely to be unhoused, and experience poverty and food insecurity.[39,40] By ensuring that everyone, including LGBTQ+ communities, have access to care, harmful diseases like cancer can be detected and treated earlier – often resulting in better health outcomes and lower costs for the health care system.

Disparities in Cancer Risk Factors in LGBTQ+ Communities

Figure 62: Cancer Risk Factors by Sexual Orientation, Adults 18 Years and Older, United States, 2024

In 2024, 12% and 13% of lesbian/gay or bisexual individuals smoked currently, a higher percentage than heterosexual individuals (10%). During the same timeframe, 43% of bisexual individuals did not meet recommended aerobic physical activity, compared to 49% of heterosexual individuals, and 49% of lesbian or gay individuals.

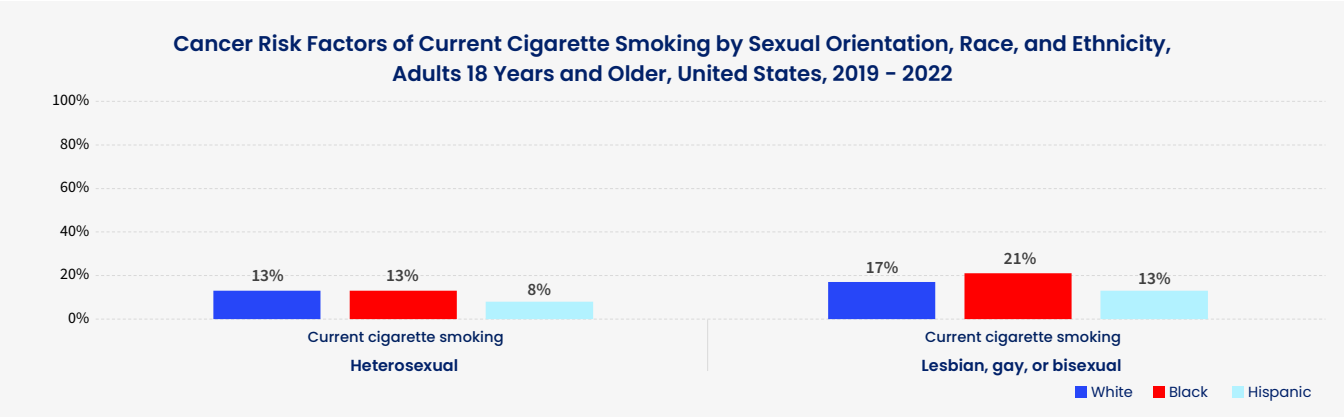
Alcohol consumption increases the risk of liver, esophageal, colorectal, oral, stomach, and female breast cancers.[41] Lesbian, gay, or bisexual individuals are more likely than heterosexual people to drink alcohol excessively, especially among women.[42] For example, as the figure below shows, 10% of bisexual individuals who drink heavily consume more than seven drinks per week compared to 8% of gay/lesbian persons and 6% of heterosexual persons.



Notes: Estimates are age adjusted. Estimates are age adjusted to the year 2000 US population standard using 5 age groups: 18-24, 25-34, 35-44, 45-64, and ≥65 years and by 4 age groups: 25-34, 35-44, 45-64, and ≥65 years for education. *Includes 150 minutes or more of moderate-intensity aerobic activity or 75 minutes or more of vigorous-intensity aerobic activity each week. Heavy alcohol consumption considered > 14 drinks per week for males and > seven drinks per week for females. **Source:** National Health Interview Survey, 2024.

Figure 63: Cancer Risk Factor of Current Cigarette Smoking by Sexual Orientation, Race, and Ethnicity, Adults 18 Years and Older, United States 2019 – 2022

This chart shows cancer risks by intersectionality for LGBTQ+ people of color. LGBTQ+ individuals of color (Black and Hispanic) have increased smoking prevalence in comparison to their White counterparts in the LGBTQ+ community than in comparison to heterosexual individuals. Overall, irrespective of race, LGBTQ+ individuals have a higher prevalence of smoking in comparison to heterosexual individuals.

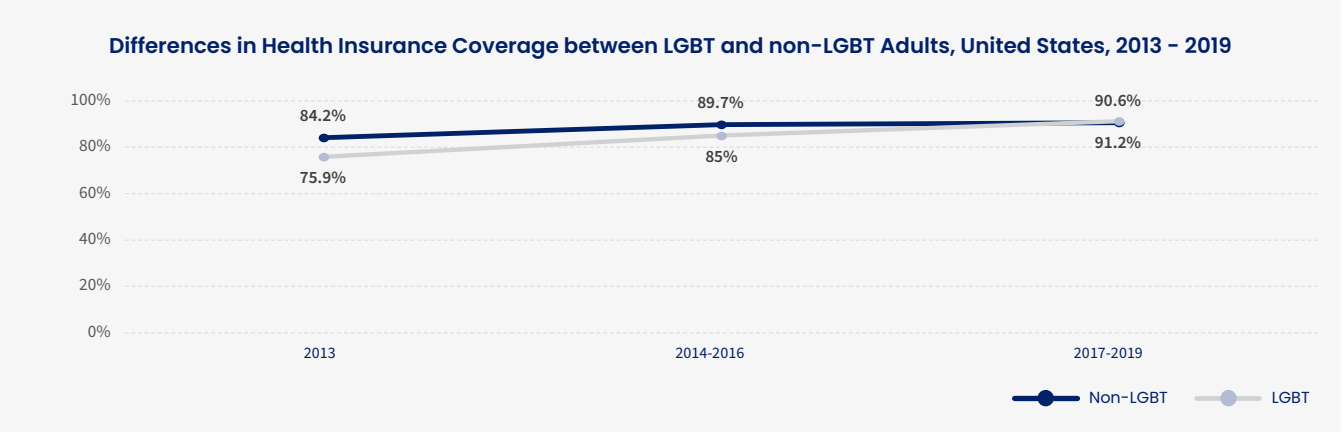


Notes: Estimates are age adjusted. Estimates are age adjusted to the year 2000 US population standard using 5 age groups: 18-24, 25-34, 35-44, 45-64, and ≥65 years. Survey estimates for gay, lesbian and bisexual Asian American and Pacific Islander and American Indian and Alaska Native individuals were unstable and are not shown. **Source:** National Health Interview Survey, 2021-2022.

Disparities in Access to Coverage in LGBTQ+ Communities

Figure 64: Differences in Health Insurance Coverage between LGBT and Non-LGBT Adults, United States, 2013 - 2019

Although LGBTQ+ individuals were historically less likely to have health insurance than the general population, increased access to care as a result of the implementation of the Affordable Care Act in 2014 and the marriage equality Supreme Court decision in 2015 have narrowed this gap. Many LGBTQ+ individuals also depend on Medicaid for health coverage, especially people of color.[43]

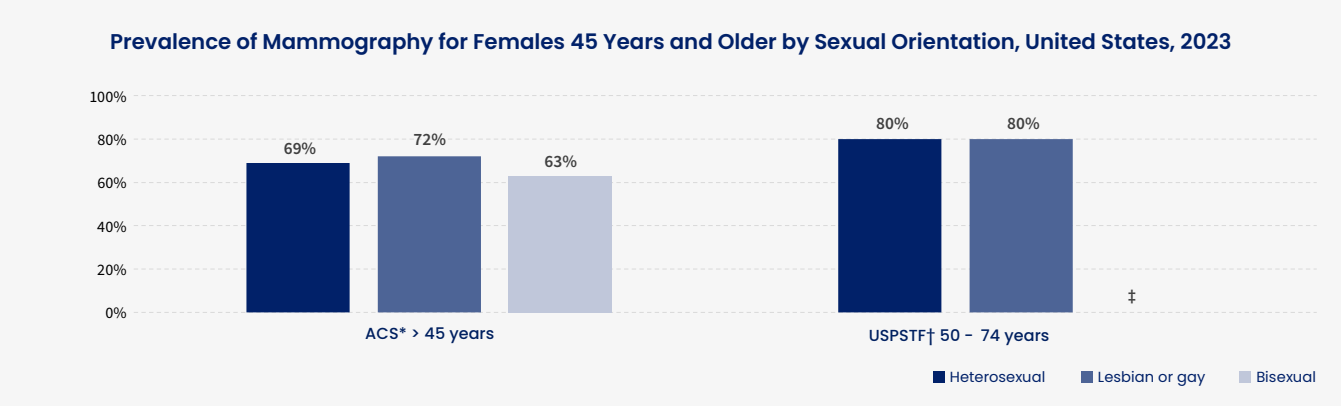


Notes: Sample sizes for each period are 25,077 (2013), 58,344 (2014–16), and 52,569 (2017–19). Adjusted differences are based on a linear probability regression model controlling for age, sex, race and ethnicity, education, residence in a metro area, citizenship status, employment and self-reported health status. Source references "LGBT" throughout report and not does include "Q+" in abbreviation.
Source: Health Reform Monitoring Survey, 2013 – 2019.

Disparities in Cancer Prevention, Screening, and Early Detection in LGBTQ+ Communities

Figure 65: Prevalence of Mammography for Females 45 Years and Older by Sexual Orientation, United States, 2023

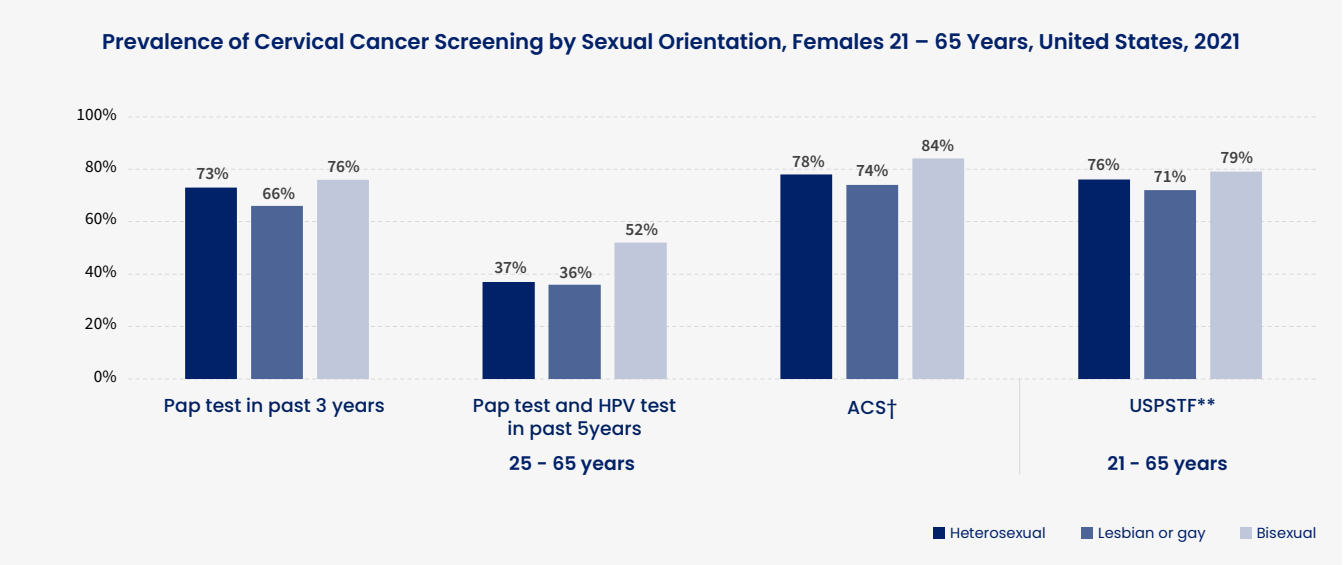
In 2023, across both guidelines (ACS and USPSTF), heterosexual and gay/lesbian individuals had a greater prevalence of being up to date with their mammograms in comparison to bisexual individuals. The USPSTF guidelines were updated in 2024 and therefore not all recent USPSTF recommendation changes are yet measurable. For this reason, we report mammography prevalence per the 2016 USPSTF recommendations in this report.



Notes: *ACS Recommendation: Mammogram within the past year (ages 45-54 years) or past two years (ages ≥55 years). Estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. ‡USPSTF 2016 Recommendation: Mammogram within the past two years. Estimates are age adjusted using two age groups: 50-64, and 65-74 years. Survey estimates were considered unstable and suppressed if the denominator sample size (n) was <50 or the relative standard error was ≥30%, such as estimates for bisexual individuals.
Source: National Health Interview Survey, 2023.

Figure 66: Prevalence of Cervical Cancer Screening by Sexual Orientation, Females 21– 65 Years, United States, 2021

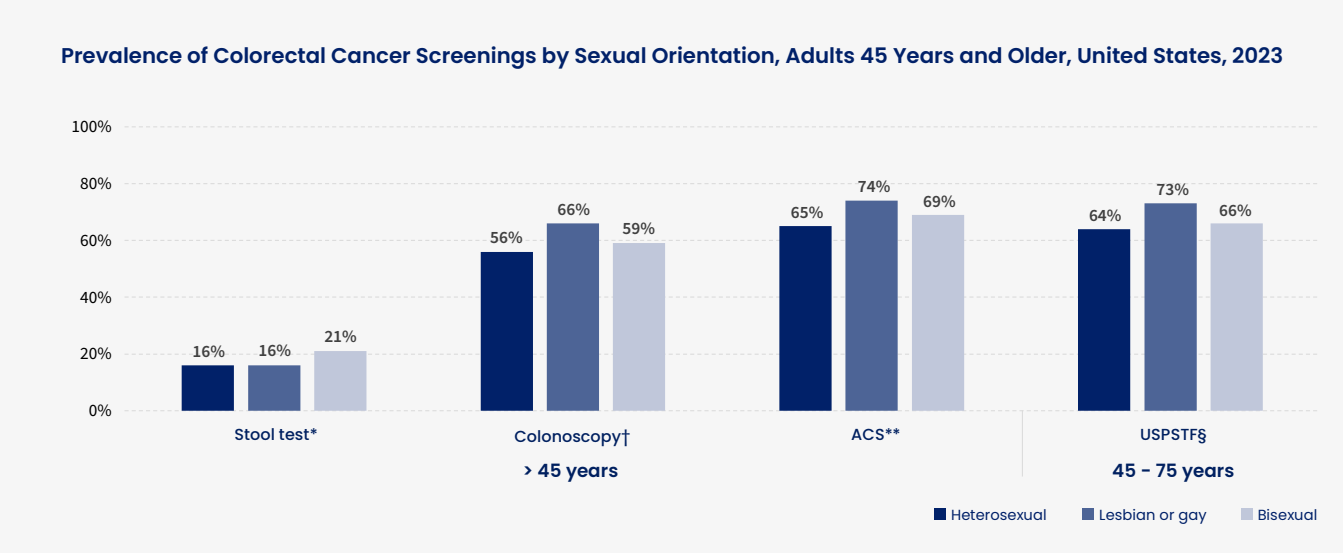
In 2021, across all screening guidelines, gay/lesbian individuals had the lowest prevalence of being up to date with their cervical cancer screenings in comparison to heterosexual and bisexual individuals. Bisexual individuals had the highest screening prevalence, in comparison to heterosexual and gay/lesbian individuals.



Notes: Estimates are among females who have not had a hysterectomy. All estimates are age adjusted to the year 2000 US population standard. Up-to-date cervical cancer screening data are not available in the National Health Interview Survey 2023. †Pap test in the past 3 years or Pap test and HPV test or HPV test alone within the past 5 years among females 25-65 years. Pap test, combined Pap and HPV tests, ACS estimates, and USPSTF education estimates are age adjusted using 4 age groups: 25-29, 30-39, 40-49, and 50-65 years. **Pap test in the past 3 years among females 21-65 years or Pap test and HPV test or HPV test alone within the past 5 years among females 30-65 years. USPSTF estimates are age adjusted using 4 age groups: 21-29, 30-39, 40-49, and 50-65 years. **Source:** National Health Interview Survey, 2021.

Figure 67: Prevalence of Colorectal Cancer Screenings by Sexual Orientation, Adults 45 Years and Older, United States, 2023

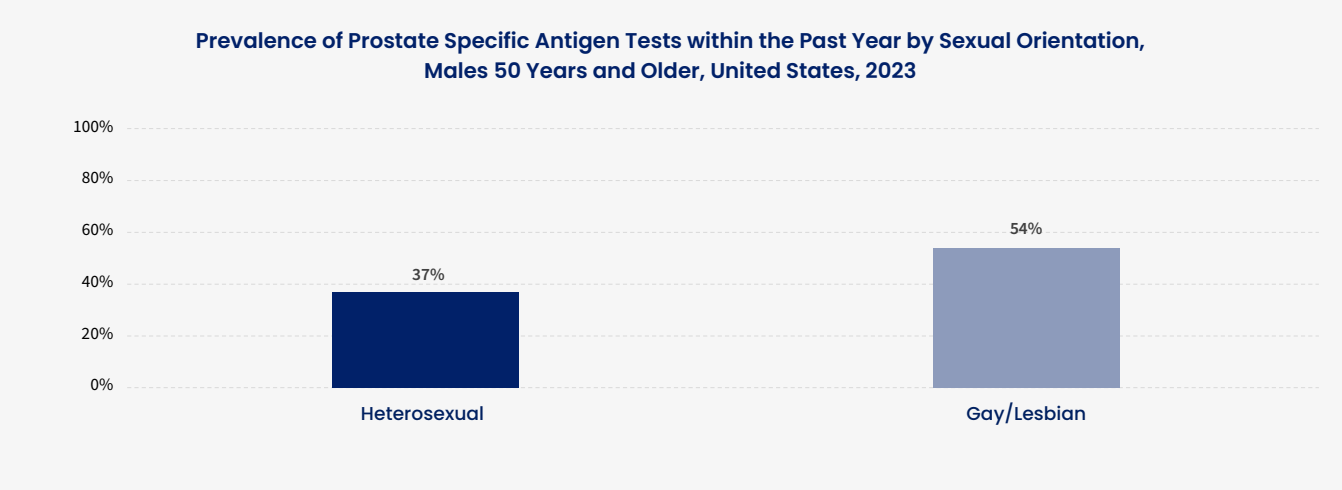
In 2023, the prevalence of colorectal cancer screening was highest for gay/lesbian individuals for colonoscopy (66%) and according to ACS (74%) and USPSTF (73%) guidelines, followed by bisexual individuals at 59%, 69%, and 66%, respectively. Screening prevalence was marginally lower for heterosexual individuals across the three categories at 56% for colonoscopies, 65% for ACS, and 64% for USPSTF. Conversely, for stool tests, bisexual individuals had the highest prevalence (21%) compared to gay/lesbian individuals (16%) and heterosexual individuals (16%).



Notes: *Stool tests, including fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past one year or multi-target stool DNA (sDNA) test, within the past three years. †Within the past ten years. **ACS Recommendation: FOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, or sDNA test in the past one, five, ten, five and three years, respectively. Stool testing, colonoscopy, and ACS estimates are age adjusted to the year 2000 U.S. population standard using three age groups: 45-49, 50-64, and ≥65 years. §USPSTF Recommendation: FOBT/FIT, sigmoidoscopy, colonoscopy, CT colonography, or sDNA test in the past one, five, ten, five and three years, respectively, or sigmoidoscopy in the past ten years with FOBT/FIT in the past one year. USPSTF estimates are age adjusted using three age groups: 45-49, 50-64, and 65-75 years.
Source: National Health Interview Survey, 2023.

Figure 68: Prevalence of Prostate Specific Antigen Tests within the Past Year by Sexual Orientation, Males 50 Years and Older, United States, 2023

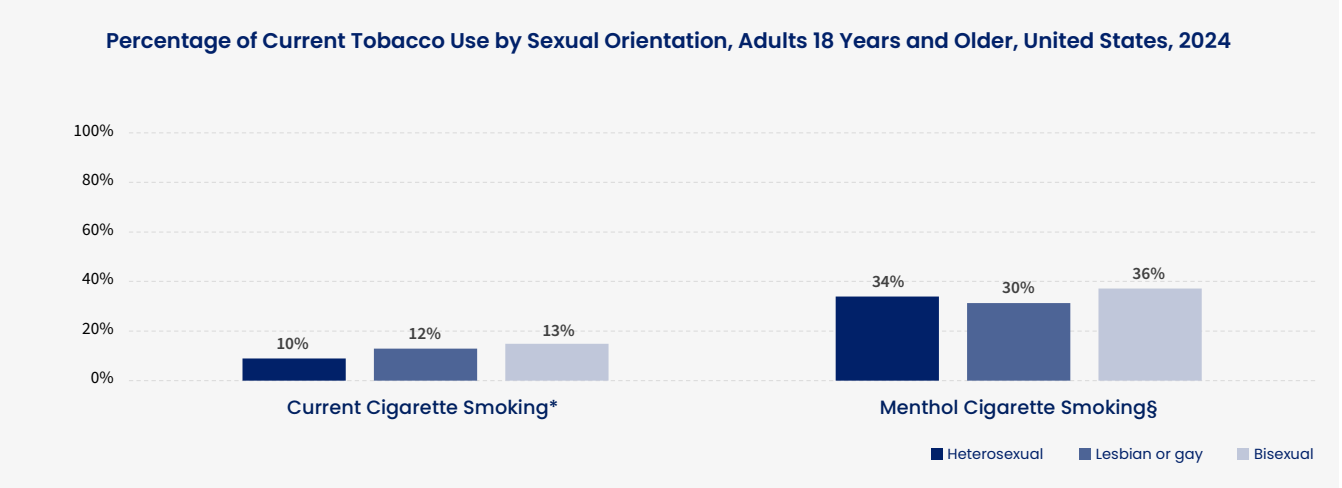
In 2023, gay/lesbian individuals had a markedly higher prevalence of prostate cancer screening (54%) in comparison to heterosexual individuals (37%). Prostate cancer survival rates increase when it is detected early through testing like the prostate-specific antigen (PSA) test. However, prostate cancer screening recommendations have changed over time based on evidence of benefits and harms, and current guidelines are in the process of being updated. Currently, guidelines stress the need for shared decision making between patient and clinician (i.e., discussion of potential benefits, risks, patient values and preferences) in screening decisions.[16,17]



Notes: Prostate cancer screening is defined among males who have not been diagnosed with prostate cancer. Estimates are age adjusted to the year 2000 US population standard using two age groups: 50-64 and ≥65 years. ACS (males 50+ years) screening guidelines recommend shared decision making between patient and provider to guide screening decisions for PSA testing. **Source:** National Health Interview Survey, 2023.

Figure 69: Percentage of Current Tobacco Use by Sexual Orientation, Adults 18 Years and Older, United States, 2024

Across product type, current tobacco use is higher for gay, lesbian and bisexual individuals compared to their heterosexual counterparts.



Notes: *Ever smoked 100 cigarettes in lifetime and currently smoke every day or some days. §Of those who currently smoke, those who usually smoked menthol cigarettes . **Source:** National Health Interview Survey, 2024.

Disparities in Rural Communities

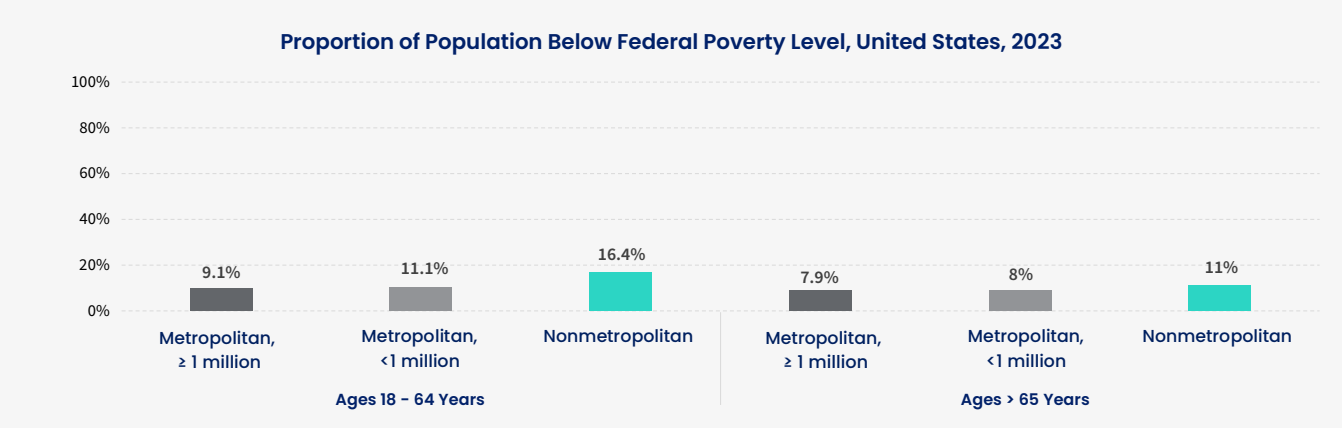
Individuals diagnosed with cancer residing in rural areas face challenges in accessing cancer care and experience worse outcomes than their counterparts living in more metropolitan areas. Although an estimated 17%-20% of the U.S. population resides in rural areas, only 3% of medical oncologists practice in rural communities, and over 70% of counties in the U.S. do not have medical oncologists.[44] Compared with nonrural areas, the rural health care system is more spread out and has fewer generalist and specialists, including oncologists, as well as fewer hospitals and other treatment facilities, such as dedicated cancer centers, laboratories or radiation therapy services.[45,46,47,48] Cancer patients and survivors living in rural communities are also more likely to have limited incomes and face serious financial hardship.[49]

Compared to people living in large metropolitan areas, individuals in rural areas are more likely to develop and die from cancer. The risk for rural residents is roughly 40% higher for lung cancer, 30% higher for cervical cancer, and 20% higher for colorectal cancer.[50] Significant barriers contributing to greater obstacles in access to cancer prevention, screening, treatment and survival care are deeply rooted in long-standing conditions that will take an intentional effort to address in order to achieve equitable cancer outcomes for rural communities.

Disparities in Cancer Incidence, Mortality and Survival in Rural Communities

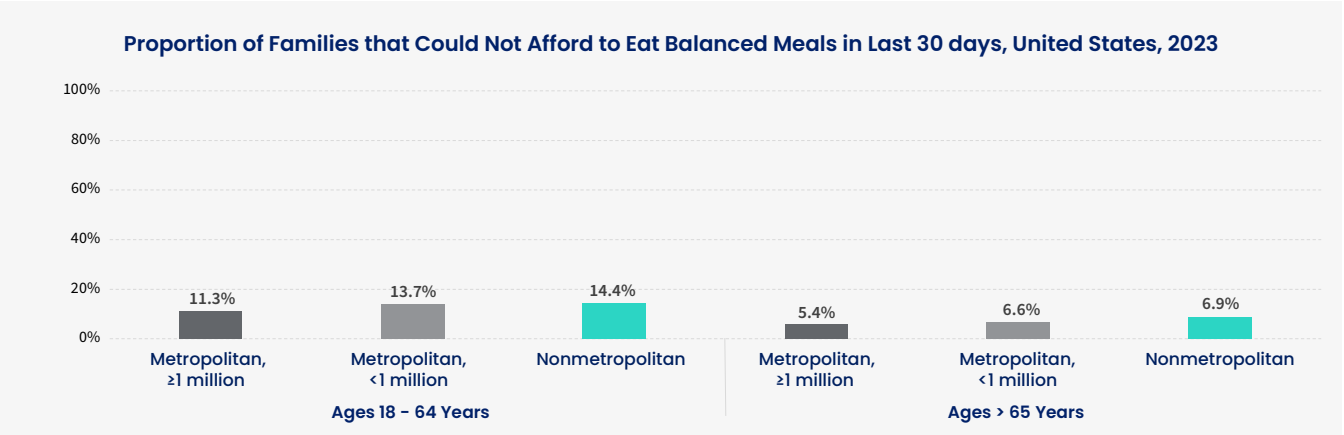
Figures 70 – 71: Select Socioeconomic Characteristics by Age Group and Urbanicity of County of Residence, United States, 2023

In 2023, it was reported that across age groups (18-64 years and > 65 years), individuals residing in nonmetropolitan areas consistently had a higher prevalence of income below the federal poverty level compared to individuals residing in metropolitan areas with populations greater than or equal to one million or less than one million. Specifically, younger individuals residing in nonmetropolitan areas (18-64 years) had a higher prevalence (16.4%) of having incomes below the federal poverty level compared to older individuals (> 65 years) living in nonmetropolitan areas (11%).



Having consistent access to affordable nutritious food has a direct impact on a person's health and can help prevent, manage, and treat chronic diseases like cancer. Evidence consistently shows that individual factors – like race, ethnicity, health insurance status, income, and where a person lives – strongly impact regular access to healthy food. The number of cancer patients who experience food insecurity is estimated to range between 17% and 55%.[51]

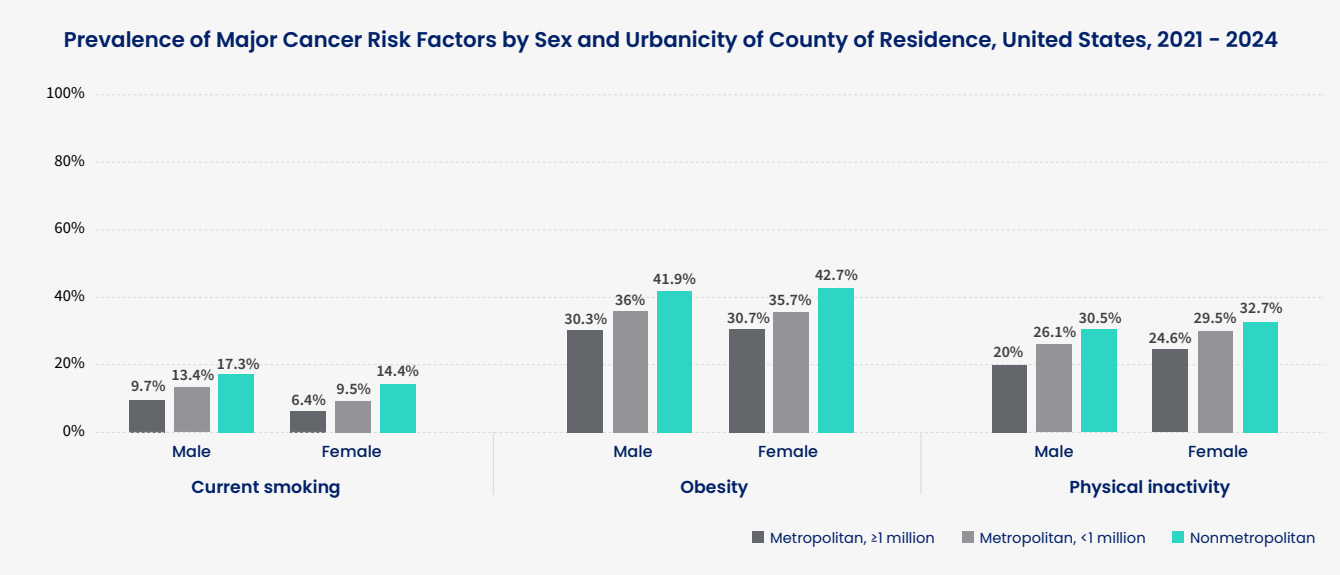
In 2023, it was reported that for those in the 18 to 64 year age group, individuals residing in nonmetropolitan areas had a greater prevalence of individuals whose families could not afford to eat balanced meals in the last month (14.4%), in comparison to those in metropolitan areas with a population lower than one million (13.7%) and a population greater than or equal to one million (11.3%). Conversely, for those older than 65, prevalence of individuals whose families could not afford to eat balanced meals in the last month showed little difference by place of residence, ranging from 6.9% in nonmetropolitan areas, to 6.6% in metropolitan areas with a population less than one million, and to 5.4% in metropolitan areas with a population greater than or equal to one million.



Notes: Data are age adjusted prevalence in individuals aged 18 years and older (25 and older years for education level).
Source: National Health Interview Survey, 2023.

Figure 72: Prevalence of Major Cancer Risk Factors by Sex and Urbanicity of County of Residence, United States, 2021 – 2024

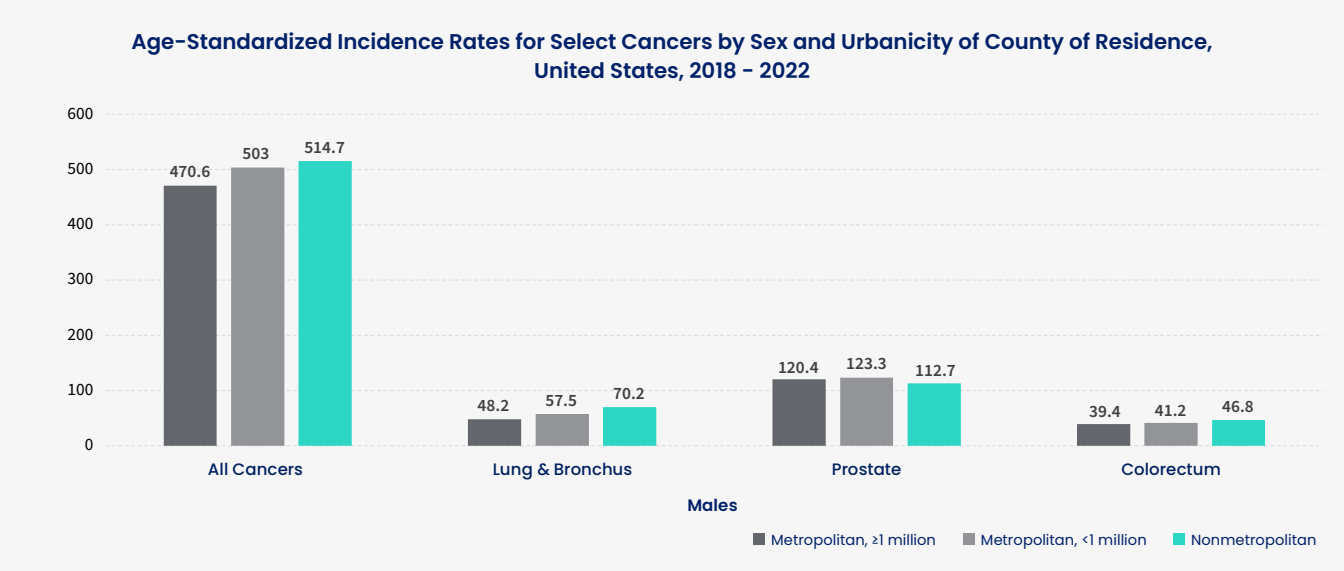
In 2024, the prevalence of modifiable cancer risk factors such as smoking, obesity and a lack of physical inactivity was greater for individuals residing in nonmetropolitan areas in comparison to metropolitan areas. Consistently across the board, the prevalence of risk factors was lowest among those living in metropolitan areas with a population greater than or equal to one million.

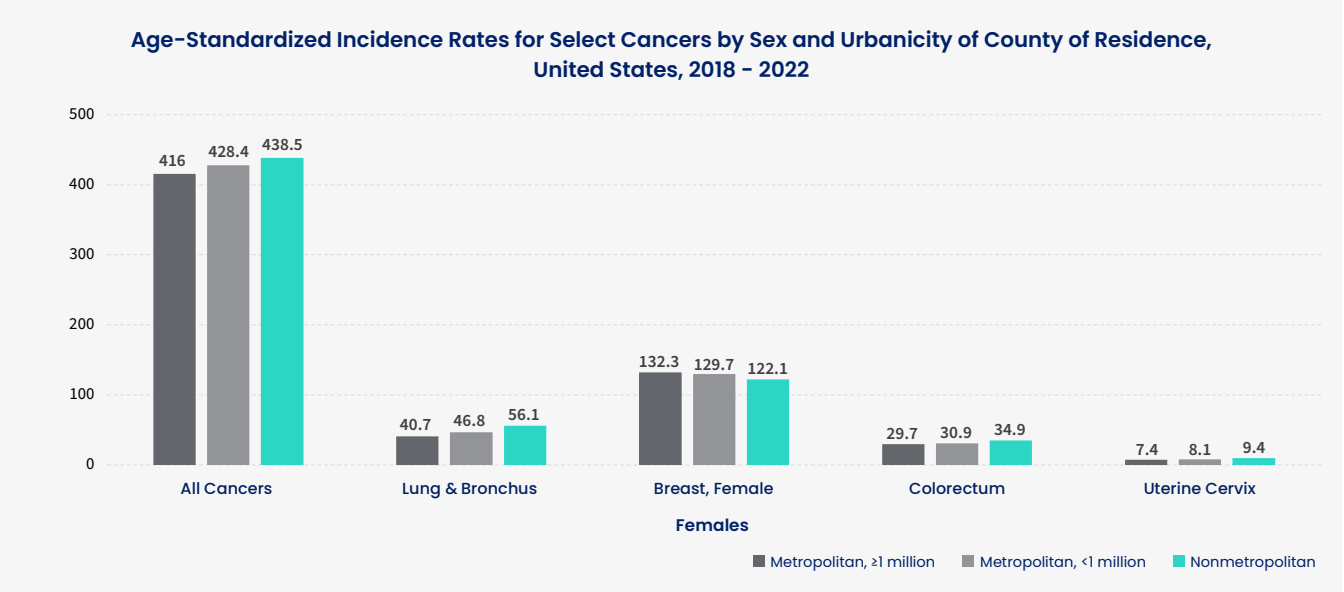


Notes: Current cigarette smoking was defined as smoking at least 100 cigarettes in a lifetime and currently smoking every day or some days. Obesity was defined as body mass index ≥30 kg/m. Physical inactivity was defined as no aerobic leisure-time physical activity.
Source: National Health Interview Survey, 2024.

Figures 73 - 74: Age-Standardized Incidence Rates for Select Cancers by Sex and Urbanicity of County of Residence, United States, 2018 - 2022

Between 2018 and 2022, nonmetropolitan females had higher incidence rates for uterine, colorectal and lung cancer compared to metropolitan females. For nonmetropolitan males, the incidence of colorectal and lung cancer was also greater compared to metropolitan males.

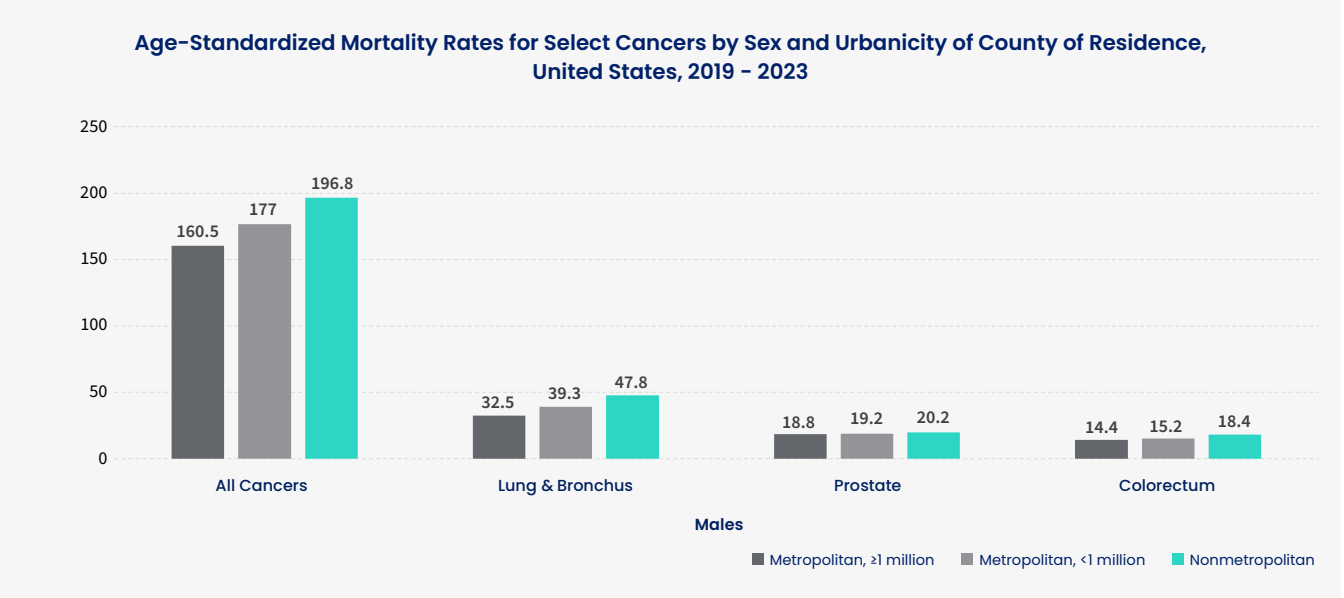


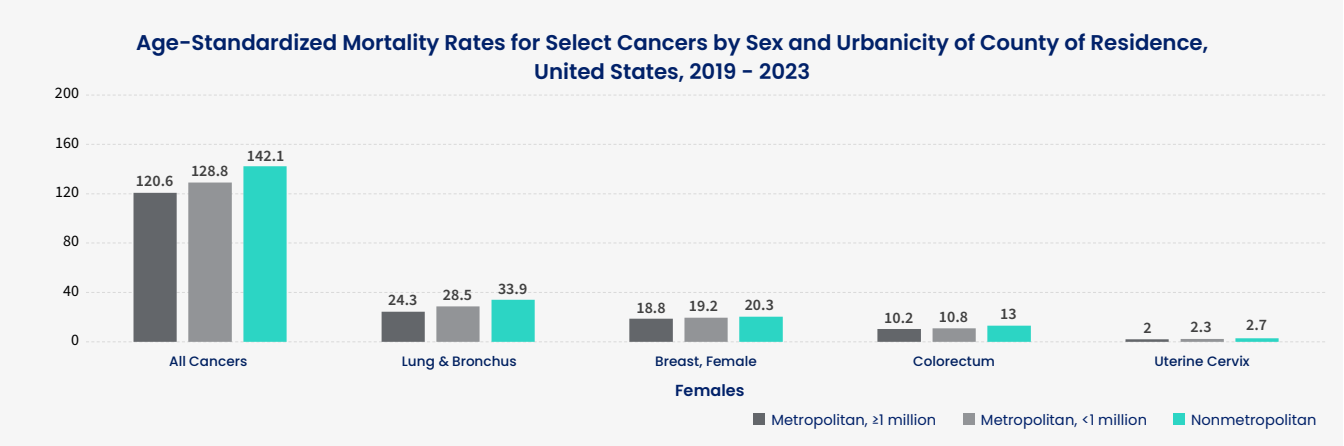


Notes: Rates per 100,000 population and age adjusted to the 2000 U.S. standard population.
Source: Surveillance, Epidemiology, and End Results 22 registries (covering 48% of the U.S. population).

Figures 75 - 76: Age-Standardized Mortality Rates for Select Cancers by Sex and Urbanicity of County of Residence, United States, 2019- 2023

Between 2019 and 2023, nonmetropolitan females had higher mortality rates for all cancers in comparison to their metropolitan counterparts. Similarly, nonmetropolitan males had higher mortality rates for all cancers compared to metropolitan males. This suggests disparities in healthcare access and health outcomes for nonmetropolitan populations, irrespective of gender.

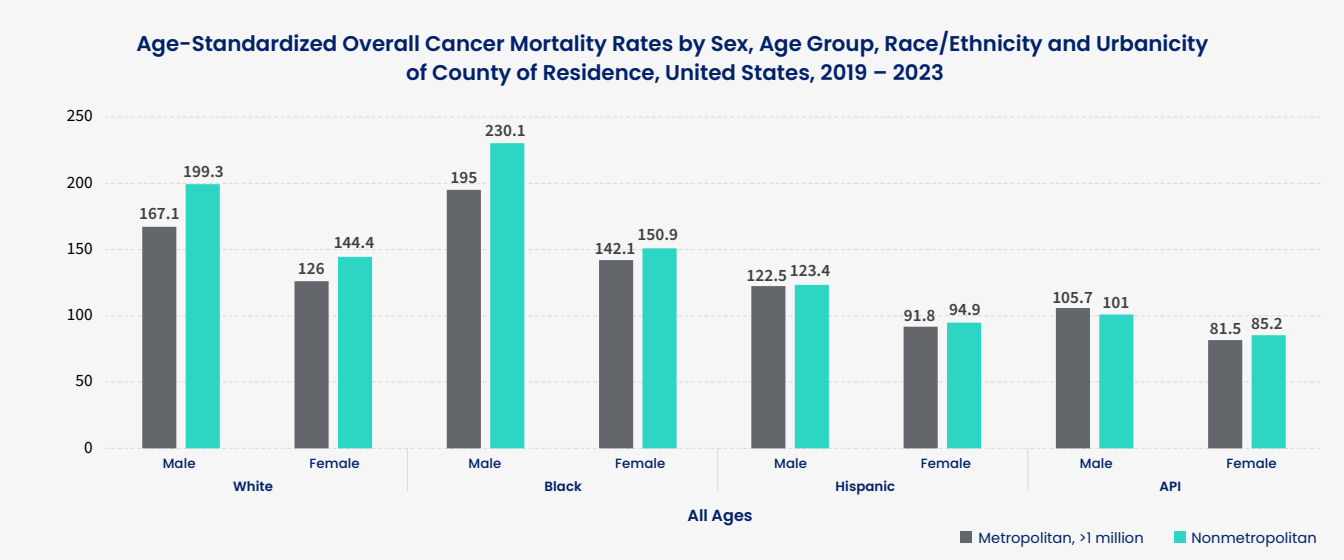




Notes: Rates per 100,000 population and age adjusted to the 2000 U.S. standard population. **Source:** National Center for Health Statistics.

Figure 77: Age-Standardized Overall Cancer Mortality Rates by Sex, Age Group, Race/Ethnicity and Urbanicity of County of Residence, United States, 2019 – 2023

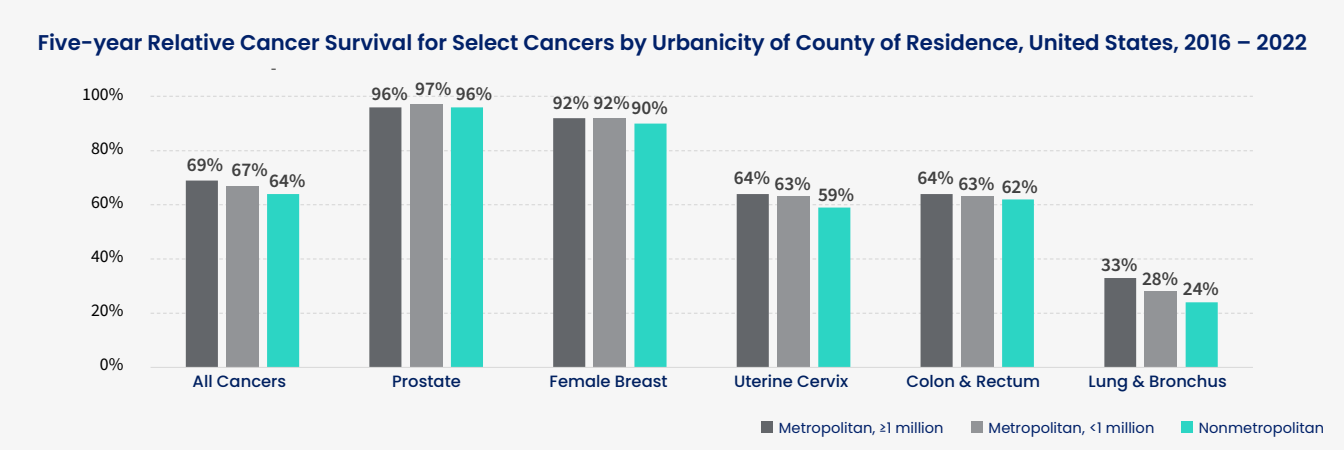
Between 2019 and 2023, across all groups, males consistently had higher mortality rates than females, and individuals in nonmetropolitan areas had higher rates than those residing in metropolitan areas, except for API males. This urban-rural gap was especially stark with large differences seen in non-Hispanic White and non-Hispanic Black populations.



Notes: Rates are per 100,000 population and age adjusted to the 2000 U.S. standard population. The American Indian or Alaska Native population is not included in this analysis because classification factors from the National Center for Health Statistics to adjust for racial misclassification on death certificates for this population are not available by urbanicity of the county of residence.
Source: National Center for Health Statistics.

Figure 78: Five-year Relative Cancer Survival for Select Cancers by Urbanicity of County of Residence, United States, 2016-2022

Between 2016 and 2022, the five-year relative cancer survival rate for select cancers was lowest for nonmetropolitan individuals across almost all cancer types compared to their metropolitan counterparts.

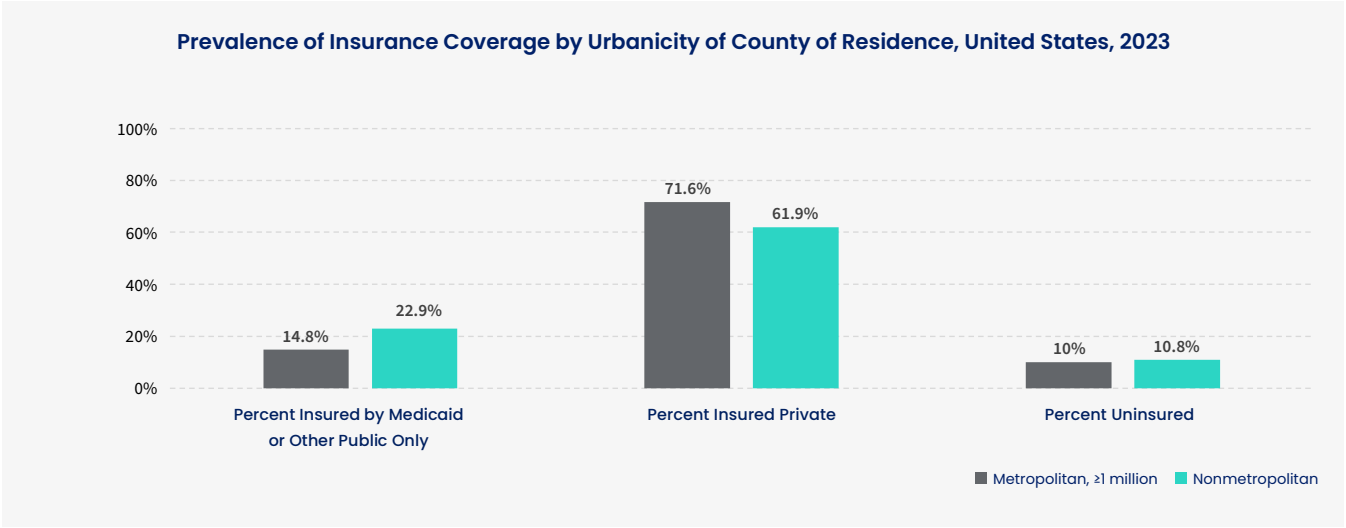


Notes: Five-year survival for cancer in individuals aged ≤99 years diagnosed in 2016–2022, excluding in situ carcinomas, age standardized to the International Cancer Survival Standards. SEER, Surveillance, Epidemiology, and End Results program.
Source: Surveillance, Epidemiology, and End Results Program, 21 registries (excluding Illinois) data.

Disparities in Access to Coverage in Rural Communities

Figure 79: Prevalence of Insurance Coverage by Urbanicity of County of Residence, United States, 2023

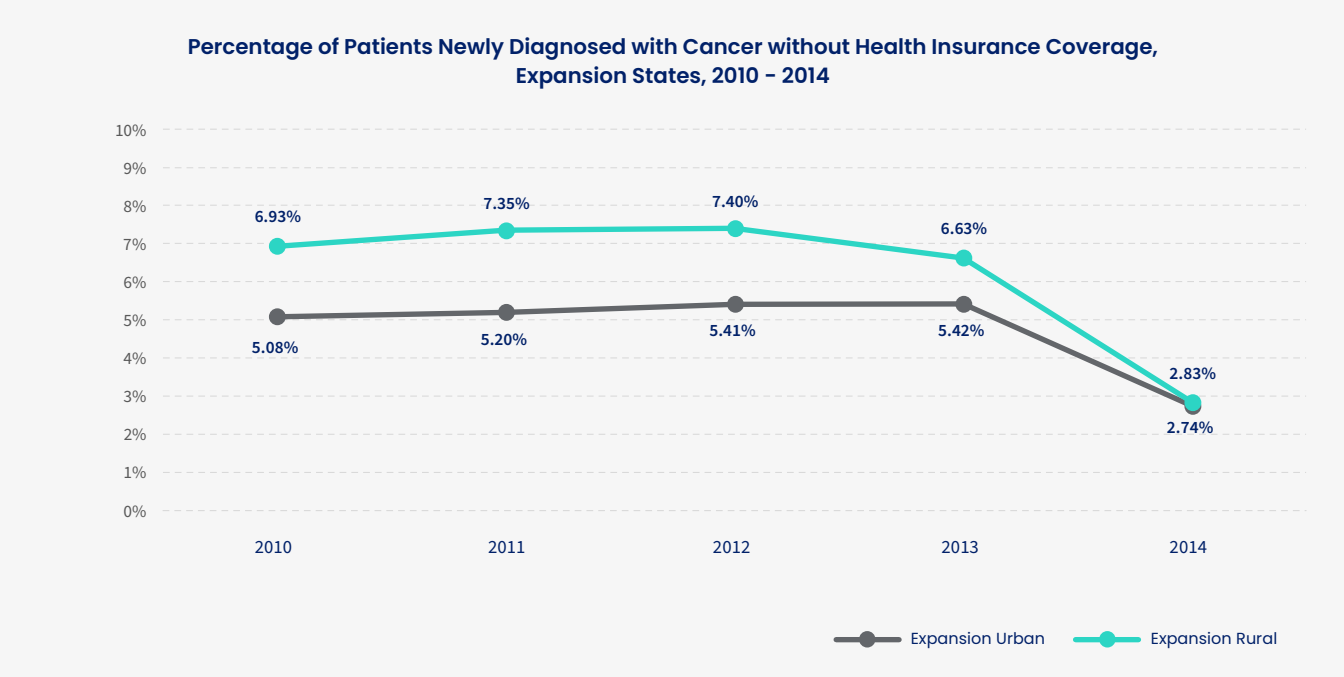
The percentage of Medicaid coverage was higher among nonmetropolitan individuals (22.9%) compared with metropolitan individuals (14.8%), but nonmetropolitan individuals had lower rates of being privately insured (61.9%) compared to metropolitan individuals (71.6%).

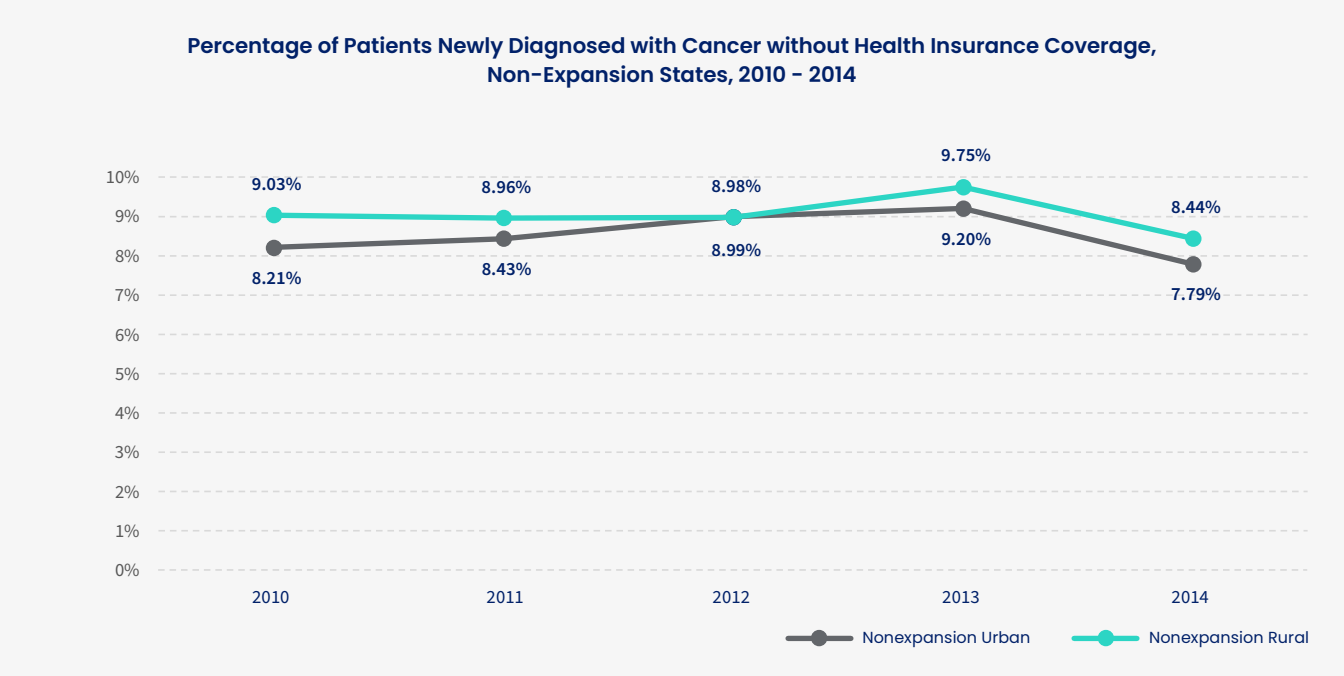


Source: National Health Interview Survey.

Figures 80 - 81: Percentage of Patients Newly Diagnosed with Cancer without Health Insurance Coverage, Expansion States and Non-Expansion States, 2010 - 2014

Following the implementation of Medicaid expansion under the Affordable Care Act in 2014, rural-urban health insurance coverage disparities decreased in expansion states among individuals aged 18-64 years newly diagnosed with cancer, but not in non-expansion states.



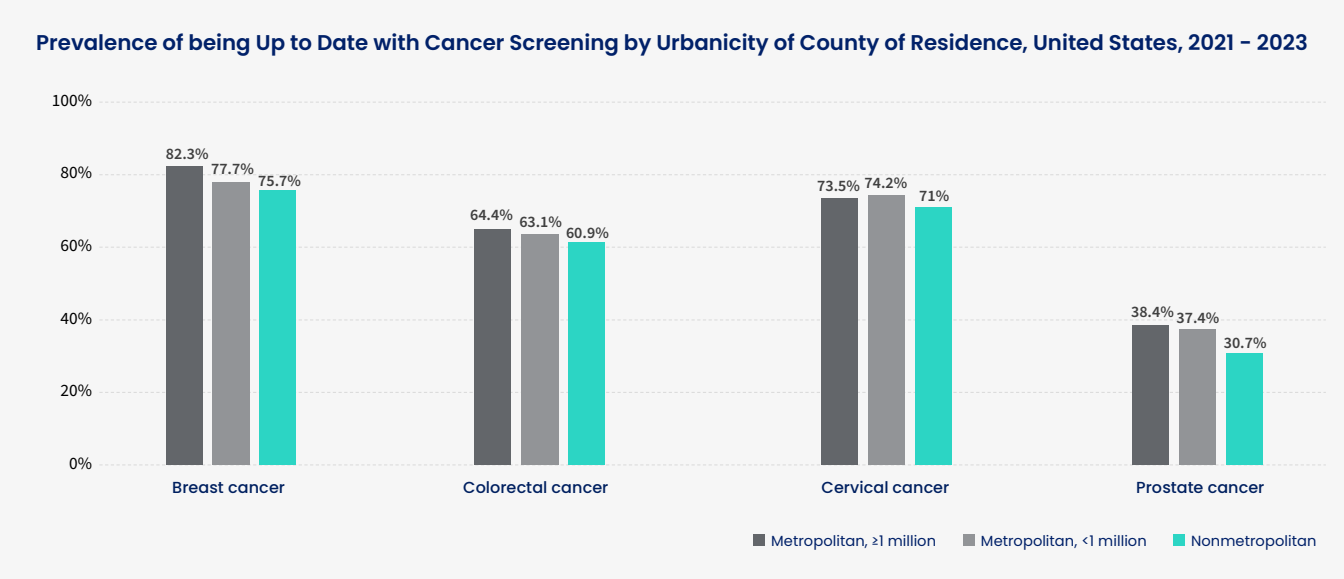


Notes: North American Association of Central Cancer Registries (NAACCR CiNA) 2010 - 2014 Data.
Source: Han X, Yabroff KR, Ward E, et al: Comparison of insurance status and diagnosis stage among patients with newly diagnosed cancer before vs after implementation of the patient protection and Affordable Care Act. JAMA Oncol 4:1713-1720, 2018.

Disparities in Cancer Prevention, Screening, and Early Detection in Rural Communities

Figure 82: Prevalence of being Up to Date with Cancer Screening by Urbanicity of County of Residence, United States, 2021 - 2023

From 2021 to 2023, the prevalence of being up to date with breast, colorectal and cervical cancer screening was slightly lower in nonmetropolitan areas than in large metropolitan areas. Prostate cancer screening is also presented below but lung cancer screening is not because data was not available.



Notes: Mammogram within the past year (ages 45–54 years) or past two years (aged 55 years and older) based on ACS guidelines; past two years based on USPSTF recommendations (aged 50–75 years). Fecal occult blood test/fecal immunochemical test, sigmoidoscopy, colonoscopy, computed tomography colonography, or stool DNA test in the past one, five, ten, five, and three years, respectively, based on ACS guidelines (aged 45 years and older) and USPSTF recommendations (aged 45–75 years). Papanicolaou test in the past three years (aged 25–65 years based on ACS guidelines and 21–65 years based on USPSTF recommendations) or Papanicolaou test and human papillomavirus test within the past five years (aged 30–65 years). Results for those aged 65 years and older are not shown for cervical cancer screening because only women aged 65 years in this age group were age-eligible for the screening. Serum prostate-specific antigen testing in the past year (aged 50 years and older based on ACS guidelines and 55–69 years based on USPSTF recommendations) among men who have not been diagnosed with prostate cancer. Both the ACS and the USPSTF recommend prostate cancer screening after shared decision making, for which data were not available from the National Health Interview Survey.
Source: National Health Interview Survey.

Disparities in Disability Communities

In 2022, over 70 million adults in the U.S. live with some type of disability. Under the Americans with Disabilities Act (ADA) a disability is defined as a physical and/or mental impairment that greatly limits one or more major life activities and may be genetic or acquired.[52] Disabilities can occur at any time across the lifespan, be permanent or temporary, "visible" or "invisible" to others, be experienced as part of the aging process and/or as a result of side effects caused by a cancer diagnosis or treatment.[53] Recent studies show that more than 25% of cancer survivors report significant levels of disability after cancer diagnosis, including disabilities that impact mobility and self-care.[54] Individuals with disabilities face unique challenges accessing cancer care, including preventive services. Unfortunately, to date there has been limited cancer related research to provide insight into the full scope of disparities in cancer care in the disability community.[55]

A critical factor for eliminating disparities and ensuring health equity is the guarantee that all people have access to quality, affordable health care. By ensuring that everyone, including individuals with disabilities, has access to care, harmful diseases like cancer can be detected and treated earlier – often resulting in better outcomes and less costs to the health care system.

29%

of adults in the U.S. live with some type of disability

1 in 4

individuals with a disability lack a regular health care provider or have unmet health needs due to cost

People living with disabilities are more likely to live with obesity, use tobacco products, be less physically active, live with social isolation, and have a greater likelihood of having comorbidities. In addition to elevated risk factors, which can increase their risk for chronic conditions like cancer, heart disease, and diabetes, people with disabilities have low cancer screening rates, which leaves them at elevated risk of later stage cancer diagnoses. Lower preventive care among people with disabilities can translate into increased risk for death and disease. Studies show that people with disabilities experience higher death rates from any cause, and from cancer, compared to those without disabilities.[56]

Compared to women without a disability, those with a disability report significantly higher rates of breast cancer and cervical cancer.

Women with a disability have lower recent mammography and Pap test rates than women without a disability.

In the U.S., 1 in 4 adults with disabilities lack a regular health care provider or have unmet health needs due to cost.[57] Adults with disabilities face health care access barriers, including insurance acceptance and accessible infrastructure at health care facilities. Medicare and Medicaid are common health plan options for people with disabilities. However, disparities in access to cancer care persist even among people with these health plan options because Medicaid patients at cancer hospitals in the U.S. face acceptance rates differing substantially within and between facilities.[58] Individuals with disabilities are more likely to reside in rural areas and are less likely to receive breast, cervical, and colorectal cancer screening.[59,60] Additionally, this population faces transportation barriers, making seeking health care services more challenging.[58]

Disparities in Cancer Prevention, Screening, and Early Detection in Individuals with Disabilities

Despite the enactment of the ADA 30 years ago, people with disabilities continue to experience inaccessible cancer diagnostic and screening equipment in clinical settings. For example, clinicians have noted challenges for positioning patients during routine procedures, including manual breast exams, screening mammography, and breast biopsies.[61] Additionally, most general practitioners do not have accessible scales or exam tables.[62] These barriers impact cancer screening adherence and survival outcomes for individuals with disabilities. Specifically, adults reporting cognitive and mobility disabilities have lower cancer screening adherence compared to adults without disabilities.[63,64] The evidence consistently shows that females with a disability have much lower breast and cervical cancer screening rates compared to females without disabilities.[62,65,66] In fact, people with disabilities report significantly higher levels of breast and cervical cancer diagnoses compared to those without disabilities. ACS CAN advocates for policies that address cancer disparities for individuals with disabilities and improve access to cancer preventative services, which are outlined below.

ACS CAN Policy Recommendations

to Address Cancer Disparities and Advance Health Equity

As the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, ACS CAN advocates for evidence-based public policies at the local, state and federal level to reduce the burden of cancer and cancer-related disparities and improve health outcomes for everyone. ACS CAN supports the following policies to advance health equity for various populations across the cancer care continuum:

Policy Recommendations to Address Disparities in Cancer Incidence, Mortality and Survival

- **Timely, accurate demographic data collection and publication is essential to advance health equity.** The availability of accurate, objective, and impartial data for race and ethnicity is critical to evidence-based health equity work. Separating out racial and ethnic information to unmask critical group differences and disparities is vital to cancer prevention and control efforts. Similarly, gaps in cancer information about LGBTQ+ communities are due to persistent lack of sexual orientation and gender identity (SOGI) data collection. In the same vein, databases often do not include information on disability, including non-physical or undisclosed disabilities, that can pose challenges to measuring disability-based disparities. Adding subgroups to the required minimum reporting categories can provide opportunities for improved reporting of information pertaining to the health of the nation's diverse population. When certain groups are underrepresented in survey data it becomes difficult to identify existing widespread disparities and can result in misleading data that fail to show striking differences in comorbidity burden and survival outcomes across different subgroups. ACS CAN supports funding and policies to promote timely collection and publication of demographic data that aid researchers, program managers and policymakers in identifying disparities to improve health equity in cancer prevention, detection and treatment.

- **Increasing access to patient navigation services.** Patient navigation can help to eliminate health disparities and reduce costs across the cancer care continuum by addressing the needs of historically marginalized and excluded communities, as well as those living in under-resourced communities. For example, one study showed that women in the patient navigation intervention group had significantly higher likelihood of being up to date on their breast cancer screening at the end of the follow-up period compared to women in the control group who did not receive these services, with the largest impact among African American Medicare beneficiaries living in urban areas who were previously not up to date on their breast cancer screenings.[67] Culturally appropriate patient navigation services can improve health outcomes for diverse populations through community outreach and targeted care coordination. Yet to date, patient navigation services are still absent or limited in many cancer programs and hospital settings due to cost concerns and lack of clinical reimbursement. Throughout the U.S., a patchwork of coverage exists depending on where patients live and the type of insurance coverage they have and is not continuous throughout the cancer care continuum, resulting in fragmented care. Ensuring access to patient navigation services will only be achieved by ensuring payment for patient navigation services is available across both public and private payers. ACS CAN is advocating for state and federal legislation and policies to increase access to patient navigation for people across the cancer care continuum, prioritizing policies that create sustainable funding to ensure continued patient access to patient navigation services across the cancer continuum.

- **Protecting and sustaining cancer registry funding.** As data collection is impacted by current federal policies and funding cuts, it is important that adequate funding is maintained for cancer registries which help identify emerging trends and help researchers measure progress in early detection and survival rates for cancer. Cancer registries also guide planning and evaluation of cancer control programs, set priorities for allocating resources, and assist with research regarding cancer causes and prevention strategies. By identifying trends or shifts in the burden of cancer, clinicians, public health professionals, and policymakers can begin to reverse negative trends. ACS CAN supports policies that fund and maintain access to high-quality and useable registry data, such as supporting the NCI's Surveillance, Epidemiology and End Results (SEER) cancer registry program and the CDC's National Program of Cancer Registries (NPCR), which provides technical, operational and financial support to almost all state cancer registries to help ensure data collected are representative of the U.S. population.

Policy Recommendations to Address Disparities in Access to Care

- **Protecting Medicaid coverage and expanding Medicaid in the remaining states that have not done so.** Protecting access to Medicaid and closing the coverage gap helps to improve cancer outcomes by offering access to prevention services and timely cancer screening and early detection services, as well as affordable treatment services and care. Having access to health insurance coverage is one of the greatest predictors of whether or not someone survives their cancer.[68] Medicaid is a lifeline for cancer patients because it ensures affordable health care for people who can't otherwise afford it. Recent federal cuts and the upcoming implementation of work requirements in Medicaid will mean some people will lose coverage – including potentially those living with cancer. This means their care could be interrupted or stopped completely. Others could lose access to regular cancer screenings and prevention, which would have a devastating impact on cancer patients and their families across the country. Additionally, there are millions of people who fall into the "Medicaid coverage gap" because their state has not expanded Medicaid. These individuals remain ineligible for Medicaid but earn too little to qualify for premium tax credits for qualified health plans in the Marketplace; 60% of these uninsured individuals are people of color, and the vast majority live in the American South. ACS CAN advocates for protecting access to care through Medicaid and urges all states to expand Medicaid.

- **Safeguarding access to care through insurance protections.** ACS CAN is committed to removing any barriers to accessing affordable, quality health care that threatens the fulfillment of our vision to end cancer as we know it, for everyone. Discrimination against certain populations, such as LGBTQ+ individuals and disabled individuals, that prevents the coverage for certain services creates disincentives for those individuals to seek insurance coverage, thereby creating another barrier to accessing cancer care.

- **Ensuring access to care without discrimination.** ACS CAN continues to support protections under Section 1557 of the Affordable Care Act (ACA), which ensures broad protection against discrimination on the basis of race, national origin, sex, age or disability in health care services. ACS CAN continues to oppose conscience and other discriminatory bills that threaten to deny cancer care and other health care services based on factors like religious beliefs or other forms of discrimination. Similarly, ACS CAN also supports the implementation and enforcement of regulations finalized in May of 2024 pursuant to Section 504 of the Rehabilitation Act. Section 504 prohibits individuals with disabilities from being excluded from or denied the benefits of any program or activity receiving federal financial assistance. This prohibition covers all health care and human services programs and activities funded by the U.S. Department of Health and Human Services, including Medicaid and Medicare. When implemented, the regulations will increase access to health care services including screening and preventive services by requiring health care facilities have equipment that can accommodate individuals with disabilities such as exam tables that can raise and lower or scales that can be rolled onto by an individual who uses a wheelchair.

- **Ensuring health insurance plan network adequacy for affordable and equitable cancer care.** Accessing health care services can be challenging for certain groups of people generally and more specifically within their in-network contracted health plans. Lacking health insurance is also more prevalent in rural populations who are less likely to be covered by employer-sponsored health insurance and more likely to be covered by Medicare and Medicaid or to be uninsured than their urban counterparts.[69,70] ACS CAN aims to ensure health insurance networks adequately provide all enrollees with reasonable and timely access to an in-network facility that provides cancer screenings, follow-up testing, high-quality treatment and appropriate health care providers.

- **Expanding access to comprehensive affordable cancer care to the uninsured.** Reducing the rates of people who are uninsured in this country not only ensures that serious diseases like cancer can be detected and treated earlier, but it also often means better patient outcomes and less costs to the individual and the larger health care system. The ACA expanded health insurance coverage to millions of Americans. However, despite these coverage gains, millions of people in the U.S. remain uninsured, with data showing that noncitizens are more likely to be uninsured. In 2023, nearly one-third (33%) of noncitizen immigrants were uninsured, while the uninsured rate for U.S. born citizens was 7.5% and 8.9% for naturalized citizens.[71] A critical factor for eliminating disparities and ensuring health equity is to guarantee that all individuals have access to affordable coverage, regardless of immigration status.

- **Increasing access to quality cancer care for marginalized people through telehealth services and telemedicine.** Telehealth provides people with cancer and survivors, and people at risk of cancer, with a convenient means of accessing preventive, primary and cancer care – a particularly important option for individuals who have been under-resourced, including residents of rural communities who often find it difficult to find transportation and paid time off to travel to metropolitan areas for care. ACS CAN supports legislation that makes it easier for patients to have long-term access to appropriate telehealth services, including bringing broadband technology to rural areas.

- **Addressing and preventing medical debt.** Many patients with complex diseases like cancer find it hard to afford their treatments and incur medical debt when they are unable to pay for treatments or other expenses immediately. People of color, people living in rural areas, in the South and in Medicaid non-expansion states are more likely to have significant medical debt that can impact their lives and families for decades. ACS CAN supports policies that prevent and address medical debt such as removing medical debt from credit reports, improving and expanding provider financial assistance programs, ensuring patients can use discount/assistance programs for prescription drugs and policies that push providers to resolve medical billing issues before they impact patients – particularly those from underserved populations.

Policy Recommendations to Address Disparities in Cancer Prevention, Screening and Early Detection

- **Protecting and increasing colorectal cancer screening and control program funding.** Colorectal cancer control programs raise public awareness about colorectal cancer and improve access to screening, patient navigation and treatment services. Programs use evidence-based patient and provider interventions to promote screening and reduce barriers to eligible adults. For example, the Centers for Disease Control and Prevention's (CDC) Colorectal Cancer Control Program (CRCCP) provides grant funding to 20 state health departments, eight universities, two tribal organizations and five other organizations to help prevent colorectal cancer.[72] The goal of the CRCCP grant work is to increase colorectal cancer screening rates among high-need groups. Without a continued, dedicated federal and state investment in colorectal cancer prevention and early detection, the U.S. could experience a reduction in screening, leading to increases in preventable colorectal cancer cases and deaths. ACS CAN supports federal and state funding for programs like the CRCCP, which increase screening, reduce the colorectal cancer burden in the U.S. and is an essential program in the fight against cancer, as it helps to reduce health inequities by serving those at most risk for the disease.

- **Ensuring Congress passes the Prostate-Specific Antigen (PSA) Screening for High-Risk Insured Men (HIM) Act.** Prostate cancer survival rates increase when it is detected early; however, there has been a recent increase in diagnosis of men with advanced prostate cancer.[73] Screening can help detect prostate cancer at an early stage, often before any signs and symptoms are present and before the disease becomes more advanced and more difficult to treat; however, cost sharing or out-of-pocket requirements can be a barrier to accessing screening. The PSA Screening for HIM Act would give men at high risk for prostate cancer improved access to screening by requiring health insurance coverage for evidence-based prostate cancer preventive care and screenings, like the PSA test, without cost sharing.[74] Whoever decides to move forward with screening after a discussion with their health care provider about their individual risk factors for developing prostate cancer should have access to screening that is barrier-free without cost sharing.

- **Protecting and increasing funding for the lifesaving National Breast and Cervical Cancer Early Detection Program (NBCCEDP).** The CDC's NBCCEDP is the only national cancer screening program for breast and cervical cancer in the U.S. for populations that historically have not had adequate access to or have likely experienced other barriers to breast and cervical cancer screening. The NBCCEDP uses evidence- and population-based approaches, such as public education, outreach, patient navigation and care coordination, to increase screening and reach to limited-income, uninsured and underinsured women in all 50 states, the District of Columbia, 6 U.S. territories and 13 tribes. Despite the NBCCEDP's proven success, federal and state funding is inadequate to reach all women who are eligible to receive lifesaving screenings. ACS CAN urges Congress and states to adequately fund cancer programs, including the NBCCEDP.

- **Eliminating cost sharing for cancer screening and all follow-up tests.** Research shows that required cost sharing – including co-pays, co-insurance, and deductibles – can be a significant barrier for individuals who need preventive services.[75] This can be especially true among people with limited incomes for whom these payments can represent a significant percentage of their income. Out-of-pocket costs for individuals lead to delayed or missed cancer screenings. Delayed or missed screenings can lead to delays in follow-up testing and treatment, which ultimately impacts a person's survival. The ability to detect cancer early can have a dramatic effect on survival. While the law is clear that cost sharing should not apply to preventive services, without federal or state laws defining what constitutes screening, payers are determining what is or is not a no-cost preventive service. As a result, individuals are being charged when additional screening tests are recommended, such as after an abnormal screening, or if supplemental screening is recommended for people who are above average risk. ACS CAN supports comprehensive insurance coverage and the elimination of cost sharing for all recommended cancer screening and follow-up testing for asymptomatic individuals by all payers.

- **Increase access to and uptake of evidence-based vaccines that protect against cancer-causing viruses, treat cancer, and safeguard cancer patients and their families by maximizing community immunity.** Central to cancer prevention is access to Human Papillomavirus (HPV) vaccines. HPV causes almost all cervical cancers, 90% of anal cancers, and 60-70% of oropharyngeal, vaginal, vulvar and penile cancers. Despite the HPV vaccine's ability to prevent most HPV-related cancers, vaccination rates remain very low. Almost two decades of research and safety monitoring have shown that the HPV vaccine is both safe and effective. ACS CAN strongly believes in preventing cancer before it develops and detecting cancer early when it is more easily treated. ACS CAN supports evidence-based efforts to increase HPV vaccination rates, consistent with ACS HPV vaccination guidelines, to prevent cervical and other HPV-related cancers in the U.S.

- **Ensuring physical accessibility of transportation, products and services that individuals need to access routine preventive services and cancer screenings.** Research from the American Cancer Society shows that transportation insecurity can be a barrier to screenings and is associated with disparities in cancer care and patient outcomes.[76] Policies that increase access to non-emergency medical transportation services and facilities compliant with the Americans with Disabilities Act help address the transportation barriers that prevent cancer patients and others with serious illnesses from accessing timely and effective care, including routine preventive services and cancer screenings. Additionally, improving coverage for home self-collection modalities for cancer screening is another avenue to improve uptake for those with physical accessibility barriers. Increasing access to home testing must be accompanied with coverage for adequate follow-up for diagnosis and treatment.

- **Eliminating tobacco use to address health disparities.** Tobacco use is one of the primary drivers of cancer-related health disparities because its use disproportionately impacts people based on race, ethnicity, sexual orientation, gender identity, disability status, mental health, income level, education level and geographic location.[77,78,79] Eliminating health disparities depends heavily on eliminating tobacco use. The tobacco industry's aggressive marketing use of advertising, price discounting and flavors to intentionally target people of color, LGBTQ+ people, and people with limited incomes has caused both disproportionate tobacco use and tobacco-related disparities among these populations.[80,81,82] Multiple factors continue to influence tobacco product use and initiation among middle and high school students, including availability of flavored products, marketing, and misperceptions regarding harm. For decades, tobacco companies have used flavors, in cigarettes, cigars, e-cigarettes and hookah, to lure and target youth and young people and expose them to a lifetime of nicotine addiction, disease and premature death. Continued surveillance provides an understanding of the prevalence and frequency of tobacco product use, the popularity of specific brands and flavors, and how product use behaviors change over time as the tobacco product marketplace continues to diversify. ACS CAN will continue to advocate for comprehensive evidence-based policies at the local, state and federal levels that aim to reduce disparities and improve health outcomes for all individuals. Effective policies known to prevent tobacco use and address tobacco-related disparities include adequately funding tobacco prevention and cessation programs; ensuring cessation services are comprehensive and accessible; increasing the price of tobacco products through regular and significant tax increases on all tobacco products; enacting comprehensive smoke-free laws that cover all workplaces, including restaurants, bars and gaming facilities; continuing to urge the Food and Drug Administration to use its full authority to regulate tobacco products and prohibit all flavored products, including menthol; and preserving local control of public health policies.

- **Supporting access to affordable, nutritious food.** Poor diet, and excess weight, along with physical inactivity and alcohol consumption are second only to tobacco use as modifiable risk factors for cancer. Research has found that food insecurity – defined as experiencing hunger, worry about running out of food, or not having consistent access to nutritious food - can be associated with poor diet quality, obesity and reduced fruit and vegetable intake.[83] Evidence consistently shows that individual factors – like race, ethnicity, health insurance status, income and where a person lives – strongly impact regular access to healthy food. For instance, living in a rural area, living in a community without stores that offer healthy foods, being American Indian or Alaska Native or Black, having limited income and limited education have all been shown to be independently associated with poor diet quality.[84] Having consistent access to affordable nutritious food has a direct impact on a person's health and can help prevent, manage and treat chronic diseases like cancer. ACS CAN advocates for policies at the federal, state and local level aimed at addressing food and nutrition insecurity and reducing health disparities.

Policy Recommendations to Address Research Disparities

- **Improving access to a skilled and inclusive cancer workforce.** People of color are still underrepresented in the medical care and research workforce.[85,86] Research awards from the National Institutes of Health (NIH) are a major source for biomedical research funding and helping investigators to continue their research activities. However, researchers from racial/ethnic minority groups generally apply to and receive these grants at a lower rate compared with other researchers.[68,87] Improving access for qualified individuals to career opportunities in the primary care and oncology workforce and in leadership positions could reduce provider biases that may be associated with differences in care in health care settings,[88,89] improve patient-provider communication, shared decision making, and health outcomes,[90] and increase people of color's satisfaction and trust in health systems.[91,92] In addition to deploying interventions already known to be effective,[93] further research is needed to identify new approaches that can improve access to career opportunities in the cancer care workforce.

- **Reducing barriers to participating in clinical trials.** Clinical trials are vital to advancing new and improved standards of care and give patients the opportunity to participate in research and development of new treatments. While patient willingness to enroll in clinical trials is high, some patients decline to participate due to costs. They are often responsible for non-medical costs, such as transportation and lodging associated with trial enrollment. These costs can occur when no local trials are available and patients must travel to distant trial sites, or when there is a need for more frequent clinic visits for additional trial-related treatment or monitoring. The additional costs can lead to unequal participation rates between high- and limited-income people with cancer; the patients most impacted tend to be those traditionally underrepresented. For instance, women who belong to certain racial and ethnic groups[94] are underrepresented in breast cancer clinical trials, and those with limited incomes are less likely to participate.[95] To address this issue, the Clinical Trial Modernization Act would allow clinical trial sponsors to provide financial support to trial participants and the technology needed to participate in trials remotely, which would particularly benefit rural communities. Offering to reimburse patients for non-medical costs associated with trials can increase overall enrollment and thereby help make it less costly for them to participate in clinical trials during their cancer treatment. ACS CAN advocates for policies that can increase participation in clinical trials by populations disproportionately impacted by cancer and reduce barriers to enrollment.

- **Enforcing statutorily required clinical trial diversity plans at FDA.** Statutory requirements passed as part of the Food and Drug Omnibus Reform Act (FDORA) of 2022 require drug sponsors to submit diversity action plans to FDA for their pivotal drug trials. These action plans describe methods to ensure representative participation in clinical trials, which can help ensure that drugs developed are effective and safe across all demographics. The guidance around this requirement has not been finalized and FDA has not begun enforcing this law. It is critical that this bipartisan provision be fully implemented.

- **Expanding community clinical trial infrastructure.** Clinical trial availability is very heterogeneous across the U.S. NCI, through cancer center and NCI Community Oncology Research Program (NCORP) grants, helps fund infrastructure; however, 97% of funded sites are located in densely populated urban areas. To address the lack of opportunities in rural areas, NCI should expand its investment in community trial infrastructure.

Addendum: List of Figures by Disparity Type

This addendum provides a list of the chartbook's figures and map organized by disparity type across populations rather than by subpopulation.

Disparities in Cancer Incidence, Mortality and Survival across Communities

Disparities in Access to Coverage across Communities

Disparities in Cancer Prevention, Screening, and Early Detection across Communities

Disparities in Clinical Trial Participation across Communities

Disparities in Cancer Risk Factors across Communities

Source of Statistics

The sources of data used throughout the chartbook are from previous publications produced by the American Cancer Society:

- American Cancer Society Cancer Prevention and Early Detection Facts and Figures, 2026
- American Cancer Society Cancer Prevention and Early Detection Facts and Figures, 2025-2026
- American Cancer Society Facts and Figures, 2025
- Cancer Statistics for African American and Black People, 2025
- American Cancer Society Facts and Figures, 2024
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- American Cancer Society Cancer Statistics, 2024
- American Cancer Society Cancer Facts and Figures for Hispanic/Latino People, 2024-2026
- American Cancer Society Cancer Facts and Figures for Asian American, Native Hawaiian, and Other Pacific Islander People, 2024-2026
- American Cancer Society's report on the status of cancer disparities in the United States, 2023
- American Cancer Society's Progress in reducing cancer mortality in the United States by congressional district, 1996–2003 to 2012–2020

Appendix: American Cancer Society Guidelines

Screening increases the chances of detecting certain cancers early, when they might be easier to treat. The American Cancer Society recommends certain cancer screening guidelines which can all be accessed at:

- American Cancer Society Breast Cancer Screening Guidelines
- American Cancer Society Cervical Cancer Screening Guidelines
- American Cancer Society Colorectal Cancer Screening Guidelines
- American Cancer Society Endometrial Cancer Screening Guidelines
- American Cancer Society Guidelines for Human Papillomavirus (HPV) Vaccine Use
- American Cancer Society Lung Cancer Screening Guidelines
- American Cancer Society Prostate Cancer Screening Guidelines

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