Disparities in Cancer Care
Community Oncology Alliance Position Statement

Community Oncology Alliance Position
The Community Oncology Alliance (COA) recognizes there are profound and widespread disparities in cancer burden and cancer care among various groups and seeks to diminish these disparities whenever possible. It is estimated that 34 percent of cancer deaths among U.S. adults ages 25 to 74 could be prevented if socioeconomic disparities were eliminated. Cancer disparities are pervasive, sometimes obvious, but often unconscious in nature. Population groups that may experience cancer disparities include groups defined by race/ethnicity, disability, gender identity, geographic location, income, education, age, sexual orientation, national origin, and/or other characteristics.

As an individual advocacy organization, we cannot begin to address every aspect of disparities. However, COA and its members strive to recognize disparities whenever possible and are committed to do being leaders in collective efforts to end them.

Background

Access
Individuals of racial/ethnic minority groups are more likely to be uninsured with limited access to care. Patients in rural areas face limited access to medical and oncology providers, long travel times, and low recruitment to clinical trials, all of which affect quality of care and health outcomes. Rural counties also have high rates of cancer-related mortality and other negative treatment outcomes. The combination of lack of insurance and/or care that is prohibitively distant from patients' homes can have a significant effect on multiple aspects of patient care and thus prognosis.

Screening Rates and Stage at Diagnosis
Screening is a well-established method of detecting cancer while still in an early stage. It follows that when treatment begins during an earlier stage of cancer, the outcome is more likely to be better. Thus, any disparity in screening rates can be critical to patient prognosis. There is mounting evidence of the need for, and value of, organized approaches to cancer screening (e.g., use of registries to identify unscreened patients, delegation of tasks, outreach through letters and/or phone, point of care reminders); organized approaches are critical to addressing disparities in cancer screening and follow-up. The central barrier to implementing these evidence-based interventions is a lack of resources, particularly in practices that serve poor and minority patients, but also a need for a redesign of primary care away from exclusively visit-based care and towards team-based care.
Affordability and Financial Toxicity
Not only is there a link between cancer care and affordability, but studies also show that the financial toxicity of paying for cancer care has an impact on the prognosis for those who struggle to pay for that care. As noted in a 2006 study on disparities in cancer care, any poor person experiences a broad spectrum of problems that are universal issues for people of low income. When you are poor, you not only have diminished access to medical care and treatment, you [also] have poorer housing, less social support, and a risk-promoting lifestyle, with a greater likelihood of smoking. If you are worried about food, shelter, and avoiding crime, you are not going to think so much about getting a mammogram, especially if you can't pay for it.11

Importantly, racial and ethnic health disparities, including cancer health disparities, exert enormous direct medical costs and indirect costs through loss of productivity12,13 One study projected that eliminating health disparities for racial and ethnic minorities would have reduced direct medical costs by about $230 billion and indirect costs associated with illness and premature death by more than $1 trillion from 2003 to 2006.14 In another study, it was estimated that disparities in premature deaths from cancer between African Americans and whites cost $3.2 billion in lost earnings in 2015.15

Survival Rates
Certain ethnic groups are at an increased risk of developing a specific cancer or dying from a specific cancer. Some key cancer incidence and mortality disparities in the United States include:

- African Americans have higher death rates than all other racial/ethnic groups for many, although not all, cancer types.
- African American men are twice as likely as white men to die of prostate cancer.
- People with more education are less likely to die prematurely (before the age of 65) from colorectal cancer than those with less education, regardless of race or ethnicity.
- Latinx and African American women have higher rates of cervical cancer than women of other racial/ethnic groups.
- American Indians and Alaska Natives have higher death rates from kidney cancer than any other racial/ethnic group.16
- African American women have a 39 percent higher risk of dying from breast cancer compared with their white counterparts17
- Hispanic children and adolescents are 20 percent and 38 percent more likely to develop leukemia than non-Hispanic white children and adolescents, respectively.18
- Asian and Pacific Islander adults are twice as likely to die from stomach cancer as white adults.19
- American Indian and Alaska Native adults are twice as likely to develop liver and bile duct cancer as white adults.20
For others, the cancer incidence and prognosis are dependent not on ethnicity but on geography, access to insurance coverage, income, or sexual preference:

- Men living in Kentucky have lung cancer incidence and death rates that are about 3.5 times higher than those for men living in Utah.\(^{21}\)
- Patients with localized hepatocellular carcinoma, the most common type of liver cancer, who have no health insurance, have overall survival that is less than half as long as those who have private health insurance (8 months versus 18 months).\(^{22}\)
- Men living in the poorest counties in the United States have a colorectal cancer death rate that is 35 percent higher than that for men living in the most affluent counties.\(^{23}\)
- Bisexual women are 70 percent more likely to be diagnosed with cancer than heterosexual women.\(^{24}\)

**Representation in Clinical Trials and Precision Medicine**
Clinical trials overwhelmingly fail to represent the demographic diversity of the populations that the drugs in development aim to serve. Precision medicine is predicted to revolutionize the clinical practice of cancer, in part by using molecular biomarkers to assess patients' risk, prognosis, and therapeutic response more precisely. However, reliance on biomarkers could present challenges for diverse populations that are not equitably represented in precision medicine research.

A 2017 study examined the populations included in genome-wide association studies – the most common type of research that detects genetic alterations that are associated with disease risk. The study found that nearly 80 percent of individuals in genome-wide association studies were of European descent, 10 percent were Asian, two percent African, one percent Hispanic, and less than one percent were of other populations.\(^{25}\) Lack of diversity in clinical trials is a moral, scientific, and medical issue. When trial participants are homogenous (e.g., primarily one gender, race/ethnicity, or age group), findings may be skewed and result in a body of clinical knowledge that is not generalizable.\(^{26}\) The downstream effect is ineffective drugs.

**Workforce Diversity**
There is a growing need for medical oncologists in general. Additionally, there is under-representation in the oncology workforce of African American, Hispanic, and female physicians in comparison to white males. A lack of workforce diversity can negatively impact quality and health incomes for minority patients.\(^{27}\) URM is an acronym describing the underrepresented groups in medicine compared to relative numbers in the general population. The URM group includes, but is not limited to, African Americans, Native Americans, and Hispanic Americans.\(^{28}\) Efforts are underway to encourage further diversity in the oncology workforce, including physicians and advanced practice providers.

**Summary:**
There are disparities in all aspects of cancer care: access to screening, access to care, and the ability to pay for care. Diverse racial/ethnic groups often do not have proper access to
screening or to quality cancer care. Too often, such individuals arrive for care with cancer in a later stage, and thus a poorer prognosis. They struggle to pay for care and carry the burden of significant financial toxicity of their cancer care. Failure to include multiple ethnic groups in clinical trials results in more disparities, making new treatments and precision medicine less applicable and less available to patients beyond those of European descent.

COA believes health care disparities must be addressed to ensure that cancer care is more equitable, available, and effective for all Americans. We call on the relevant federal agencies, other cancer-related organizations, and Congress to join in efforts to eliminate disparities. Health care inequality will likely worsen with advances in therapy and the use of precision oncology unless parallel work to address health care disparities occurs. Failure to address systemic bias in health care provision and genetic databases will make existing disparities worse. At the forefront of the COA mission is a recognition of health care disparity and the impact that it has to many Americans facing cancer. The hope is to include this important issue as part of all COA initiatives.

Date:
Approved by the Board of Directors of COA on April 22, 2021.

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