

Cancer in the Medically Underserved Population



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KEYWORDS

- Cancer • Incidence • Mortality • Underserved • Screening • Prevention
- Health disparities • Global health

KEY POINTS

- In the United States, the lifetime risk of developing cancer is about 1 in 2 in men and 1 in 3 in women. Liver cancer is increasing among all population groups.
- The World Cancer Research Fund estimates that about 20% of all cancers diagnosed in the United States are related to body fatness, physical inactivity, excess alcohol consumption, and/or poor nutrition.
- There was a decline in breast and cervical cancer screening between 2008 and 2013. However, there was significant increase in colorectal cancer screening during the same period.
- Disparities in cancer incidence and mortality are not fully explained by correlations of race and lower socioeconomic status, or minority race and insurance status.
- The incidence and mortality of cancer is decreasing in Western countries through decreasing prevalence of known risk factors, early detection, and improved treatment.

INTRODUCTION

Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled it can result in death.¹ Cancer is the second most common cause of death in the United States. It accounts for nearly 1 in 4 deaths. In the United States, the lifetime risk of developing cancer is 1 in 2 in men (42%) and 1 in 3 in women (38%). According to the American Cancer Society (ACS), 1,685,210 new cases of cancer will be diagnosed in 2016 and an estimated 595,690 deaths will occur as a result of cancer. A significant proportion of cancer can be prevented. In 2016, about 188,800 of the estimated 595,690 cancer deaths

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in the United States will be caused by cigarette smoking, according to a recent study by ACS epidemiologists. In addition, the World Cancer Research Fund (WCRF) estimates that about 20% of all cancers diagnosed in the United States are related to body fatness, physical inactivity, excess alcohol consumption, and/or poor nutrition, and thus could also be prevented.² Cancers that are related to infectious agents, such as human papillomavirus (HPV), hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), and *Helicobacter pylori* could be avoided by preventing these infections through behavioral changes or vaccination, or by treating the infection.¹

An Institute of Medicine report titled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” mentioned that one of the core aims of health care is the provision of care that does not vary in quality because of race, ethnicity, sex, socioeconomic status, and geographic considerations. This report showed compelling evidence of significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable.³ This report revealed that underrepresented and underserved populations are less likely to receive routine medical procedures and experience a lower quality of health services. As defined by Vincent Morelli in the introduction of this issue, medically underserved areas and medically underserved populations are determined by the Health Resources and Services Administration by measuring 4 variables: (1) ratio of primary care physicians per 1000 population; (2) infant mortality; (3) percentage of the population below the poverty level; and (4) percentage of the population age 65 years or older. It has been estimated that more than 100 million Americans are medically underserved.⁴

Otis Brawley,⁵ Chief Medical and Scientific Officer and Executive Vice President of the ACS, observed in his study on colorectal cancer that there were similar age-adjusted mortalities in black and white people in the 1970s. Significant disparities in mortality began in the early 1980s. This disparity coincided with the advent of large-scale screening programs and coverage for colonoscopies. Although overall mortalities have declined for all racial/ethnic populations and socioeconomic levels, the rate of decrease among white people was faster, thus exacerbating the disparity over time.^{4,5}

There are 2 predominant hypotheses that have formed the basis for why inequities exist. Current data do not support or refute either one. Genomic sequencing has not supported a definite biological construct on which to base disparities. However, there is some evidence that raise questions about possible differences in treatment response, and the need to consider interaction of tumor and host biology.⁶

Others have attributed disparities solely to societal and health care system factors as they relate to unequal access to care. Observed disparities are not fully explained by the correlations between minority race and lower socioeconomic status, or minority race and insurance status (uninsured or publicly insured).⁷ It seems that underserved patients with Medicaid or no insurance present with more advanced cancer and are less likely to receive definitive cancer-directed surgery and/or radiation therapy. In addition, these patients have far worse survival rates.⁸

There is growing evidence to support different outcomes as a result of inequities in the structure of the health care system.⁹ Patients from disadvantaged populations tend to receive care in settings that differ in terms of quality. For example, patients with breast and colon cancer treated at hospitals with large minority populations had higher mortality regardless of race.¹⁰ Patient preferences in treatment and other clinical management options should be considered by providers; however, providers must distinguish between deeply rooted values and transient beliefs that may be amenable to information and intervention.⁴

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