SPECIAL TOPICS IN CANCER CONTROL

There are some topics in cancer control that span the cancer continuum and affect patients at all points of the cancer journey. In particular, access to health care and cancer disparities are two areas that present opportunities and challenges for patients, public health professionals, and health care providers across the continuum. These two topics are highlighted below and are mentioned throughout the Cancer Plan.

ACCESS TO HEALTH CARE

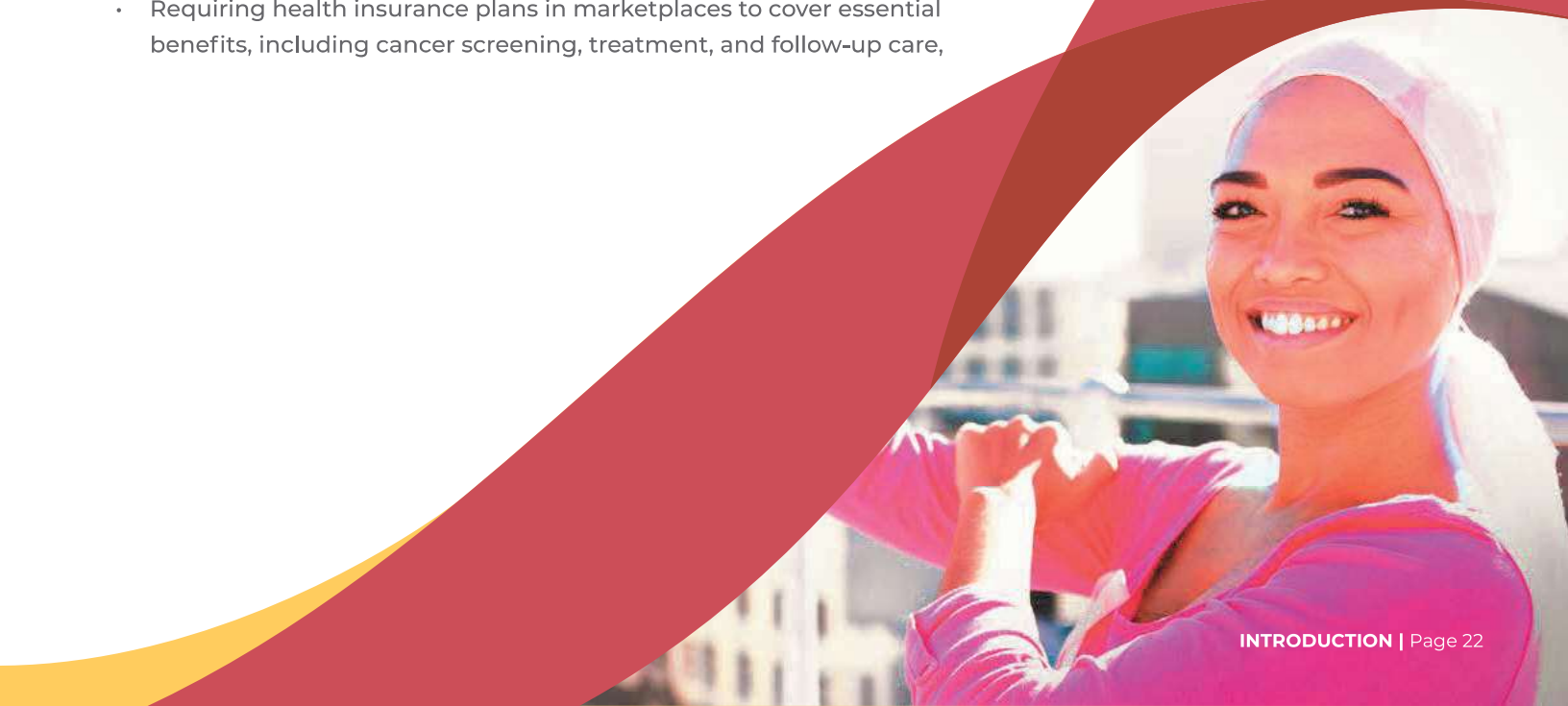
Health insurance coverage helps patients access affordable, quality health care. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, they can be faced with large medical bills. Uninsured people are:

- More likely to have poor health status,
- Less likely to receive medical care,
- More likely to be diagnosed later, and
- More likely to die prematurely.[4]

Access to health care is vitally important for optimal cancer prevention, early detection, and treatment. Uninsured cancer patients are at greater risk to be diagnosed with a relatively more advanced, late-stage cancer due to delays in cancer diagnosis.[5] The uninsured are also at increased risk of financial hardship from cancer treatment.[6]

In 2010, the Patient Protection and Affordable Care Act (ACA) put into place comprehensive health insurance reforms, including several notable provisions that make cancer prevention, screening, diagnosis, and treatment more accessible. These include:

- Expanding Medicaid eligibility for adults,
- Establishing health insurance marketplaces for individuals and small businesses to purchase health insurance plans,
- Requiring health insurance plans in marketplaces to cover essential benefits, including cancer screening, treatment, and follow-up care,



- Prohibiting insurers from refusing to provide health insurance coverage based on a pre-existing condition,
- Offering tax credits to low- and moderate-income families and small businesses to make health insurance more affordable, and
- Making many recommended preventive services available at no cost through most plans.

Maryland's health insurance marketplace, Maryland Health Connection, became operational in 2013 and open enrollment is available each fall, with enrollment available at other times of the year under certain circumstances. In 2019, nearly 157,000 Marylanders were enrolled in a private health plan through the Maryland Health Connection.[7] In addition, in 2019 more than 200,000 people qualified for the expanded Medicaid program, the government insurance for low-income people, helping reduce the number of uninsured people in the state to about 6%.[8,9] See the Maryland Health Connection website for details: www.marylandhealthconnection.gov.

Many newly insured Marylanders may not be aware of the cancer prevention and screening services that are available through their health insurance plan, or of the importance of these services. Health care systems and medical providers are in a strong position to ensure that patients are informed about and take advantage of health insurance benefits by discussing United States Preventive Services Task Force (USPSTF) guidelines with patients and recommending appropriate services.

Preventive services, including cancer preventive services and screenings with a USPSTF A or B recommendation, are now available at no cost through most health insurance plans. These recommendations are included throughout the Cancer Plan, both in the narrative content of each section and in the strategies. The complete list of USPSTF A and B recommendations is available online: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations. All health insurance plans differ, and patients should contact their insurer for details about coverage and out-of-pocket costs including co-payments, deductibles, and coinsurance.

CANCER DISPARITIES

Healthy People 2020 (HP 2020) defines health disparities as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[10] Although not all differences in cancer rates represent disparities as defined by HP 2020, cancer data suggest that Maryland residents in many of these population groups (defined by socioeconomic status, race or ethnicity, geographic location, or sexual orientation) do not have the same opportunities as other populations to make choices that allow them to live long, healthy lives. These population groups face obstacles that prevent them from accessing and receiving effective health services including health promotion, disease prevention, early detection, and high-quality medical treatment and, as such, are faced with poorer health outcomes.

Social Determinants of Health

HP 2020 states that social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[11] Simply put, differences in social determinants of health influence an individual's unhealthy exposures and behaviors, and can lead to disproportionate rates of cancer across a population (Figure 2). Evidence suggests that social determinants of health play a far more pivotal role contributing toward health disparities than biological factors.[12]

Figure 2. Pathway of Social Determinants of Health

The Prevention Institute's Health Equity and Prevention Primer lists four general social determinants of health: Place, Social, Health Care Services, and Equitable Opportunity.[13] These determinants can influence individual exposures and behaviors that can lead to an increase in cancer incidence and mortality.

Place refers to the physical environment that surrounds an individual throughout their life (where they live, work, and play), and includes exposure to water and air pollution (e.g. airborne particulates) and unsafe streets, as well as access to healthy fruits and vegetables (e.g. farmer's markets) and affordable and safe housing (e.g. homes free of radon exposure).

Social is the social and cultural environment of a community and includes familial norms (e.g. cigarette smoking), religion, and trust among neighbors and social networks.

Equitable Opportunity refers to the distribution of opportunity and resources in a community, and includes racial injustice, unemployment, and educational opportunities.

Health Care Services are factors that ensure high-quality, linguistically, and culturally appropriate services for all communities and include access to high-quality cancer screenings and culturally competent interactions with health care providers*.

*Unconscious or unintentional bias on the part of health care providers and public health professionals can impact communication with patients, care provided, and ultimately patient outcomes. Providers may intentionally or unintentionally have and communicate different expectations for patients in disadvantaged populations (defined by race, ethnicity, income, education, etc.), which in turn, may influence patient expectations and/or behavior and lead to health disparities.[14]

Table 1 provides specific examples of each social determinant of health with precipitating unhealthy exposures and behaviors.

Table 1. Example of social determinants of health and precipitating unhealthy exposure and behaviors

SOCIAL DETERMINANTS OF HEALTH	
Type	**Examples**
PLACE	Limited access to healthy fruits and vegetables
	Unhealthy air
SOCIAL	Norms and customs
HEALTHCARE	Lack of health insurance; limited access to care
	Medical providers with poor skills in cultural competency
EQUITABLE OPPORTUNITY	Institutional racism

EXPOSURES AND BEHAVIORS
Unhealthy eating habits contributing to obesity
Exposure to radon
Cigarette smoking among family members
Cancer screenings not completed
Potential for treatment delivery
Limited jobs and housing available for minorities leading to increased stress

INCREASE risk of cancer incidence and mortality

Cancer Disparities in Maryland

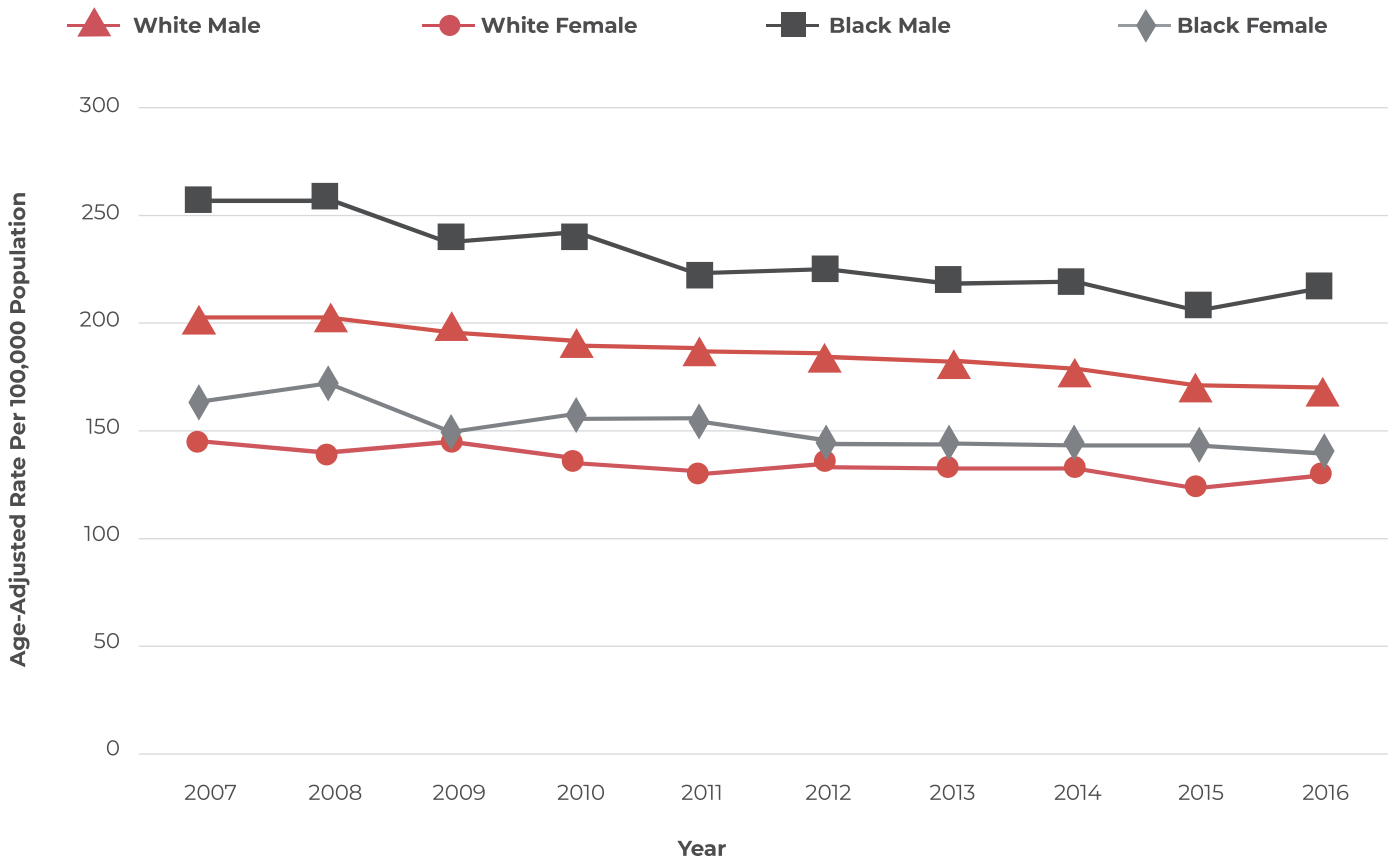
Disparities in cancer incidence, mortality, and screening rates are experienced across many population groups in Maryland, including racial and ethnic minorities; individuals living in Baltimore City, rural, and other geographic areas of the state; and the uninsured. See Section 2 of the Cancer Plan for data on differences and/or disparities in cancer rates. While the availability of data for cancer disparities by language, disabilities, and sexual orientation is not consistently available in Maryland, studies done nationally and in other states have shown that they exist.[15,16,17]

Race and ethnicity

Racial and ethnic minorities are more likely to be socioeconomically disadvantaged, suffer from racial injustice, live in substandard housing, and have less access to high-quality health care. In Maryland, as of 2018, racial and ethnic minorities represented 43.8% of the population. It is estimated that the Black or African American population made up 29.8% of the total population; the Asian population made up 6.2%; the American Indian and Alaska Native population made up 0.3%; the Native Hawaiian and Other Pacific Islander population made up 0.1%; and the Hispanic population made up 9.8%.[18]

- 59% of individuals living below the poverty line are minorities in Maryland.[19]
- Black men and women had higher cancer mortality rates than their White counterparts from 2007 to 2016, and Black men continued to have the highest overall cancer mortality rate among both sexes and racial groups over the last ten years in Maryland (Figure 3). This figure also demonstrates a difference in mortality rates between men and women, with men having higher cancer incidence and mortality rates, although this may not represent a disparity as defined by HP 2020.
- Blacks or African Americans in Maryland had the highest overall cancer incidence and mortality rate of any racial or ethnic group, including White, during the period 2012 to 2016 (Table 2).*

Figure 3. All Sites Cancer Mortality Rates by Race and Sex in Maryland, 2007-2016



Source: CDC WONDER, NCHS Compressed Mortality Files, 2007-2016

*Table 2 suggests lower cancer incidence and mortality rates among other minority populations; however, this may be at least partially an indication of difficulties with accurate data collection among these populations, rather than an indication of health status.

Table 2. Maryland Cancer Incidence and Mortality by Race and Ethnicity, 2012-2016

YEAR 2012-2016		
	Overall Incidence	Overall Mortality
White	453.6	158.6
Black	437.6	179.4
Hispanic/Latino	288.3	75.1
Asian	265.2	86.7
A I/A N	206.2	61.8

Rates are per 100,000 and age-adjusted to the 2000 US standard population.

Source: Maryland Cancer Registry 2012-2016; NCHS Compressed Mortality File in CDC WONDER, 2012-2016

Geographic location

In Baltimore City, an urban, densely populated region, the cancer mortality rate is 33% higher than other parts of the state.[20] Similarly, much of Maryland's rural population also suffers from cancer mortality rates that are higher than the state average.[21] There are likely many underlying differences between geographic areas that lead to disparities in cancer rates, such as the prevalence of poverty in these areas.

Health insurance coverage

A higher proportion of Marylanders with health insurance report being up to date with recommended screenings for colorectal, breast, and cervical cancer compared to those without health insurance.[22]

Populations of Concern for Cancer Disparities

In the past, the subject of racial disparities has focused on racial/ethnic differences in outcome—especially Black-White disparities. There is differential access to health promotion, disease prevention, early detection, and high-quality medical treatment by race, resulting in poorer outcomes.

There is increasing understanding that other groups are also medically underserved and suffer poorer outcomes. Unfortunately, existing databases do not demonstrate these disparities as clearly. Rural Marylanders have greater difficulty accessing health care, both preventive and therapeutic, most often due to distances that must be traveled to see a health care provider. Some of this disparity is also driven by socioeconomic deprivation and issues with cost and affordability of health care.[23]

The lesbian, gay, bisexual, transsexual, queer and questioning (LGBTQ) community, also referred to as sexual minorities, is another group that is medically underserved and suffers disparities in health outcomes.[24] Sexual minorities represent between 3 to 12% of the adult U.S. population.[25] They span all races, ethnicities, ages, socioeconomic statuses, and regions of the United States.

There is insufficient data on sexual minorities in national databases and registries recognized by HP 2020.[26] Sexual minorities, however, do appear to have a higher prevalence of smoking, alcohol use, and obesity. These are factors that increase risk of cancer and are areas in which public health and health care providers might focus. Pregnancy reduces the risk of breast cancer, and there are some data to suggest that lesbians are at higher risk of breast cancer due to a higher likelihood of having never given birth.[27]

Surveys show that many sexual minorities underutilize and delay seeking health care. This is often related to concerns about discrimination and stigma.[28,29,30] The common perception of a barrier to health care access demonstrates the need for culturally competent health care providers and welcoming health care systems. Indeed, health care providers need to focus on providing a safe environment for LGBTQ-friendly services.

By some estimates, as many as one in five U.S. adults has a physical disability.[31] Disabilities in mobility and cognition are the most common. Persons with disabilities also experience significant disparities in cancer outcomes. Disparities in receipt of care (preventive and therapeutic) have been noted.[32,33] The causes include access barriers such as transportation, as well as the perception of prejudice on the part of provider. Again, the health care provider having cultural competence and providing a safe, welcoming environment are important.

Immigrants are also at an increased risk for some cancers because of risk factors they are exposed to in their countries of origin, as well as potential language and cultural barriers to cancer screening.[34] Additionally, health issues and potentially carcinogenic exposures (including sun and pesticide exposure) in the migrant worker population in Maryland are an emerging public health concern.

Interventions and Promising Practices to Eliminate Cancer Disparities

Literature suggests that any efforts to reduce or eliminate cancer disparities without addressing social issues such as poverty, culture, and social injustice are unlikely to be successful.[35,36] Important factors for the success of interventions to eliminate cancer disparities include:

- Conducting a needs assessment to define specific areas of concentration prior to implementing an intervention.
- Data collection, analysis, and reporting that identifies and tracks results for disadvantaged subpopulations.
- Using intensive recruitment and follow-up methods, specifically targeting disadvantaged populations.
- Ensuring community commitment and input, and full involvement in planning from community members, leaders, and stakeholders.
- Educating community members, leaders, and stakeholders on how to advocate for interventions, programs, and policies.
- Ensuring that the intervention is culturally competent by assuring the use of culturally competent intervention staff and educational materials.
- Ensuring adequate diversity of the intervention staff and workforce.
- Employing the use of multidisciplinary teams and multiple strategies.
- Deploying intervention elements that seek to mitigate the harmful effects of adverse social determinants of health. Community Health Worker interventions are particularly promising for this purpose.
- Providing resources that allow the intervention to be sustainable.

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The opportunities presented by health care access and the challenges around cancer disparities are addressed throughout the Cancer Plan. In particular, Section 2 takes a closer look at disparities in cancer incidence, mortality, and screening rates in Maryland.

The remaining content of the Cancer Plan is divided into three sections based on areas along the cancer continuum: primary prevention of cancer; high burden cancers in Maryland; and survivorship, palliative care, and hospice care. As you read through the Cancer Plan, be mindful of opportunities to incorporate objectives and strategies into your work or life!