More than 50 years ago, Martin Luther King Jr said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” Yet more than 30 years after the report from Heckler in 1985 on the national state of minority health in the United States, inequities in cancer care have persisted, widened, and, in some cases, emerged in new areas. Disparities in health status refer to the variation in rates of disease occurrence and disparities between populations defined by demographical, socioeconomical, or geographical factors, most of which exist in populations referred to as minorities and underserved groups. These groups may be classified by race (eg, black, Asian), ethnicity (eg, Hispanic, Ashkenazi Jewish), sexual orientation (eg, gay, lesbian), gender (eg, transgender, gender queer), socioeconomic status (eg, low income, poor, underserved), or age (eg, seniors, adolescents and young adults [AYAs]).

Evidence suggests that health disparities in the United States result from a combination of poverty, limited access to quality care, perceived racism/discrimination, genetics, biology, and environmental exposure. A common thread in health disparities specific to cancer is their multidimensionality and complex nature: covering the lifespan, across the continuum of cancer care from prevention to survivorship, and transcending socioeconomic and transcultural contexts. A growing body of literature suggests that cancer-related disparities are fueled by a multifaceted and concurrent interplay of factors that range from biology and genetics to lifestyle and behavior. As such, intersectionality, a theoretical focus on the interlocking factors of cultural influence and the multiple identities perceived by patients (eg, a racial/ethnic minority who also identifies as a sexual minority), helps explain how these complex realities exacerbate disparities.

It is important to consider reducing health disparities in terms ofmodifiable factors. That is, race and ethnicity do not change, but certain contextual and behavioral aspects, including cancer risk, screening behavior, and cancer care needs, can be identified and addressed. The core of critical interventions requires appropriate attention to the cultural and health literacy levels of individuals and groups. Furthermore, as a community of clinicians, researchers, and educators, we can change the way cancer control and prevention services are delivered by reducing the perceived racism/discrimination and associated stress in minority and underserved populations. Psychological stress caused by perceived discrimination and stereotyping, poverty, and differential access to care can produce higher rates of depression and other morbidities that in turn impact quality of life and health outcomes.

Articles in this issue of Cancer Control examine multiple aspects of health disparities in a variety of racial/ethnic minorities and other underserved patient populations. This issue is a collection of articles that broadly address health disparities in cancer care from 2 perspectives: going beyond race and ethnicity (addressing subethnicity and emerging disparate populations, eg, AYAs, gender and sexual minorities) and addressing multiple points across the continuum of cancer control and contextual factors (eg, geography). These articles explore pathways and mechanisms propelling cancer-related disparities, and they offer summary evidence to address such disparities.

A narrative review of the literature by Dr Hamel and colleagues examines participation in clinical trials and takes a close look at the barriers to enrollment in clinical trials, with an emphasis on the under-representation of racial and ethnic minorities in research studies. The authors identify barriers across 3 levels — system, individual, and interpersonal — and conclude that many of the interventions utilized to address minority accrual to clinical trials have focused on a single level. They suggest that successful interventions must be multilevel.

Dr Schabath and fellow researchers review the literature to summarize the rates of incidence, mortality, and survival among racial and ethnic minorities with lung cancer. Identifying racial and ethnic differences in lung cancer will aid in the creation of effective prevention and treatment strategies that in turn may reduce the overall burden of lung cancer.

Dr Pinheiro and others examine a unique aspect of disparities research by focusing on the subethnic groups within blacks. The authors examined the mortality rates among blacks in the United States (eg, blacks, Haitians, Jamaicans) and compared them with their country of origin. Their research suggests that US-born blacks have the highest risk of cancer-related mortality when compared with blacks from other countries.

Dr Lynce and colleagues summarize what is
known about Latinas and breast cancer, noting the existence of genetic mutations of high and moderate penetrance within this ethnic population. They conclude that reduced awareness and uptake of genetic counseling were observed within this group and that tailored interventions are needed.

Dr Mattingly and fellow researchers summarize the literature on sexual minority women with breast cancer, concluding that limited research exists on this population primarily due to lack of collection of sexual orientation information in databases.

Mr Seijo and coauthors address the lack of banked tissue among racial and ethnic minorities. Their team reports on an established infrastructure for a biobanking hub in the southeastern United States and Puerto Rico to create a web-based database and tissue microarrays for breast cancer.

Dr Borrayo and colleagues examine the determinants of treatment delays among underserved Hispanics with lung and head and neck cancers. They report that women experience longer delays than men. Other observed factors associated with longer delays include fewer comorbidities, receiving treatment at a public facility, and being underserved (eg, uninsured). This article identifies actionable factors amenable to intervention to improve outcomes in disadvantaged Hispanic patients.

Dr Gilbert and others take an innovative approach to addressing racial and ethnic disparities in prostate cancer treatment and outcomes by going beyond the traditional factors of race and socioeconomic factors. Their focus is on the geographic distribution of disparities (ie, how a place of residence interacts with race and socioeconomic factors). Using the Geographic Information System, they illustrate an example showing locations in the state of Florida where disparities in prostate cancer are the most problematic. The authors identify geographical differences in treatment across racial and socioeconomic strata, thus availing a better tool for public health officials, health systems, health care professionals, and policymakers to use when addressing health disparities.

Dr Sharma and coauthors address a less-common cancer and rare disparity in developed nations, penile cancer, in which racial differences exist in both rates of disease incidence and associated survival outcomes. Their chief findings extend beyond racial disparities to include younger age, lower educational and income levels, marital status, lack of circumcision, and a number of sexual behaviors as factors that compound disparities in this disease. This article reminds readers to broaden their view of disparities beyond race and ethnicity.

Dr Kumar and colleagues tackle a topic fraught with clinical and scientific uncertainties: screening, early detection, and prevention of prostate cancer among high-risk African American men. Their work examines biological etiology, biomarkers, and pathways, specifically underscoring the need for chemoprevention agents and strategies. This synthesis identifies unique potential pathways that drive excess risk and burden of disease and the potential of green tea catechins as a chemoprevention agent in African American men diagnosed with high-grade prostatic intraepithelial neoplasia.

Dr Isenalumhe and fellow researchers examine the literature on AYAs with cancer for whom survival rates have not improved as they have in younger and older patients. Disparities in this population range from the unique biology of the cancer itself to delays in diagnoses further exacerbated by the psychosocial needs of this population (eg, reproductive preservation). Their article focuses on identifying these unique needs and the research advancements made to improve outcomes and quality of life in AYAs.

Dr Simmons and coauthors attend to racial/ethnic and socioeconomic disparities in tobacco use, one of the leading preventable causes of lung cancer–related death. Their contribution focuses attention on important disparities that can occur across the cancer continuum—from prevention to survivorship. They synthesize the research that has reduced tobacco-relatedorporation.

Race and ethnicity are terms often interchangeably used, although they describe different but complex concepts. They are often conflated in describing populations in health care and health disparities research. In addition, the criticism is growing about the shortcomings of using these classifications in health research.

Race is a social classification (not a biological category) that describes a person’s observable physical characteristics and identity based on phenotypic genetic characteristics such as anatomical or bone structure and skin, hair, or eye color.

Ethnicity describes the shared identity of a population based on sociocultural factors, linguistic or religious traits, or national heritage, regardless of race that often shape that group’s world-view, lifestyle, and behaviors.

Individuals can be of “mixed race or more than 1 race” and can have more than 1 ethnicity. Advances in genomic and precision medicine are helping to elucidate the genetic and biological basis of health disparities.
disparities, pointing to the limited successes of both pharmacotherapy and behavioral counseling for racial and ethnic minorities, concluding with a critical call for innovative efforts directed at each point along that continuum. These authors remind us of the critical role of culture and socioeconomic status in addition to racial and ethnic status.

The Centers for Disease Control and Prevention suggests the key to reducing cancer-related inequities is to increase screening and early detection, promote healthy behaviors, and expand access to health care for underserved populations and groups at greatest risk. The articles in this issue of *Cancer Control* help us identify the ever-expanding definition of what it means to be “at risk” as well as how minority and underserved populations are disproportionately affected by an excess burden of cancer. These articles also point us in the direction of key areas for expanding cancer care and new research to help us identify and reduce cancer-related inequities. This issue highlights promising strategies for reducing the cancer-related burden and improving the quality of life of all patients. A heightened understanding of both differences and similarities across age, sex, gender, race, ethnicity, socioeconomic class, and sexual orientation is essential to the delivery of equitable cancer care. It is incumbent upon us to focus on ways to reduce the cancer burden and disparities in rates of cancer incidence, morbidity, and mortality so that no one is left behind.

Clement K. Gwede, PhD, RN
Associate Member, Health Outcomes and Behavior Program
H. Lee Moffitt Cancer Center & Research Institute
Tampa, Florida
Clement.Gwede@Moffitt.org

Gwendolyn P. Quinn, PhD
Senior Member, Health Outcomes and Behavior Program
H. Lee Moffitt Cancer Center & Research Institute
Tampa, Florida
Gwen.Quinn@Moffitt.org

B. Lee Green, PhD
Vice President, Diversity, Public Relations and Strategic Communications
Senior Member, Health Outcomes and Behavior Program
H. Lee Moffitt Cancer Center & Research Institute
Lee.Green@Moffitt.org

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