

HEALTH DISPARITIES



Health Disparities

One of the key goals of this SCCA cancer plan is to close the gap in cancer disparities in South Carolina. For the purposes of this report, cancer disparities are defined as differences in the incidence, prevalence, mortality, and burden of major cancers that exist between specific populations. Minority and underserved populations, distinguished by race/ethnicity, socioeconomic status, and geographic location, carry a greater cancer burden than the average American.

According to the NCI Center to Reduce Cancer Health Disparities, underserved populations groups are more likely to “be diagnosed with and die from preventable cancers; be diagnosed with late stage disease for cancers detectable at an early stage through screening; receive either no treatment or treatment that does not meet currently accepted standards of care; die of cancers that are generally curable; and suffer from terminal cancers in the absence of adequate pain control and other palliative care.” (NCI, 2005a)

As a crucial first step in addressing this health gap in South Carolina, the SCCA produced its first Cancer Report Card in 2004, which identified cancers for which racial disparities were greatest in our state. Key findings from the report card and from analyses of cancer registry data include:

- **Prostate Cancer.** In South Carolina, African-American men are much more likely to develop prostate cancer and almost three times more likely to die from prostate cancer than white men.
- **Breast Cancer.** Although white women are more likely to develop breast cancer than African-American women in South Carolina, African-American women are 1.5 times more likely to die from this disease than white women.
- **Cervical Cancer.** In South Carolina, African-American women are 2.5 times more likely to die (or have a 250 percent greater risk of dying) from cervical cancer than white women.
- **Esophageal Cancer.** Both incidence and mortality rates are at least twice as high for African Americans as for whites. Incidence rates for a certain type of esophageal cancer (squamous cell) are six times higher for African-American men than whites (SCCA, 2004)
- **Oral/Pharynx Cancer.** African-American men in South Carolina have higher rates of dying from oral/pharynx cancer than whites, and this health disparity is significantly higher in South Carolina than the rest of the nation (SCCA, 2004).

These findings are reflected in cancer incidence and mortality data for South Carolina/US (Tables 1 and 2), which provide summary data for six cancer sites. For more detailed data on cancer disparities in South Carolina and implications for cancer research, please refer to the July 2005 e-Journal of the South Carolina Medical Association (<http://www.scmanet.org/>).

Cancer Incidence

Incidence for all major cancers in South Carolina, except female breast cancer, is higher among African-Americans than all other groups (Table 1).

Table 1. Cancer Incidence: Age-adjusted incidence rates* ** and number of incident cases (*italic*) for selected cancers in SC by race/ethnicity. SC 1996-2001 rates, compared to 2001 US rates.

Race/ ethnicity	Lung/Bronchus				Colorectal			
	SC	US	SC	US	SC	US	SC	US
	Men	Men	Women	Women	Men	Men	Women	Women
	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
	N		N		N		N	
All Races	106.4	87.7	48.1	53.2	65.8	62.7	45.4	45.8
	10561		6293		6286		5938	
Black	110.3	109.0	34.7	47.7	69.4	66.7	50.1	52.0
	2352		1090		1459		1578	
White	105.1	86.8	52.2	54.6	64.4	62.2	43.7	45.0
	8158		5157		4764		4309	
Hispanic***	35.9	52.0	--	24.8	32.7	51.6	18.5	34.6
	23		12		24		16	
Asian or Pacific Islander	81.3	50.4	46.6	25.2	82.4	46.7	37.9	33.9
	35		31		35		29	

Race/ ethnicity	Prostate		Oral		Breast		Cervical	
	SC	US	SC	US	SC	US	SC	US
	Men	Men	Men	Men	Women	Women	Women	Women
	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
	N		N		N		N	
All Races	175.5	161.2	19.5	15.3	123.0	127.2	11.2	8.4
	17,338		2,030		15,696		1,395	
Black	264.1	234.1	24.8	17.3	108.0	106.7	15.4	11.9
	5,385		602		3,505		515	
White	148.1	151.8	17.9	15.0	127.2	129.9	9.7	8.0
	11,578		1,412		12,023		839	
Hispanic***	89.7	129.6	--	11.3	61.3	86.6	11.6	11.8
	54		10		54		17	
Asian or Pacific Islander	287	85.0	--	9.5	122.1	78.1	22.8	7.5
	86		10		100		22	

* The following suppression □

** Incident Data are subject to change as datasets are updated. Data originates from the 1996-2001 masterfile (finalmaster2004).

**Rate per 100,000 population, age-adjusted to 2000 US standard million, using 19 age groups.

**Cells with 15 or fewer deaths do not have rates due to the instability of small numbers when calculating rates.

***Hispanic origin is not mutually exclusive from race categories (white, black, Asian/Pacific Islander).

Cancer Mortality

Cancer death rates for all major cancers in South Carolina, except lung cancer, are higher among African-Americans than all other groups (Table 2).

Table 2. Age-adjusted mortality rates* ** and number of deaths (*italic*) for selected cancers in South Carolina by race/ethnicity (SC 1996-2001, US 2002).

Race/ ethnicity	Lung/Bronchus				Colorectal			
	SC	US	SC	US	SC	US	SC	US
	Men	Men	Women	Women	Men	Men	Women	Women
	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
	N		N		N		N	
All Races	93.0	73.5	38.4	41.5	26.7	23.8	17.7	16.5
	8983		5053		2396		2333	
Black	104.0	95.7	28.1	40.2	33.9	33.4	21.8	22.8
	2176		879		676		689	
White	90.2	72.7	41.8	42.6	24.8	23.2	16.4	16.0
	6782		4160		1717		1636	
Hispanic***	---	36.7	---	14.8	---	17.1	---	11.2
	10		10		10		10	
Asian or Pacific Islander	41.1	36.6	---	17.6	---	15.9	---	10.1
	18		10		<5		10	

Race/ ethnicity	Prostate		Oral		Breast		Cervical	
	SC	US	SC	US	SC	US	SC	US
	Men	Men	Men	Men	Women	Women	Women	Women
	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
	N		N		N		N	
All Races	40.7	28.1	6.2	4.1	27.3	25.5	3.6	2.5
	3068		623		3519		452	
Black	82.9	63.0	12.1	6.3	35.7	34.1	6.5	5.0
	1360		284		1149		213	
White	29.4	25.8	4.4	3.9	24.3	24.9	2.6	2.3
	1702		335		2360		232	
Hispanic***	---	22.0	---	2.7	---	15.7	---	3.2
	10						<5	
Asian or Pacific Islander	---	10.3	---	3.2	---	12.9	---	2.3
	<5		<5		10		10	

* The following suppression □

** Mortality Data originates from the 1996-2003 cancer mortality file

**Rate per 100,000 population, age-adjusted to 2000 US standard million, using 19 age groups

**Cells with 15 or fewer deaths do not have rates due to the instability of small numbers when calculating rates.

*****Rates will not match SC published data for Whites, Blacks and All Races combined.

*** Hispanic origin is not mutually exclusive from race categories (white, black, Asian/Pacific Islander).

Population data from SEER/NCI bridges population estimates.

Health Disparities

Socioeconomic Status and Disparities

The reasons for the staggering disparities in cancer rates in South Carolina are multi-faceted and not completely understood. Causes ranging from behavioral factors to genetic susceptibility to environmental exposures have been suggested, and may all play significant roles. At the same time, the complex interplay between socioeconomic status and health cannot be disregarded. (NCI, 2005a).

Health factors associated with socioeconomic status include reduced access to care, delayed diagnosis, and disparities in treatment (ACS, 2005b). The social environment, including deeply rooted cultural beliefs and expectations, contribute to and compound these factors.

Poverty. Over 14 percent of South Carolinians live below the poverty level. African Americans are far more likely to live in poverty than whites in South Carolina: 26.4 percent of African Americans live below the poverty level, compared to 8.6 percent of whites (SC Budget and Control Board, 2002).

Access to Care. An estimated one in five South Carolinians are uninsured, according to the SC Department of Insurance. For people living on the edge, regardless of race, health care is seen as a luxury, rather than a necessity. In a recent study, almost half of uninsured adults with chronic conditions reported that they went without needed medical care or prescription drugs due to cost (RWJ, 2005). The underinsured are also at risk. Even with coverage, people may delay getting tested or treated for cancer because they cannot afford co-payments, cannot afford to take time off work for appointments, or may have no way to reach medical facilities.

Geographic Isolation. In rural areas of the state, lack of transportation can restrict access to care. Public transportation is usually sparse or nonexistent in rural areas, and fewer residents own or have access to vehicles. Across all rural South Carolina counties, the percentage of residents who lack a vehicle ranges from 6 to 22 percent, with an average of 15.2 percent in majority African-American counties (SOHR, 2001).

Disparities in Stage at Diagnosis. SCCCRC data from 1998-2001 indicate that whites are more likely to be diagnosed with early-stage cancer than African-Americans. From 1998-01, 46.4 percent of whites were diagnosed in early stage (all cancers) compared to only 39.5 percent of African-Americans.

Disparities in Treatment. There is compelling evidence that minorities receive a different standard of health care than whites in America, even when income, insurance, and access are equal (IOM, 2003). A number of factors are thought to contribute, but there is evidence that bias and stereotyping drive these differences. The SCCA is committed to finding solutions to this disturbing and critical issue in cancer care through collaboration between the African American community, research and public health groups, and the medical and allied professional fields.

Health Disparities

Strategies for Action

These issues underscore the compelling need for a focused plan to eliminate cancer disparities in South Carolina. SCCA strategies span the spectrum of cancer prevention and care in South Carolina, from finding new ways to reach underserved rural people for cancer screening and care, to cutting-edge cancer research. Community-based participatory research shows particular promise in addressing health disparity issues in South Carolina. Collaboration is vital to this approach, especially partnership with the faith community, which is often the heart of African-American community in South Carolina.

Examples of strategies include:

- Informing and engaging local organizations and faith communities about the growing gap in health disparities in South Carolina and the need for cancer information, screening, and treatment services.
- Encouraging lifestyle changes to reduce risk factors including tobacco use, physical inactivity, and poor nutrition.
- Creating targeted public and professional education campaigns, with culturally appropriate messages for ethnic/racial/religious groups in South Carolina.
- Improving early cancer detection through screening procedures, increased access to screening and treatment services, and informed patient/client decision-making.
- Addressing transportation barriers for underserved cancer patients.
- Encouraging the participation of racial/ethnic minorities in research at all levels, from community-based interventions to clinical trials.
- Encouraging more minorities to enter the medical and allied professional fields.
- Encouraging more minority scientists to engage in public health research in South Carolina, particularly in research addressing health disparity issues.

In framing this plan, a commitment was made to use the best evidence available at this time to guide recommendations, including resources from the *Guide to Community Preventive Services*, *Promising Practices in Chronic Disease Prevention and Control*, and recommendations from the US Preventive Services Task Force. The SCCA is committed to designing flexible strategies and to reframe these strategies as new research emerges and new community partners join in these efforts.

Health Disparity Objectives

A number of the objectives in this section are listed elsewhere in the plan under the relevant sections (i.e., Prevention, Early Detection). They are restated here to emphasize the commitment of the members of the SCCA to respond to these inequalities in health measures. Members of the Health Disparities work group will monitor and assist other task forces in ensuring disparities are addressed through this long-range plan.

Health Disparities

Awareness

“The unequal burden of disease in our society is not just a scientific and medical challenge. It also presents a moral and ethical dilemma for our Nation.”

Making Cancer Health Disparities History, 2004

In South Carolina, African-American men are more likely to be diagnosed with prostate cancer than white men and are almost three times more likely to die from this disease. (from report)

Objective 1. By June 2006, increase public and professional awareness about cancer health disparities and cancer prevention, treatment, and screening.

Strategy 1. Collaborate with government agencies, schools of public health and medicine, community groups, and the faith community to educate the public and professionals about topics related to health disparities and cancer. These include:

- The importance of social, economic, and environmental factors influencing community health;
- The role of behavioral and biological factors in deterring cancer risk;
- Types of interventions and strategies that can reduce the risk for developing cancer.

Strategy 2. Provide current and accurate information about cancer prevention and treatment issues.

Strategy 3. Identify best practices for health communication and interventions for minority populations to improve service delivery strategies and resource allocation.

Strategy 4. Encourage schools of public health and health sciences (medicine, nursing, etc) to better coordinate programs and recruitment activities with Historically Black Colleges and Universities.

Health Disparities

Prevention

Objective 1. By June 2006, develop collaborative relationships with at least four statewide and local community and state entities with similar missions and goals for physical activity and nutrition policies in South Carolina.

Strategy 1. Promote policies and legislation that provide safe, enjoyable, and accessible environments for physical activities in schools and for transportation and recreation in communities (i.e., Green Spaces; walking paths).

Strategy 2. Develop collaborative relationships to initiate programs to promote healthy eating patterns, including the consumption of recommended quantities of fruits and vegetables.

Objective 2. By June 2010, decrease the rate of tobacco use among adult South Carolinians (age 18+) from 26% to 12% (SC BRFSS, 2003).

Strategy 1. Increase awareness among African-American men about the dangers of mentholated cigarettes, through targeted media campaigns.

Strategy 2. Increase local presence and activity in communities through development of local tobacco coalitions.

Strategy 3. Increase capacity and diversity of local tobacco coalitions in coordination with the SC Tobacco Collaborative.

Objective 3. By June 2010, increase the proportion of the SC population that consumes at least five servings of fruits and vegetables from 23.9% to 50% (SC BRFSS, 2003).

Strategy 1. Promote adequate nutrition intake among children and adults, targeting African-Americans.

Strategy 2. Promote the integration of healthy eating habits within the routine health education given by health care providers.

Objective 4. By June 2010, increase the proportion of adults who engage regularly in moderate physical activity for at least 30 minutes per day from 24.1% to 30% (SC BRFSS, 2003).

Strategy 1. Develop partnerships with city planners, and transportation entities to modify environments and promote policies that support physically active lifestyles.

Strategy 2. Work with communities and law enforcement agencies to provide safe, convenient areas to enhance physical activity.

Early Detection

Objective 1. By June 2010, increase the proportion of women age 40+ who have received a clinical breast exam (CBE) within the preceding two years from 77.4% to 82% (SC BRFSS, 2002).

Strategy 1. Promote core competencies in CBE for providers; integrate CBE materials developed through the Breast and Cervical Cancer Early Detection Program (BCCEDP) into medical and nursing graduate education, and residency training programs.

Strategy 2. Identify and address barriers to the implementation of CBE training for continuing medical education.

Strategy 3. Collaborate with faith-based organizations, breast cancer service providers, and community organizations to recruit women who are rarely or never screened.

Objective 2. By June 2010, increase the proportion of women age 40+ who have received a mammogram within the preceding two years from 76% to 80% (SC BRFSS, 2002).

Strategy 1. Identify data sources in addition to BRFSS to establish more accurate mammography screening rates in SC.

Strategy 2. Implement findings from SC research on efficacy of public education campaigns to promote breast cancer screening, focusing on groups at highest risk for not being screened (i.e., small media campaigns; faith-based outreach).

Strategy 3. Collaborate with the Advocacy/Policy Task Force to seek state funding to extend mammography services comparable to BCCEDP to uninsured women who do not qualify for the program.

Strategy 4. Develop a campaign with the SC Medical Association, SC Nurse's Association, Physician Assistant associations, and the Carolina Medical Review to promote mammography referral for all women 40+ seen by providers in primary care or internal medicine practices.

Early Detection

Objective 3. By June 2010, increase the proportion of women at risk for cervical cancer (including never/rarely screened* who comprise but are not limited to racial/ethnic minorities, uninsured, age-specific and rural populations) who have received screening services within the preceding three years from 83% to at least 90% (SC BRFSS, 2002).

*** Never/Rarely screened includes women who have never had a Pap test and those who have not had a Pap test in the past five years.**

Strategy 1. Collaborate with faith-based organizations and community organizations, and other community partners to disseminate cervical cancer information.

Strategy 2. Collaborate with the Research Task Force to:

- Identify areas/sub-populations who are at highest risk for not being screened for cervical cancer;
- Utilize community-based participatory research activities and findings to identify factors contributing to the disparities;
- Adapt and implement evidence-based interventions relevant to South Carolina's at-risk population.

Strategy 3. Engage and support community and program partners in existing cervical cancer screening efforts and priorities to reach never/rarely screened women for Pap tests. Program partners can include the Breast and Cervical Cancer Early Detection Program, Team-Up Project, Witness Project, Community Networks Program, and other programs as they are identified.

Objective 4. By June 2010, increase the proportion of men newly diagnosed with prostate cancer at the localized stage from 72.6% to at least 75%.

Objective 5. By June 2010, raise men's awareness of the need to make informed decisions about screening for prostate cancer.

Strategy 1. Convene a task force of experts to include African Americans and community activists to review current national screening guidelines and make recommendations for implementation of guidelines for best practice in South Carolina.

Strategy 2. Add a question to BRFSS to learn what SC males 40+ know about their personal risk for prostate cancer.

Strategy 3. Support dissemination of new information to provide the public, and especially African-American males, with evolving science, technology, and guidelines for prostate cancer.

Early Detection

Objective 6. By June 2010, increase the proportion of oral/pharyngeal cancers newly diagnosed among African-American males at early stage (in-situ or localized) from 22.1% to at least 30%.

Strategy 1. Collaborate with dental and medical associations and other health organizations to promote public and professional awareness of risk factors for oral/pharyngeal cancer.

Strategy 2. Support dissemination of new information to provide the public with evolving science, technology, and guidelines for prevention/ early detection of oral/pharyngeal cancer.

Strategy 3. Collaborate with faith-based organizations and community organizations to raise awareness about oral/pharyngeal cancer.

Objective 7. By June 2010, increase the proportion of esophageal cancers newly diagnosed among African-American males at early stage (in-situ or localized) from 20.5% to at least 33%.

Strategy 1. Monitor ongoing science and research regarding the early detection and treatment of precursors to esophageal disease and the possible efficacy of screening/detection methods for esophageal cancer.

Strategy 2. Support dissemination of new information to provide the public with evolving science, technology and guidelines for prevention/ early detection of esophageal cancer.

Strategy 3. Collaborate with faith-based organizations, community organizations, and employers in targeted geographical areas to reach high-risk, African-American males concerning risk factors.

Patient Care

Objective 1. By 2006, assess and address the magnitude of indigent cancer care to improve access to care.

Strategy 1. Conduct a literature review to establish the state of indigent cancer care.

Strategy 2. Create a workgroup to review and analyze appropriate and relevant data:

- Collaborate with and assist the SC Central Cancer Registry (SCCCR) in securing the appropriate resources to compile the data.
- Identify sources of free care and ascertain related cost and charges.
- Conduct data linkage between Hospital Discharge Data (1996-2002) and SCCCR incident cases (1996-2001).
- Analyze linked data, report by payer status, race, cancer type, and stage.

Strategy 3. Identify existing resources in communities to promote access to care in South Carolina.

Strategy 4. Work with other partners to advocate for a cancer Medicaid waiver in South Carolina.

Objective 2. By 2006, identify and address transportation barriers for cancer patients.

Strategy 1. Survey radiation oncology centers on issues related to patient transportation.

Strategy 2. Cultivate networks within communities in order for them to develop their own transportation solutions.

Strategy 3. Distribute, periodically update, and educate health care providers on additional transportation resources.

Strategy 4. Re-survey radiation oncology centers routinely to assess changes.

Health Disparities

Advocacy and Policy

Objective 1. To secure sustained legislative support to extend Medicaid coverage for treatment of breast and cervical cancer to all indigent women in South Carolina. Through the collaborative efforts of the SCCA, this objective was achieved for FY2006-2007.

Strategy 1. Educate key legislators and program officials to maintain support for the coverage.

Objective 2. By June 2007, secure legislative support to extend Medicaid coverage for screening, early detection, and treatment of colorectal cancer to indigent persons.

Strategy 1. Research the experiences of other states on obtaining Medicaid coverage; develop a briefing paper on issue.

Strategy 2. Educate key legislators and program officials to gain support for the coverage.

Strategy 3. Explore option of using tobacco tax increase (excise/sales tax) and/ or Tobacco Settlement funds for the required state match.

Research

Objective 1. By June 2006, re-publish reports prioritizing cancer research in South Carolina in a hard copy of the Journal of the SC Medical Association.

Note: These reports were originally published in a special on-line symposium (July 2005) issue of the journal. This republication will allow comments from the communities/ constituencies involved to be incorporated into the final papers. To our knowledge, this is the first time that community-based participatory research (CBPR) has been part of the process of developing research priorities and strategies.

Objective 2. By June 2006, the SCCA will launch/sponsor a public relations campaign to educate the South Carolina public about scientific research and participation in cancer research studies.

Strategy 1. Hire public relations firm/individual to work with the SCCA to develop/create the core purposes of the campaign and its priority messages.

- Compose culturally appropriate messages for ethnic/ racial/religious groups in South Carolina;
- Assure that messages will be understandable to low health literacy audiences;
- Develop timeline and target areas for campaign rollout;
- Create media pieces for above campaign (radio, TV, print);
- Implement timeline in targeted areas;
- Evaluate effectiveness of campaign;
- Revise/edit campaign and rollout to rest of state.

Strategy 2. Create a model recruitment campaign that capitalizes on the statewide generic campaign above, which can be used by a variety of research disciplines in cancer control.

- Determine effective messages and culturally appropriate methods of communicating research information;
- Offer research seminars at Historically Black Colleges and Universities (HBCUs) in South Carolina to raise research awareness and increase interest in pursuance of cancer research careers among minorities;
- Make research findings available for dissemination through community-based organizations and outreach projects (posters, brochures, etc.).

Research

Objective 3. By October 2007, develop a core resource that will assist cancer researchers with the recruitment, retention, and compliance of human subjects into cancer research protocols of all types.

Strategy 1. Build on existing resources, and create new core competencies to assist basic science researchers, clinician scientists, and population-oriented researchers with recruiting human subjects into a variety of studies.

- Promote recruitment into cancer research protocols of all types through outreach projects, community health initiatives, and telephone surveys.
- Determine the demographic characteristics of people participating in clinical trials across the state.
- Increase by 15% the number of minorities participating in cancer clinical trials.
- Increase by 15% the number of cancer screening, prevention, and treatment clinical trials that target African-Americans.

Objective 4. By 2008, establish and maintain closer partnerships among researchers, communities, and community leaders.

Strategy 1. Develop and encourage relationships with community gatekeepers.

Strategy 2. Establish a caucus of community members, gatekeepers, and researchers to address community problems and expand knowledge related to cancer research and control.